

comment

“Are personal health budgets a cost effective use of public resources?” **DAVID OLIVER**

“We still err on the side of safety rather than personal autonomy” **HELEN SALISBURY**

PLUS The broken pension covenant; No deal Brexit: the greatest concern is medicines

TAKING STOCK Rammya Mathew

Empathy is vital to being a good doctor

The aspiration to be a good doctor is probably common to us all, but what does it really mean? Has anyone defined “good?” I’m reminded of many personal statements I’ve read over the years in which students, vying for a highly sought after place in medical school, claim to be cut out for the job because they’re empathetic or willing to go the extra mile to help others.

Empathy is an ambiguous concept, but in medicine it can be loosely defined as an emotional experience between clinician and patient, where the clinician identifies with and transiently experiences the patient’s emotional state. Importantly, it’s thought to increase one’s motivation to help others, so it’s no surprise that empathy and altruism tend to go hand in hand.

Empathy is also a trait highly valued by patients, yet evidence indicates that doctors often lack it and that it declines throughout our medical training. Is there something wrong with the way we train doctors, or is it normal for our empathy to decrease with repeated and sustained exposure to emotions such as grief, pain, suffering, and fear—which we encounter almost every day through our interactions with patients?

In my own consultations I’m aware that I sometimes forget the clock and give patients the time they need because it feels like the right thing to do. But admittedly I’ve sometimes brushed aside cues, knowingly or unknowingly, that should have been greeted with empathy—perhaps because I was tired, stressed, running late, or simply unable to give any more that day. Does that make me an unempathetic or bad doctor?

As healthcare professionals, it feels as though we do very little to cultivate our empathy or to prevent it from being eroded by the various environmental stressors we face. I wonder whether the emergence of mindfulness in new medical school curriculums will better equip prospective doctors to maintain

their empathy levels in a high pressure, emotionally charged working environment.

We’ll never get it perfect all of the time, but it feels as though we should be giving as much of ourselves as we can, so that we feel fulfilled in our jobs and our patients feel cared for—but not so much that we become burnt out and emotionally depleted. This is important for our own wellbeing, but is also central to our vocation, which is about alleviating suffering, not just curing disease.

Arguably, Edward Livingston Trudeau’s philosophy, “to cure sometimes, to relieve often, to comfort always,” may be overly idealistic—but it does bring home the need to understand and nurture our capacity for empathy, when pursuing our aspiration to be “good” doctors.

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We seem to do very little to cultivate our empathy or to prevent it from being eroded by the various environmental stressors we face

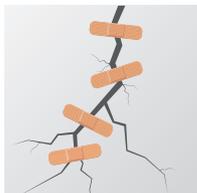


Reform pension tax quickly to ease doctors' sense of injustice

It's sobering that the government changed the system, imposed tax changes, and dismissed lifelong commitment to the NHS

I am one of thousands of senior doctors facing a situation where my pension, once perceived as a benefit for long and committed service to the NHS, is now a liability. The combination of an imposed new pension scheme and a fiendishly complex regime of punitive taxation on pension growth has caused me to question the true reward for working hard for the NHS.

My trust in "the system" is rapidly evaporating. The covenant was that you worked long and hard, dedicating your life to the NHS; in return you received a reasonable



income and a comfortable retirement. It's a sobering realisation that the government can ignore the covenant, change the system, and impose tax and pension changes, dismissing your lifelong commitment.

Employed doctors in the NHS have lived with simple tax affairs.

Employers remove tax at source, there is a limited range of tax deductible expenses, and there is no real need to engage with financial experts. Into this came tapering annual allowance, two pension schemes, and myriad financial complexity—a system so complex that advisers, pension experts,



and even Her Majesty's Revenue and Customs have calculated tax charges incorrectly. Many doctors were blissfully unaware of the problems until huge unexpected tax bills began to appear on their doormat

In *The Wealth of Nations* Adam Smith described the four "canons of taxation" as equality, fairness, convenience, and efficiency. The NHS pensions regime in 2019 meets none of these ideals. The tax on NHS pensions is difficult to predict, requiring information that is available only six months after the end of the tax year, making it too late to actively change the liability. The annual allowance has been shrinking since 2010, but the then chancellor George Osborne lit the fuse for this crisis in 2016 when he introduced tapering of the annual allowance.

Spiral of taxation

Now, all income is used to determine our personal pension tax allowance, including non-pensionable pay. Even pension growth is counted as earnings. This creates something of a spiral of taxation: the more our pensions grow, the less they are allowed to grow without being hit by additional tax.

The annual allowance tapering rules have created cliff edges where small increases in income can create a pension tax bill larger than the extra earnings. Once in the taper zone, the pension tax bill will become an annual feature of staying in the NHS pension scheme. The only control a doctor can exert is to change their income by working less.

