comment

"Care is being rationed by delay, gaming, arbitrary rules, and bureaucracy" **DAVID OLIVER**
"Who's going to provide a medical service if GPs no longer visit?" **HELEN SALISBURY**
PLUS Are you a heartsink doctor?; Changing the patient experience culture

WOUNDED HEALER Clare Gerada

Reflections on my last Christmas on call

For nearly 40 years I've been part of an on-call rota, but this Christmas will be my last on-call commitment, ever. In my first hospital jobs I was on call one in three, which included 8 am on Friday to 5 pm on Monday. As a new partner at my general practice I worked one in five, my pager never far from my side.

I still recall those night home visits, never quite knowing where to go, with only the *A-Z* as a guide. In recent years I've gradually withdrawn from the full on-call rota, stopping the red-eye shift a few years ago, weekends more recently; and now I have only Christmas day to go as my last share of public holidays.

I can't say I'm sorry not to have my evenings and weekends interrupted, but there are things I will miss: the intimacy of seeing acutely ill patients in their home and the comradeship of colleagues from other practices as we worked shifts in the GP out-of-hours cooperative.

Out-of-hours care is a quintessential part of medicine and necessary for good patient care, but it's becoming more difficult to deliver. GPs' care schedules are so intense it's no surprise that filling shifts, especially out of hours, is harder—evidenced by a finding that GPs now see twice as many patients as is safe.

In hospitals, the move to a consultant delivered service seven days a week means doctors are required to be on call—and, for certain specialties, resident on site—for their entire careers. A BMA survey of consultants found that 87.6% of respondents took part in a non-resident on-call rota.

Today's junior doctors may have escaped onerous 90-100 hour weeks, but their lives are more disrupted by complicated rosters. A rota, for example, might include: one 12.5 hour day shift a week; one weekend in four of 12.5 hour days; one week and one weekend in six of 12.5 hour nights, as well as one weekend of 10 hour days. Despite changes brought in by the junior doctors contract, shifts ending at 1-3 am are not uncommon, playing havoc with biological clocks.

Out-of-hours work affects social and family life, but it was always thus. What's changed and contributes to the rise in mental illness among doctors, young and old, is the intensity of day and night time working, the lack of continuity within a stable team (the "firm"), and the expectation that doctors will continue to provide out-of-hours care for their entire career.

Medicine is changing; so too are the expectations of the public, policy makers, and politicians regarding their health service. But what hasn't changed (and won't change substantially, even with digital innovations) is that care is delivered by people—doctors, nurses, paramedics, porters, radiologists, and more—who all have human needs.

I'll enjoy my last Christmas on call—but I'll keep in mind all of those colleagues who continue providing care in the most unsocial of hours, working to keep the NHS safe in a system that's failing to do the same for them.

Clare Gerada, GP partner, Hurley Group, London clare.gerada@nhs.net
Cite this as: *BMJ* 2019;367:l6568

Care is delivered by people who all have human needs

PERSONAL VIEW
Jonathan Glass

How not to be the heartsink doctor

There has been much talk of "difficult" patients but what of the unengaged, bored clinician

Every Friday morning our department has an academic meeting, lasting an hour. They are a highlight of the week. Occasionally we have a "round the room" session, where each of the consultants spends a few minutes discussing how they approach a patient group—men with erectile dysfunction, for example, or women who have recurrent urinary tract infections.

This week the subject was our experiences with those who have been termed "heartsink" patients. Each of us was supposed to talk about cases that we've found difficult, whether it was a patient with a particularly challenging condition or a puzzling set of symptoms, likely to be organic in origin. It's those cases that cause the doctor to hold their head in their hands while they generate the mental strength to call the patient into the clinic room.

I thought a lot about the idea of the heartsink patient before creating the one slide I used for my contribution. The kind of person who fits the description has often engaged with healthcare many times in their lives. They've seen the otolaryngologist about their sinus problems, been diagnosed with irritable bowel syndrome by the gastroenterologist, discussed their headaches with the neurologist, and their heavy periods with the gynaecologist. They are familiar with how the healthcare system works, they're used to seeing the junior doctor in clinic, and are often sent around the houses to different specialists.

This made me reflect on what we're doing wrong as healthcare professionals. My suspicion is that these patients are often met in clinics by what they might consider to be the "heartsink" doctor.