The government's own impact statement predicted there would be behavioural responses, such as "reducing contributions" and those "in the taper region reducing their incomes." There is no specific mention of the

No deal Brexit: the greatest concern is medicines

The leak of a secret document on the effect of a "no deal" Brexit sent the UK government's news management operation into overdrive. The document is reported to predict significant disruption of medicines lasting up to six months, with HGVs facing a delay of up to 1.5 to 2.5 days at the border. These problems will impact on many sectors, however, for health professionals, the greatest concern is medicines.

Medicines have several characteristics that make them especially vulnerable to supply chain threats. These can be fatal, something that is observed every day in many low income countries where procurement, transport, and

supply problems allow sub-standard medicines to reach the market—for example, because of breaks in cold chains. They also encourage the activities of organised crime syndicates, diverting genuine medicines to the black market or introducing counterfeits. The UK's departure from systems for sharing intelligence will make this more difficult to detect.

As the leaked document conceded, the requirement to apply Good Distribution

It is simply not good enough for ministers to say that these documents are wrong. They must provide ones that are right

Practices makes it impossible to stockpile many medicines. This calls into question the frequent reassurances by ministers that this is happening.

The fundamental problem with medicines is that, in an increasing number of cases, one cannot be substituted for another. The pharmacogenomics revolution has seen a transformation of cancer care. Drugs are targeted to individual molecules that can vary widely within what appears to be the same type of cancer. Giving the wrong one is useless. In some cases, even a small change in formulation can have serious effects. Added to this is the fact that supply chains for



The covenant was that you dedicated your life to the NHS for a reasonable income and a comfortable retirement

impact on those in public service defined benefit schemes, such as the NHS pension.

Classic economics, where decisions are based on cold headed logic, don't apply here. A behavioural economic model looking at the psychology of deliberate complexity, the perceived unfairness, multiple changes, and severe penalties if we get complex calculations wrong helps explain why doctors may take the "safe and simple" option of reducing sessions or coming out of the scheme, even if they are financially worse in the long run.

Recent surveys by the BMA and NHS Employers show around a third of senior doctors have cut their hours in response to pension taxation, with another third planning to do so next year. In an NHS where at least 10% of consultant and GP posts are unfilled and that relies on consultants doing 20% of their clinical work as overtime, it doesn't require an economics degree to see that the staffing crisis will be hit hard and fast.

Largely as a result of BMA lobbying, the new prime minister has signalled the need for reform. It needs to be swift and it needs to be effective, because even if the financial landscape is changed for the better, the sense of injustice, coupled with the unpredictability of behavioural economics, might result in a more permanent dearth of skilled doctors. That would be bad for the medical profession, bad for patients, and bad for the NHS.

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many medicines are fragile at the best of times. With thousands of different products, ensuring that supplies are adequate and get to the right place at the right time is immensely complex. Even now, there are shortages of hormone replacement therapy, a very commonly used treatment.

It is simply not good enough for ministers to say that these documents are wrong. They must provide ones that are right. The health secretary Matt Hancock has frequently said that all will be well if everyone does what they need to do. Maybe he could explain how on earth they will do that if the government's assessments are secret?

Martin McKee is professor of European public health at the London School of Hygiene and Tropical Medicine

ACUTE PERSPECTIVE David Oliver

Evaluating personal health budgets

A key component of the NHS long term plan was a set of commitments on personalised care. These included a target for 200 000 people to benefit from personal health budgets by 2023-24. The current number is around 40 000.

This raises questions. Will these budgets benefit the right people? Will they introduce risks or bring opportunity costs for other service users? Are they a cost effective use of scarce public resources? Are any safeguards required?

In England, personal budgets and direct payments linked to personalised care plans have existed in social care for some time. They were partly a response to depersonalising, paternalistic care that didn't give people the choice and control they wanted. The Care Act 2014 made personal care budgets mandatory for all eligible recipients. Unlike the NHS, English social care remains means tested and based on eligibility criteria. Around a quarter of all spending on home based adult social care is directly paid.

Positive stories abound from recipients of the budgets. Many say it's helped transform their lives and care, giving them more control. Some healthcare professionals have a very positive view of the potential to revolutionise how they offer treatment, care, and support.

NHS England plans to build formal evaluation into its expansion plan for the budgets. But we already have intelligence from earlier multicentre pilots and evaluations,

summarised by the University of Kent's Personal Social Services Research Unit. And the National Audit Office reported on personal care budgets in 2016. Its conclusions were mixed, showing such budgets could improve the holder's experience and save money, but could also increase costs and be hard to administer. Any benefits were likely to come from improved outcomes for users, not from savings.

Critics question whether it's prudent to spend NHS funds on relatively poorly evidenced models of support when we're failing to provide well proved services. Some fear giving money to individuals is ideologically driven and represents further fragmentation and stealth privatisation.

There's also concern that direct payments may leave vulnerable people with a heavy responsibility adding to their stress, especially without adequate support. And, without sufficient safeguards, people could use their money frivolously or buy substandard care from poorly regulated sources. Advocates see these issues as a paternalistic failure to cede control.

Me? I don't think that personal budgets in health and social care, or newer integrated budgets covering both, will be the norm any time soon. I'm less interested in ideology and more concerned about pragmatic, transparent evidence on the value they offer users, coming from scarce public resources—and about the implications and costs for other users needing health and social care.

What do readers think?

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I don't think personal budgets in health and social care will be the norm any time soon

Balancing safety with autonomy

If a 90 year old is climbing ladders, should your first instinct be to congratulate her or to warn her of the dangers? I discussed this recently with a friend, whose elderly patient kept chickens that took to roosting in the trees. On balance, we agreed that the benefit of tending her allotment and chickens probably outweighed the risks of ladder climbing, even though her balance wasn't what it used to be.

Nearly five years after the publication of Atul Gawande's *Being Mortal*, with its urgent call to reconsider how our society treats older people, we still tend to err on the side of safety rather than autonomy.

I've watched as patients variously submit to, or battle against, the restrictions that family or services seek to impose on their activities for safety's sake. When they're falling at home and calling on emergency services more frequently, there comes a point when those around them agree that it's no longer safe for them to remain independent. The safety involved here is physical, avoiding the risk of broken hips and head injuries.

Perhaps we're also considering the psychological wellbeing of the people who feel responsible: family, social workers, and a GP who would otherwise be worrying about what might happen to the frail person left unattended. There are resources to consider too, and after the umpteenth call-out to paramedics in a month, the costs mount up.

I have a secret admiration for my patients who steadfastly hold on to their independence

But what about the psychological wellbeing of the patient? Unless there's enough money and space to support live-in carers, a care home beckons. Moving to an institution usually means multiple losses: only a small space now counts as yours, and you may have little control over who enters it. Food, not of your choosing, is served at times that fit in with the smooth running of the home but not necessarily when you're hungry.

Although they worry me (and I have huge sympathy for their families), I have a secret admiration for my patients who steadfastly hold on to their independence, refusing to do the sensible thing and let others care for them. As long as they have capacity these patients choose autonomy, and a daily struggle against faltering abilities, rather than graceful acceptance of their decline. I remember one patient from years ago, who lived in chaos but was completely preoccupied with the academic paper he was writing. I suspect that the conference he was preparing for existed only in his imagination, but it gave him purpose and a reason to get up each day.

Perhaps, instead of focusing solely on safety—which appears near the bottom of Maslow's hierarchy of human needs—we should also set our sights higher and understand the necessity of freedom and purpose.

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LATEST PODCASTS



Sustainable health

Climate change continues to be at the forefront of the news agenda so this podcast takes a timely look at the environment. Among the interviewees is Gillian Leng, deputy chief executive and director of health and social care at the National Institute for Health and Care Excellence (NICE). She wonders if we should be doing more to evaluate the impact that treatments have on the planet:

“What we haven't got at the moment is a really good way of measuring the environmental impact of drugs and pharmaceuticals, which would let us draw comparisons. I'd really like to be able to encourage the industry to start recording that and perhaps at some point in the future NICE could build it into our appraisal. Whether [a treatment's] impact on the environment would ever override the benefits to patients is debatable, but it might be one of the factors that makes clinicians choose one thing over another.”

Burnout: Don't try to make the canary in the coal mine more resilient

Burnout is a problem in healthcare, but unlike other patient safety issues we tend to conceptualise it, and try to prevent it, at an individual level. A recent analysis article in *The BMJ* urged us to start treating burnout as a systems level problem. In this podcast we talk to two of the authors, including Christina Maslach who explains how she'd define burnout:

“We're talking about how people deal with a workplace that increasingly is out of whack with what human beings are capable of. Burnout is a warning sign telling you that something is not going well within the larger job environment in which people are working. And so the problem becomes focusing on what's going on in that job environment and not simply just saying, ‘Well gee, you're not strong enough, go back and get more sleep, take care of yourself.’”



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Edited by Kelly Brendel, deputy digital content editor, *The BMJ*

After the Paris attacks in 2015 53.2% of survivors received care from medicopsychological emergency teams within 48 hours

and screening programme. Individuals were screened for PTSD and other problems, such as depression and phobia,³ with detailed assessments for people with positive screening results leading to the option of referral for treatment.

This programme confirmed that survivors with mental health problems were unlikely to be detected through conventional routes such as primary care. Access to specialist services was inconsistent; existing referral pathways and financial contracts acted as barriers. The project established that individuals did not mind being contacted through the screening programme, that treatment led to positive outcomes, and that a central team could facilitate equal access to treatment resources and monitor outcomes and costs.⁵

However, lack of central planning led to unclear allocation of responsibility and absence of funding for the extra activity.³ The trust was obliged to operate at risk for most of the programme. There was a widespread failure to share data about affected people, even within the NHS, because of a belief that it would breach the Data Protection Act. As a consequence, we do not know how many people were affected by the incidents.

International responses

Mass violence incidents, including terror attacks, are a global problem. There is much potential for learning from responses in other countries. After the terror attacks in Oslo and Utøya Island in 2011, survivors, mainly young people, dispersed across the country.