They will know the doctor I'm talking about—unengaged with no interest in the patient. The doctor who is thinking about what they're doing at the weekend or whether they're going to make it to their child's parents' evening, or who has become disillusioned with the job they thought they had signed up to 30 years ago when they left medical school. Don't think the patient doesn't spot you—they are likely to be adept at recognising the heartsink doctor almost as soon as they walk in.

What defines the heartsink doctor? Heartsink doctors arrive in clinic bored and uninterested. They try to rush the consultation and are distracted by their phone or their bleep. They don't make eye contact with the patient—their focus is directed at the computer screen. They make no attempt to discover anything about the person in front of them other than their presenting symptoms. They are condescending, superior, and paternalistic, and don't respond to any cues that the patient or their relatives might offer.

They leaf through the notes, having not done so before the patient entered the room. They listen poorly, and don't give the patient

BMJ OPINION Miles Sibley

Changing the culture of learning from deaths

With the revelation that a "toxic culture" led to the deaths of mothers and babies at the Shrewsbury and Telford Hospital NHS Trust, patient safety in maternity services is once again in the spotlight.

Clearly, the failure to listen to patients and bereaved relatives is not unique to the Shrewsbury and Telford trust, nor to maternity services. Similar observations can be found in the Francis Mid Staffordshire report, and in avoidable deaths reports from Southern Health, Gosport, and the Northern Ireland hyponatraemia inquiry. They crop up again in ombudsman reports such as Learning from Mistakes and Ignoring the Alarms.

There will always be a risk of errors occurring in the high pressure and unpredictable environment of acute care. So errors need to be examined and explained. Instead we find that, over and over again,

Patient experience evidence should be embedded in training, clinical guidelines and practice protocols

after avoidable deaths, grieving relatives are locked out of investigations, refused access to information, and denied justice.

Why does this keep happening?

Ted Baker, chief inspector of hospitals, suggests it is a cultural problem. Commenting on the slow uptake of Learning from Deaths guidance, he said, "We still see the same problems in some NHS trusts. Problems such as fear of engaging with bereaved families, lack of staff training, and concerns about repercussions on careers, suggest the culture of organisations may be holding people back from making the progress needed."

The reference to organisational culture is important. But it is not enough to set up

We should never forget we are in the remarkable position of having a window on the lives of many fascinating people

time to speak or voice their concerns. They fail to adapt their language and responses and don't recognise any cultural concerns that might be pertinent. They are protocol driven and fail to individualise the care they offer. They are looking to refer the patient on to another specialty at the earliest opportunity.

Endless demands

I understand how we can all fall into the trap of becoming such a doctor. The demands placed upon us by the healthcare system are endless. In my first ever ward round, my consultant, Paul Abel, said to me, "Jonathan, today you will be given a list of things to do; you will never finish it." He was right. Our challenge, however, is to give patient number 11 the same freshness as patient number 1.

It can be hard to put away our other stresses and focus on the person in front of us. But we should never forget we are in the remarkable position of being given a window on the lives of so many fascinating people. If we can maintain the enthusiasm for that privilege, it will help us continue to deliver high quality frontline care to those patients whose cases challenge us. The so-called heartsink patient may, in fact, need our time the most. We need to avoid becoming the heartsink doctor.

Jonathan Glass, consultant urologist, Guy's & St Thomas' Foundation Trust jonathan.glass@gstt.nhs.uk

Cite this as: *BMJ* 2019;367:l6660

inquiry after inquiry, looking at each culpable organisation in turn.

Perhaps the most important thing we can do is to inject a sense of urgency in tackling these cultural problems. The term "anecdotal evidence" must be challenged. Patient experience evidence should be embedded in training, clinical guidelines and practice protocols—just as medical evidence is. NHS England has the Patient Experience Library at its disposal—it just needs to use it. Healthwatch funding should be restored to its 2013 level. That is a job for the secretary of state. None of this would be hard to do, but it needs commitment from leaders.

Changing the culture of patient experience work will not end avoidable deaths. But it will give patients a better chance of being heard.

Miles Sibley, director for the Patient Experience Library, www.patientlibrary.net

ACUTE PERSPECTIVE David Oliver

Rationing care by delaying decisions

Practitioners at the interface between the NHS and adult social care can see a truth that's often invisible to outsiders: care rationing—by delay, gaming, arbitrary rules, and bureaucracy.

Official data on delayed transfers from hospital make for grim reading. But, as the National Audit Office reported in 2016, the real number of people waiting is often far higher.

Some anecdotal examples. Patients are referred for social work assessment, and it may take a week to allocate a social worker. After assessment the social worker makes repeated requests for information from the ward team. "Best interests" meetings are organised to determine care needs for patients whose mental capacity is impaired, but these take far too long to set up. It can take longer still to source care agencies for a personal package, even when agreed and funded.

Provision and funding are often subject (understandably) to local authority discussions, which can take more than two weeks. Requests come back to the wards for more information, to justify spending on home care or a care home. Patients already in a care home that's struggling to meet their needs are admitted to hospital and the doors close behind them. The acute bed is used as a holding bay and hotel to solve a longstanding community problem.

Then we have NHS Continuing Healthcare funding for which the criteria and thresholds are set out in law. Yet NHS Benchmarking figures show that assessment times vary greatly. Initial CHC assessments are generally double checked and contested, and funding is rejected or decisions are subject to long delays or family appeals.

The adage that "the acute hospital runs on a stopwatch and community services run on a calendar" has never felt so real given the pace, turnover, and bed occupancy we work with.

I'm painfully aware of the impact of sustained cuts on local authorities, which force social care managers to use what money they still have wisely, and ensure that it's used for people with the most need.

Social workers, facing a workforce and workload crisis, have to follow due process, and I don't think anyone's acting in bad faith. Clinical commissioning groups are under pressure from NHS England to limit their spending on CHC funding.

The effect of all of this is to ration care by delaying decisions. And, while people wait, they're stranded in hospital, where their health and wellbeing are at risk.

Such treatment of vulnerable older people goes against organisational values on person centred care. Procedure, bureaucracy, and money come first—not people. And this forces health and social care professionals to make decisions they know aren't always driven by the best course for the patient or family.

We're in an election campaign, so we must blow the whistle loudly on rationing by delay, and make politicians and national leaders listen.

David Oliver, consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com
Twitter @mancunianmedic

Cite this as: *BMJ* 2019;367:l6620

Procedure, bureaucracy, and money come first—not people

PRIMARY COLOUR Helen Salisbury

Why I resist giving up home visits

GPs no longer have time to visit patients in their homes, so the requirement to do so should be removed from their contract: this was the outcome of a motion put up for debate at the English Local Medical Committee conference last week. More than half (54%) voted for the motion.

It's true that we're too busy. Many partners work 12 hour days routinely, with an unmanageable workload. Travel time makes home visits inefficient, as it may take 40 minutes to do a visit that would have been a 10 minute consultation in the surgery. However, although I already do fewer house calls than I used to, there are many reasons why I'll resist giving up altogether.

We all have our pride, and many older patients who struggle with their memory or mobility will insist they're managing just fine. It may be only when you visit that you discover how much you should be worrying. When you eventually find the right flat or walk up a garden path, you may be uncertain about what's behind the door, but when it opens you learn more about your patient than you did from many surgery consultations. The neatly stacked pile of unopened medicine trays, the order or the clutter, the smells of cooking or incontinence.

When I was a junior doctor doing mostly ward based medicine, where patients were in bed, it was often a revelation to meet them later in their own clothes, seeming more fully themselves. I'm aware of a similar shift in perspective when I visit patients at home—on their territory and surrounded by their things. I hear stories I'm not told in the surgery, and it's somehow a more equal relationship when I'm their guest.

Some home visits have been taken on by other staff. Locally, we have an excellent paramedic service that attends emergencies in our housebound patients. The team can visit and assess without waiting until the end of morning surgery, which is good for patients, and good for the hospital if admission is necessary.

But what about housebound patients with continuing complex health needs—who's going to provide them with a medical service if GPs no longer visit? District nurses provide nursing care, but we must still take overall medical responsibility, discussing treatment and which tablets to start or stop. Nearing the end of life, patients and their families depend on the advice and support of their doctor, ideally one they know and trust.

So, perhaps we need to look at our priorities and ask, "Where does my value lie as a doctor?" There may be other tasks that I should jettison first. Having spent many hours this week on federation, clinical commissioning group, and primary care network business, I know where I'd like to start.