The Norwegian government approved a national primary care based outreach strategy coordinated by the Norwegian Centre for Violence and Traumatic Stress Studies, which used crisis teams in each affected municipality. Survivors were identified from a list of those attending a summer camp on the island.⁶ All were contacted directly and municipalities were recommended to assign each a contact person to provide initial support, ensure continuity, and set up screening assessments.

A follow-up study found that most (84%) had had communication with a contact person in the first four to five months, but this was not maintained; nearly half reported no communication between initial contact and 15 months after the attack.⁷ No contact was associated with lower use of mental health services, and 20% of survivors who did not receive mental health services had clinically

important distress.⁷ As the attack targeted young people, the response included family members in its outreach, finding they also had high levels of distress.⁶ Family outreach was less likely to have occurred if the parents were separated or not Norwegian.⁸

France has had medicopsychological emergency teams since 1995. These work alongside traditional emergency services providing immediate care for people affected by traumatic events. Research six months after the 2015 terrorist attacks in Paris, showed that 53.2% of civilian survivors received care from these teams within 48 hours. Those who had received this support were less likely to experience anxiety or depression than people with no immediate contact.⁹ However, among civilians who received at least one psychiatric diagnosis, 70% and 30% of those indirectly and directly threatened, respectively, had received no mental health support.

Supporting citizens affected by attacks while abroad presents further problems. England's Department of Health set up a screen and treat programme for British survivors of the terror incidents in Tunisia, Paris, and Brussels in 2015-16.¹⁰ The programme started more than a year after the first attack, encountering considerable delay because of the lack of existing policies and practice, and was hampered by the unwillingness of commercial organisations and the police to share data on those affected. Of the 483 people identified, roughly 40% returned screening questionnaires to Public Health England, 92% of whom had at least one clinically relevant score, such as for PTSD symptoms.

Manchester Arena, 2017

In May 2017 a bomb was detonated as concertgoers were leaving an event at Manchester Arena. Twenty two people plus the bomber were killed and more than 350 were physically injured. Data access after the attack was problematic, but lists identifying some of those affected were shared between the concert promoter, NHS acute care sector, police, and voluntary and community organisations. A centralised outreach and screening service, the Manchester Resilience Hub, was fully operational within seven weeks, with financing underwritten by local commissioners until a national settlement was agreed.



The service was based on the screen-and-treat design used after London 2005 and Tunisia 2015 and informed by expertise from local military veteran services on responding to incidents involving improvised explosive devices. Based on patients' feedback from earlier incidents, it focused on speed of response; the first people were contacted by telephone within 14 days.

The hub carried out extensive consultation with schools, local services, and the media to share information about trauma responses. As over 80% of those affected lived outside Greater Manchester, an online tool supported clinical triage; this enabled timely, large scale screening and facilitated regular follow-up.

Questionnaires included the trauma screen questionnaire,¹¹ generalised anxiety disorder assessment (GAD-7),¹² patient health questionnaire (PHQ-9),¹² work and social adjustment scale (WSAS),¹³ children's revised impact of events scale (CRIES),¹⁴ and revised children's anxiety and depression scale (RCADS).¹⁵ Standardised thresholds for clinical relevance were used to identify those in need of support, alongside risk criteria (suicidal ideation reported on PHQ-9; reporting no current psychological support). Many had clinically significant difficulties at initial registration: 55% of adults met criteria for possible PTSD, and up to 90% had anxiety; 25% of children and young people (8-18 years) had clinically significant depression scores; and 83% presented with possible PTSD.

The hub's main role is to give remote support and refer clients to local services for psychological therapies recommended by NICE.¹⁶ It also conducts face-to-face



Box 2 | Actions to improve mental health response to mass casualty incidents

- Update policy and guidance on designing, planning, and delivering psychosocial and mental healthcare after incidents and integrate this into pre-incident planning and exercises of all responsible authorities, including schools and colleges
- Identify funding in advance and establish agreements in principle with commissioners to enable local services to activate plans quickly and provide services for sufficient periods
- Revisit the requirements and regulations for effective information sharing across agencies with robust mechanisms agreed in advance to ensure data sharing is frictionless and timely
- Complete and implement plans for a health register to detect as many of those affected as possible and ensure the effective delivery of care

Teenagers take part in a commemoration ceremony held for the victims of Manchester Arena bomb, in May 2017

assessments for families with complex needs and a limited amount of direct therapy. Regional access to specialist trauma focused interventions has been highly variable, particularly for children and young people. The hub also runs supportive workshop days for families in response to feedback asking for more contact with other affected people.

An estimated 15 000 people were at the arena on the night of the attack. But after two years only around 3500 people had registered with the hub, just under a quarter of those present. There may be many more affected people who have not registered.

Where are we now?

Fourteen years after the London bombings, awareness of mental health needs after terrorist attacks has greatly improved and more detailed clinical plans now exist. The Department of Health and regional offices of NHS England have provided clear leadership on the response to attacks. Although formal evidence on how to respond is lacking, messaging targeted at the public coupled with centralised outreach, screening, and monitoring of those affected are accepted as appropriate to prevent untreated morbidity and ensure equality of access to treatment.