Helen Salisbury, GP, Oxford
helen.salisbury@phc.ox.ac.uk
Twitter @HelenRSalisbury

Cite this as: *BMJ* 2019;367:l6618

When the front door opens you learn more about your patient than you did from many surgery consultations

LATEST PODCASTS

Behind the pledges: health and social care spending

Every week until 12 December *The BMJ* will be bringing out an election themed podcast to unpick the main parties' proposals. This week we talk to David Oliver, a consultant and columnist for *The BMJ*, and Hugh Alderwick, assistant director of policy at the Health Foundation, about spending pledges. One area that is in need of funding reform is social care, as Hugh Alderwick explains:

"Adult social care has been in need of fixing for decades. There have been numbers of green papers, consultations, independent reviews—but politicians have ducked reform. This is one of the biggest public policy failures, I think, of a generation. The question is, what do we do about it? The risk is that the decisions get delayed. Meanwhile, more and more people go without the care they need."

Sharp Scratch: making ends meet

The latest episode of our Sharp Scratch podcast delves into a topic that can be hard to talk about: money. This episode hears from medical students, junior doctors, and an expert guest about the financial demands of becoming a doctor and where to get help. Here Lewis Hughes, a foundation year 2 doctor in the west of Scotland, relays his experience:

"For me, at medical school, money was always tight. In some ways things were more difficult than ever in that transition from final year to foundation. Student loans stopped coming in and I was no longer able to get an income from a part time job because I was working full time in medicine, but money was a long way away and in that time there are lots of new costs. So, for me and others, it's a really, really tight time."

Listen and subscribe to *The BMJ* podcast on Apple Podcasts, Spotify, and other major podcast apps

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

Improving together: collaboration needs to start with regulators

Nicola Burgess and colleagues argue for a move away from top-down regulation to a new approach that facilitates rather than hinders learning across organisations

The regulatory landscape in the UK is changing again. From 1 April 2019 NHS England and NHS Improvement became what is effectively a single organisation with far reaching responsibility for the oversight of the system. The structural features of this change, which will eventually require legislative reform, have been widely debated, not least by those affected by plans for a collaborative approach to improvement in the NHS.[1 2]

But there has been less discussion about the style and approach to regulation that might be best suited to drive improvement in the NHS as set out in the long term plan.[3] We contend that a major change is required in the way the system interacts with service providers if we are to be successful in developing a new service model for the 21st century.

Currently the NHS relies on positional authority—a hierarchical system in which regulators use their power and leverage to drive change. Drawing on organisational theory we contend that structural change in the regulatory landscape is insufficient to drive interorganisational learning for improvement.

Specifically, we argue that regulation needs to shift towards a more relational form of governance in which informal social systems foster learning across organisations. This relational authority emerges through interpersonal relationships characterised by trust and mutual respect and has to be earned over time.[4] To support our argument we draw on our experience analysing a major experiment in delivering service transformation in five NHS hospital trusts in partnership with NHS Improvement and the Virginia Mason Institute in the US (box 1).[3]

Learning across organisations is facilitated through dialogue, trust, and information sharing

KEY MESSAGES

- If collaboration between organisations is to drive improvement, regulators need to reconsider their approach to the exercise of power and authority
- Top-down governance forces organisations to seek rapid short term solutions that do not address complex problems
- Effective collaboration requires investment in developing relationships between organisations characterised by trust and reciprocity
- A relational approach between the regulator and service providers can foster interorganisational learning and governance

Box 1 | NHS-Virginia Mason Institute partnership

In 2015 a five year partnership was established between the NHS and US based Virginia Mason Institute, a non-profit organisation specialising in transforming healthcare. After a competitive tendering process, five NHS trusts were selected to form the partnership and develop localised versions of the Virginia Mason production system.

The production system is an adaptation of that used by the Japanese car manufacturer Toyota. Based on principles commonly known as Lean, the system makes patients central to all activity; any activity that doesn't add value to the patient is "waste" and should whenever possible, be eliminated.

Although the centrality of patients may seem obvious, many healthcare processes are designed around the needs of the service provider rather than patients. The partnership seeks to build skills in quality improvement within and across the five NHS trusts so that they can redesign processes to ensure the highest quality of care while reducing the cost of delivering the service. Crucially, the partnership shares a goal to support development of a sustainable culture of continuous improvement.