Obstacles remain to an effective response. Mental health services are still rarely included in planning exercises for UK emergency responses, and there are no pre-agreed funding mechanisms to support the extra administrative, outreach, and treatment costs of emergencies.

The need to seek funds creates additional workload, reduces efficiency, and introduces uncertainty at a time when extra staff and careful future planning are needed. Local trusts should not have to operate at financial risk by providing services before national funding is agreed. Commissioning arrangements should recognise that incidents may require a coordinated national response. However, it is not clear who is responsible for resolving these problems or whether anyone is considering them.

Data sharing barriers within and across organisations continue to impede the identification and clinical management of affected people, despite only a small minority of the public objecting in principle to data sharing.¹⁷ In 2007, the Cabinet Office¹⁸ clarified that it was legal to share personal information that was in the individual's interest, but organisations, including the NHS, remain cautious. For example, in Manchester, emergency services opted to inform staff of available support rather than share staff contact details with the hub. Action from the Information Commissioner's Office, or even legislation, may be needed to change practice and ensure that the 2018 EU General Data Protection Regulation does not further impede care for survivors.

We think a central mechanism to initiate a health register after an incident is crucially important. It is a practical way of bringing together personal data from organisations such as the police, health services, and commercial organisations, as well as permitting self registration, however dispersed the survivors. Such a register would facilitate subsequent outreach

attempts using mobile phones and email. Public Health England started work on a register protocol for major incidents in 2012²¹ but this has not been completed for unknown reasons.

What next?

Although the number of people experiencing mental health effects after major incidents is often greater than the number with physical injuries, and the effects can last much longer, mental health has attracted much less in the way of planning and resources. Clinical understanding about how to support and treat survivors of major incidents is reasonably advanced.^{22,23} However, care is often not being delivered adequately because of organisational and institutional failings. Box 2 sets out our recommendations to improve the UK response.

The problem, however, is international, with much wider appreciation needed of the importance of active outreach.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Improving the lives of trainee doctors

We recognise many of the challenges mentioned by Whitehouse (Junior Doctors, 13 July), particularly that high quality rotas are not guaranteed by relying solely on the contractual framework.

The Scottish government has developed a quality improvement process for the working environment of trainee doctors—the professionalism compliance analysis tool (PCAT). It has three domains: patient centred safe care, quality of training, and trainee health and wellbeing. The local team (trainee, training leads, and clinical service leads) gathers information based around these domains, which is used to produce a red-amber-green report, including qualitative data. This report informs a feedback meeting of trainees, training leads, and clinical management, who identify key areas for development using quality improvement processes with agreed timelines. Thus, trainees are engaged, empowered, and see real change as a result of their feedback. The process, data, and report are owned by the department and not used as a scrutiny tool. PCAT also identifies areas of success, enabling these to be recognised and celebrated in departments and, with permission, shared externally to disseminate good practice.

PCAT is supported by NHS leaders in Scotland and is becoming routinely embedded in all Scottish health boards supported by delivery of local and national training workshops. Systematic use of PCAT across all specialty rotas is being facilitated through NHS board human resources, medical staffing, and medical education directorates and promoted as a policy position by the Scottish government to improve the working lives of doctors in training. PCAT has been endorsed by the Royal College of Anaesthetists and the Royal College of Surgeons of Edinburgh.

PCAT is a freely available structured improvement tool for tackling the wide range of demoralising and damaging issues raised by Whitehouse. Further information and a detailed implementation pack can be obtained from j.colvin@nhs.net.

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John R Colvin, consultant in anaesthesia and intensive care medicine, Dundee

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HOW TO FIX DOCTORS' ROTAS

Holiday policies and mutual respect

Rota coordinators and doctors must both deal with insufficient resources and work scheduling difficulties (Junior Doctors, 13 July).

In Canada, policies state that holiday requests must be submitted at least four weeks in advance. The rota coordinator

must confirm or deny within two weeks. If denied, alternative times must be offered within two weeks. That is fair to both sides.

Rota coordinators in the UK can ignore requests and deny them without offering an alternative. If rota gaps lead to patient harm, the rota coordinator can simply take no responsibility. Doctors take the blame for these system failures.

No doctor should say they are “too senior to complete a task.” An inpatient is always admitted under a consultant. During rota gaps, seniors might pass clerical duties on to a junior person in another team or the patient’s GP.

NHS holiday policies and coworkers’ mutual respect need to be fixed.

Eugene Yeung, physician, Lancaster
Cite this as: *BMJ* 2019;366:l5049



GUIDELINE EVIDENCE BASE

Ignore guidelines at your peril

Elwenspoek and colleagues conclude that most UK guidelines are based on expert opinion and consensus rather than “hard” or published evidence (Uncertainties, 22 June). As chair of the standards committee of the British Transplantation Society, I agree.

The authors say that most guidelines should not be adopted uncritically but should inform discussion with patients. This is logical but impractical. Primary care providers are chronically overworked and lack the resources to devote to mass education programmes, and most patients are not sufficiently informed or motivated to engage in such decisions.

By specifying a baseline level of care, guidelines reassure patients that they are receiving safe follow-up and physicians that their practice is in line with accepted norms. Non-adherence to a recommended follow-up regimen has risks for both parties.

Guidelines are not perfect, but they underpin safe medical practice, are usually highly cost effective, and should be ignored at both the patient’s and physician’s peril.

Peter A Andrews, consultant nephrologist, Carshalton
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Every consultation should be safe

More than a decade ago, I suggested that primary care IT providers develop an artificial intelligence (AI) engine that would interact with the data entered by doctors during consultations and be linked to NICE guidelines on specific conditions.

The AI would offer prompts and direct guidance, thereby effectively delivering, in interactive form, real time assistance and bringing relevant guidelines and evidence into every consultation.

GPs are busier than ever, and NICE guidelines lack “robust evidence for optimal monitoring strategies and testing intervals,” so perhaps experts and relevant primary care professional bodies should get their heads together and develop a system that will help busy doctors and concerned patients to tackle (not just be aware of) the “uncertainties when making shared decisions about chronic disease monitoring.”

Worthy aspirations are no good; frontline practitioners need specific actions and resources that will enable every consultation to be safe, sound, and supportive for both patient and doctor.

Christopher L Manning, retired GP, Teddington
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Join an ethics committee

Maben and King discuss the opportunities and barriers for NHS staff wanting to take part in research (Editorial, 6 July). One positive aspect is that it forces potential researchers to be explicit about what they want to do, how they plan to do it, and whether their results are likely to be useful. Major harm can be done when poorly designed research hits the headlines, so quality control is important.

Clinicians who do not have the time to take part in research might consider contributing to the wider system of research quality control by joining a research ethics committee.

Members are not expected to be experts, but rather have enough common sense and interest to try to understand a project and assist the researcher in producing a high quality piece of work. This is a critical role that desperately needs the engagement of more clinicians.

Simon E Kolstoe, senior lecturer and ethics committee chair, Portsmouth

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Future consultants will need to be able to integrate research into practice

Research training is vital

The major barriers to engaging medical staff in research are lack of research knowledge and skills and poor access to research training. Not all future consultants will be involved in primary research, but they will all need to be able to read and appraise the scientific literature and integrate new research findings into clinical practice.

This is recognised in the higher training curriculum for child and adolescent psychiatrists, which since 2010 has included mandatory requirements for trainees to be able to find and analyse research carried out by others and assimilate this into a (systematic) literature review, written to a publishable standard.

The skills acquired through literature review increase scientific reasoning and the ability to write and synthesise complex data, as well as enhancing time management skills and promoting positive attitudes to self directed learning, which are all necessary for a lifetime in medicine.

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Matthew Hodes, consultant child and adolescent psychiatrist, London

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SUGARY DRINKS AND CANCER

More to diet than just sugar

Chazelas et al report that sugar intake, including fruit juice, is associated with a higher incidence of cancer (Research, 13 July).

Fruit juice is a valuable source of bioactive molecules with anti-inflammatory and anti-oxidant properties. A meta-analysis of 22 studies found that a high intake of flavonoids reduced all cause mortality (relative risk 0.74). The World Health Organization recommends the consumption of fruit and vegetables to improve health—given that intact and juiced fruit have similar molecular compositions, fruit juice can be predicted to have health giving properties. The most extensive meta-analysis of fruit and vegetable intake found that consumption of 100% fruit juice (not extrinsically sweetened) reduced all cause mortality (0.76) as well as the incidence of coronary heart disease (0.79) and ischaemic stroke (0.65).

Examining only one nutrient promotes the myth of good and bad foods, when we must emphasise



the range and balance of the many foods that make up a healthy diet.

David Benton, professor, and Hayley A Young, associate professor, Swansea

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Lifestyle changes are most effective

Chazelas et al say that additives in soft drinks might increase cancer risk. The World Cancer Research Fund International says there is no evidence to link food additives with increased cancer risk, except nitrites and nitrates in processed meat.

Evidence does show, however, that free sugars can promote weight gain and increase the risk of developing type 2 diabetes and that being overweight or obese can increase the risk of some cancers.

Public Health England says that free sugars should not contribute more than 5% of the calories we consume and that consumption of sugar sweetened beverages should be minimised. Fruit juice counts as a portion of fruit, as it provides vitamins and minerals, but should be limited to 150 mL a day.

Making healthy lifestyle changes is the most effective way to reduce cancer risk. These include regular exercise, a healthy diet, avoiding smoking, and not drinking too much alcohol.

C Albert Yeung, consultant in dental public health, Bothwell

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NHS “RESTRUCTURING”

Change from the bottom up

Calls for major structural reforms to the NHS are futile (David Oliver, 6 July). The NHS needs reform, but assuming that means changing the top-down structure is a mistake.

GPs can and should offer faster, more flexible responses that better match patient needs. Hospitals should plan capacity more effectively. Surgeons should adopt better techniques. None of these are readily achieved with top-down diktats.