Interorganisational learning

Organisational learning describes the process of assimilation and embedding new knowledge in an organisation underpinned by social interactions between individuals and groups. Cross-organisational networks are becoming more common and offer considerable potential for organisational learning. Like learning within organisations, learning across organisations is facilitated through frequent and structured dialogue underpinned by high levels of trust and information sharing.[5 6] Such reciprocity and trust, however, requires long term commitment from collaborating parties, with regular, meaningful face-to-face interactions.[6-8]

Interorganisational learning is best supported by networked forms of governance—that is, when governance is shared between a group of autonomous organisations—rather than by a hierarchical approach. Where accountability is hierarchical, provider organisations are driven to ensure compliance[9 10]; by contrast, networked governance motivates autonomous organisations to work together, learn together, and improve together.[11]

As with interorganisational learning, networked governance is relational, emerging from informal social systems characterised by solidarity among network members, a shared goal, and frequent knowledge exchange.[7-12] Although NHS policy enshrines the building blocks for more collaborative approaches to improvement through integrated care systems, pervasive top-down regulation may stymie action on the ground. Policy emphasis on managing performance can mean that staff focus on meeting targets, reducing the energy for interorganisational learning.[13]

How do we build a relational approach to governance?

Moving from top-down regulation to networked governance requires a radical change from mechanisms that rely on positional authority to mandate change, to mechanisms that employ relational authority.

Box 2 | What does relational space and relational authority look like?

The most striking feature of the NHS-Virginia Mason partnership is the quality and quantity of time invested in face-to-face meetings. Every month all five chief executives travel to London from various parts of the UK to meet the same senior executives of NHS Improvement and senior representatives from Virginia Mason. The meeting lasts for six hours, during which there are no laptops open, no phone calls taken, and dialogue is fluent, reciprocal, and supportive.

Spending six hours in a windowless room in London with senior representatives of the regulator may sound like punishment, but after more than three years these chief executives told us it was "the best day of the month."

This is because discussions are frank, honest, and reciprocal and there is an air of friendship and friendly rivalry, with an overwhelming sense that all organisational partners are learning together.

Relational investments of this nature are uncommon in the NHS; trusts typically compete against each other for business and reputation, and in-person interaction with the regulator is usually a sign a trust is in trouble.

One chief executive explains: "It's quite remarkable really . . . Regulators are usually regulators; they're usually telling you you're not doing something very well. But actually, this is different.

"It's really important in terms of how you are allowed to create the space to learn and develop, and even when things aren't going so well, there's a dialogue to be had. So, it's a different relationship."

The role of regulator is changing towards a more facilitative improvement role

The partnership between NHS Improvement and the Virginia Mason Institute shows how a relational approach to governance can be nurtured. The partnership is a five year collaboration to transfer learning from a US hospital with an enviable reputation for patient safety and quality to the English NHS (box 1). Part of this commitment was to establish a transformation guidance board to enable the five participating trusts to support one another, learn together, and foster ongoing dialogue among all partners.

The transformational guidance board is an example of a goal directed, interorganisational network,[7] where all network members are working towards a shared goal. Its members comprise chief executives of the five NHS partner trusts, senior members of NHS Improvement, and senior improvement specialists from Virginia Mason.

NHS Improvement leads the administration of the network and is an active participant. The board provides two key mechanisms that combine to foster relational authority—a protected relational space and a "compact" (non-binding informal contract[14]) on expected behaviours and commitments. These mechanisms allow interorganisational learning and network governance to emerge.

Protected relational space

A protected relational space is an area where people can work collaboratively towards establishing new norms and roles that challenge institutional practices.[15] All stakeholders are included but individuals must support the aim to change processes; it does not include people motivated to defend the status quo.

A protected relational space is crucial for fostering frank and honest dialogue about how to lead change (box 2). All stakeholders must feel psychologically safe to share the challenges they face as well as their successes; this is particularly important when relationships are characterised by a legacy of power imbalance, as in the case between a regulator and provider organisation.