The consequences of the obsession with culling management are widespread. Good managers design systems in which carers spend less time with stressful administration and more time with patients. Fewer managers equals fewer improvements.

The single reform that would most improve the NHS is focusing attention on bottom-up operational changes. That’s a management problem made too hard by perpetual management cuts. But if we are talking about reform, it is the one area where the NHS needs to change and where the change would make a difference.

Stephen Black, data scientist, Biggleswade

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OBITUARIES

Robert Bailey

General practitioner (b 1956; q Gonville and Caius College, Cambridge, 1980; FRCS, FRCGP), died while walking in the Alps on 16 April 2019

Robert Bailey (“Rob”) was a general

practitioner in Peterborough for the past 30 years. He also ran theatre and outpatient sessions in the breast unit at Peterborough hospital for many years. In addition, he worked at Thorpe Hall Hospice for 25 years, and was clinical lead for end of life care for Cambridgeshire Clinical Commissioning Group. He gave superb service as a singlehanded GP at the Minster Medical Practice. Many of his patients testified how he “always went the extra mile.” Rob was a keen cyclist and walker with huge energy, despite living with type 1 diabetes for 37 years. He was also a keen choral singer. Sadly, he died suddenly shortly before retirement. He leaves his wife and two children (one of whom is an emergency medicine consultant).

Mike Bailey

Cite this as: *BMJ* 2019;366:l4808



Neil McDougall

Consultant obstetrician and gynaecologist Glasgow (b 1945; q St Andrews 1969), died from a myocardial infarction on 26 March 2019

Archibald Neil

McDougall (“Neil”) followed his brother, a classicist, to St Andrews. After house jobs in Dundee and Glasgow he moved to the medical research unit in Newcastle upon Tyne, where he met his future second wife, Marie, over an ectopic pregnancy. Neil was appointed consultant to Rutherglen Maternity Hospital in 1981. He pioneered the use of ultrasound in gynaecology in Glasgow and further developed ultrasound in obstetrics. He was a popular mentor and teacher. Neil was a passionate sailor, racing old wooden boats with Marie. After the children were born they sailed weekends and holidays on the Clyde and west coast in a “Tupperware” yacht. Neil died aboard *Camus Bosta*. He leaves Marie, two children, and three daughters and four grandchildren from his first marriage.

Marie McDougall

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James Denis Fair Lockhart

Clinical director Merrell Dow Pharmaceuticals (b 1932; q Trinity College Dublin, Ireland, 1956; DPH Lond), d 3 July 2019

James Denis Fair Lockhart (“Denis”) was born in Tanganyika (now

Tanzania), where his father was a colonial medical officer. He completed his national service with the Royal Army Medical Corps in Malaya, where he met his future wife, Patricia Ann Alson (“Pat”). They moved to Kenya, where they were married in 1961, and Denis joined Her Majesty’s Overseas Civil Service as a medical officer. They left Kenya for Hong Kong in 1966, where he worked as a hospital doctor, and they returned to England in 1969. Denis joined John Wyeth and Company and later Richardson-Merrell, before retiring as clinical director of Merrell Dow Pharmaceuticals. He survived various bouts of colon cancer, and developed vascular dementia. Denis leaves Pat, two children, and five grandchildren.

Andrew Lockhart

Cite this as: *BMJ* 2019;366:l4797



John Ernest Bowerman

Consultant oral and maxillofacial surgeon Westminster and Roehampton hospitals (b 1931; q Bristol 1965; BDS, FDS, FRCS), died from a blood dyscrasia on 25 April 2019

John Ernest Bowerman qualified in dentistry in 1955. In 1956 he married Hilary and did national service in the Royal Army Dental Corps. However, he was released to run his uncle’s dental practice for two years. In 1960 he returned to Bristol to study medicine. To help pay for the tuition fees he carried out general dental practice in the evenings, with Hilary as the chairside assistant and secretary. After qualifying he became a registrar and later consultant at Westminster and Roehampton hospitals. John was a big influence in the development of the speciality of oral and maxillofacial surgery. He enjoyed teaching. He was invited to the Middle East to demonstrate a range of surgical procedures. He leaves Hilary, children, and grandchildren.

John Bradley

Cite this as: *BMJ* 2019;366:l4805

John Norman McMichael Schofield

Consultant ear, nose, and throat surgeon (b 1926; q Middlesex Hospital Medical School 1950; DLO Eng, FRCS Ed, FRCS Eng), died from old age on 28 April 2019

John Norman McMichael Schofield did his national service with the Royal Navy as a surgeon lieutenant from 1950 to 1953. He married Arlette in 1952 and left the Royal Navy in 1953. From 1962 to 1990 he was a consultant ENT surgeon for three south Warwickshire hospitals. John was active in professional organisations and retired in November 1990. Arlette died from motor neurone disease in August 1994. The next four years were difficult for John, but he then fell in love with Jane, and they married in October 1997. Always sporty, John had an active retirement and played golf well into his 80s. Predeceased by his only daughter in 2017, John leaves Jane, his children, his stepchildren, and their families.

Philip Schofield

Cite this as: *BMJ* 2019;366:l4789



Graham Hamilton Love

General practitioner (b 1958; q Dundee 1981), died from a glioblastoma on 24 August 2018

Graham Hamilton Love was brought up in Glasgow. He enjoyed medical school

in Dundee, before training as a general practitioner in the Stirling area, where he met his future wife and soulmate, Fiona. Graham took up practice in Glasgow’s Woodside health centre in 1985. He was the very best sort of GP—clinically astute; hard working; kind and compassionate; a “team player”; and equally popular with patients, staff, and colleagues. Sadly, after 33 years in general practice and six months short of retirement, Graham was diagnosed with a brain tumour, which proved unresponsive to treatment. Outside work he enjoyed most of all being with his family and leaves Fiona, his wife of 35 years; three children (Christopher, Shaun, and Katie, who are all doctors); and his adored grandchildren.

Sheila M Lawrie

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Richard Valery Mouzoko Kiboung

Epidemiologist who was killed by armed rebels while leading an Ebola response team in DRC

Richard Valery Mouzoko Kiboung (b 1977; q University of Yaoundé I, Cameroon, 2004), died from gunfire on 19 April 2019

In March 2019, Richard Valery Mouzoko Kiboung left his wife and four young children at home in Cameroon to join the World Health Organization's mission in the Democratic Republic of Congo (DRC) to fight the second deadliest Ebola outbreak in history.

Mouzoko, 42 years old, was dispatched to Butembo in north east DRC. He had the heavy responsibility of leading an Ebola response team in a foreign country weighing on him, combined with deep concern about his team's safety. Rebels in north eastern DRC, as well as many local people, believe that Ebola was deliberately imported or does not exist. Ebola treatment centres had been under attack from militias since January. Responders and burial teams had been threatened and assaulted. In late February, the

charity Médecins Sans Frontières suspended some of its operations after two attacks on its treatment centres.

Mouzoko regularly spent more than half of each month working in isolated communities in his native Cameroon. He served vulnerable groups, including communities of refugees, internally displaced people, and nomadic groups. He had investigated several diseases, including yellow fever, measles, polio, meningitis, neonatal tetanus, and Ebola, and he had led vaccination campaigns in many countries.

Ambush

Sadly, Mouzoko's concerns about team safety were not unfounded. On 19 April 2019 he was leading a meeting at the Catholic University of Graben hospital in Butembo, when armed rebels burst into the conference room. They ordered everyone on the floor, according to a report from the non-profit healthcare service IMA World

Health. The gunmen collected the belongings of the Ebola response team while accusing them of perpetuating false rumours about the disease. As the gunmen departed, Mouzoko was shot in the abdomen. The militants continued to shoot as they went through the hospital. Two others were wounded.

William Clemmer, a doctor who is leading the Ebola response for IMA World Health, which earlier this year merged with Lutheran World Relief, had just finished a teaching session for nursing students about two miles from the hospital when the attack occurred. Clemmer told *The BMJ* that when he finally got to the hospital grounds he was told that a couple of staff members were being treated for gunshot wounds and a "foreign doctor was gravely wounded."

"I saw nurses and staff waiting anxiously outside the building," he said. "The waiting turned to wailing and cries of anguish as it was announced the doctor had died."

Matshidiso Moeti, WHO regional director for Africa, said: "The world of public health and WHO, in particular, lost someone exceptional. We enter this profession to help others live healthier lives. We expect long careers and hope to live to see some results of our work.

"Dr Richard had great impact in his short life and helped make countless lives healthier. He was a doctor, a humanitarian, and a hero—an example for us all."

Life and career

Mouzoko was born in Bafia, Cameroon, on 31 May 1977. He studied medicine in Yaoundé, Cameroon's capital, at the University of Yaoundé I, graduating in 2004. He was passionate about public health,

Sadly, Mouzoko's concerns about team safety were not unfounded

and from 2008 until 2012 was involved in the fight against malaria in the Adamawa region of Cameroon.

In 2012 he moved to Antwerp, Belgium, to start a masters degree in public health at the Institute of Tropical Medicine (ITM). At the institute he earned a reputation as a brilliant student with rich field experience. After receiving his masters degree in 2013 he worked at the Cameroon Ministry of Health, helping to develop a national health insurance system.

In 2014 he participated in WHO's polio eradication initiative in Chad, and in 2015 he returned to Antwerp for a short course in health policy.

During his career, Mouzoko became a committed teacher, helping to train hundreds of doctors and health workers.

On 4 May 2019 Mouzoko's family and friends mourned his passing at his funeral in his hometown of Bafia. WHO's director general, Tedros Adhanom Ghebreyesus, delivered a eulogy. "The passing of Dr Richard is an enormous loss for WHO and the people of the DRC he was serving when his life was so brutally and senselessly taken away," Tedros said.

"It's also an enormous loss for Cameroon, and most of all for his family, who have lost a husband, a father, a son, and a brother."

Mouzoko leaves his wife, Friquette Tata; four children; his mother; and siblings.

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