Create a compact

Moving from positional authority towards relational authority requires a radical change in behaviour. In our example, the first step towards achieving relational authority for interorganisational learning occurred through collective structuring and negotiation of a compact— a process in which the expected behaviours and reciprocal commitments of the regulator and the chief executives are explicitly negotiated and formalised.

Members of the transformational guidance board spent almost 12 months developing the compact. Broad categories of partner

responsibilities outlined in the compact include creating the right environment; fostering excellence; listening, communication, and influencing; focus on patients; focus on staff; and a focus on leadership (box 3). In the event that the compact is disrupted—for example, if a chief executive wasn't sufficiently supported in line with the terms of the compact—a frank and honest discussion takes place about what the board should have done differently.

Shifting attitudes

Dialogue is central to interorganisational learning.[16] When relationships are hierarchical, interaction commonly veers towards "skilful discussion" designed to keep the relationship with a more powerful actor at arm's length. A protected relational space allowed our stakeholders to come together regularly, engage in honest reflection, and develop collective thinking towards a shared goal. To our surprise we regularly heard representatives from the regulator claiming they were reflecting on their behaviours as a regulator and how those behaviours inhibit the improvement capability the network seeks to build.

In tandem, the continued commitment of the trust chief executives both within their organisations and to the transformational guidance board is testament to network governance. Chief executives rarely miss a meeting or prepare inadequately. This is partly because of the value that they associate with the meeting and partly because of the social norms firmly embedded across the group. The chief executives all prepare reports of progress and challenges to share at the meetings and they engage in dialogue that supports one another towards improvement goals.

For example, one trust showcased its "heat map" of training—a document that visually depicts where trained individuals are located within the organisation. The document can be used to identify concentrations of trained individuals to inform future training plans and improvement efforts. The heat map was deemed an excellent idea and subsequently adopted by the other four trusts.

Box 3 | Compact between NHS Improvement and partner trusts

A compact was created to set down the reciprocal commitments of NHS Improvement and the partner trusts in working collaboratively towards their shared vision. The compact states:

"We aspire to fulfil these commitments and will be open to respectful communication from our partner(s) about how well we do in that regard. We accept that this is a developmental journey for all of us." Some of the responsibilities included are listed below.

NHS Improvement responsibilities

- Behave in a positive, respectful, and consistent way at all levels of interaction with trusts and be open and transparent
- Maintain integrity of positive partnership working even when under external pressure and show empathy with trust issues
- Be candid in offering constructive criticism and receptive in receiving it—always assume good intent

Trust responsibilities

- Act in a way that is respectful, open, and transparent with a commitment to early warning and no surprises
- When under pressure on wider delivery look to the method as part of the solution not a barrier
- Work with the wider system so everyone understands the methods, process, and what is required to maximise benefits

Can the approach be extended?

The role of regulator is changing towards a more facilitative improvement role.[17] To date, attempts to transform the NHS have mainly focused on structural change and tightening up regulatory processes that serve to reinforce the positional authority of the regulator. Our analysis suggests that network governance can be more effective at fostering collaboration for improvement, and that such governance occurs through development of relational authority.

We acknowledge that the partnership represents just one example of a networked governance approach and this particular example is limited to a collaboration with just five NHS provider organisations. The challenge will be how to replicate this approach across the broader system.

To reiterate our earlier contention, relational authority is earned over time. We have identified a safe relational space and the process of creating a new compact as important conditions to bring about interorganisational learning and network governance. A different approach to governance is plausible, possible, and desirable.

Nicola Burgess, associate professor of operations management
Nicola.Burgess@wbs.ac.uk
Graeme Currie, professor of public management
Bernard Crump, professor of practice in healthcare and leadership
John Richmond, research fellow, University of Warwick
Mark Johnson, associate professor of operations management, University of Warwick, Warwick Business School, Coventry

Cite this as: *BMJ* 2019;367:l6392

LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Focus resources on recent TB infections

Behr and colleagues conclude that tuberculosis (TB) has a much shorter incubation time than previously thought (Analysis, 26 October). This is supported by a considerable body of circumstantial and direct evidence, including multiple papers showing that recent transmission is high, even in developed countries with low incidence. Published estimates of 80-96% for recent transmission fit well with the estimates of 0.6-11.3% reactivation suggested by Behr and colleagues, even for drug resistant cases. The authors say that their estimates of reactivation are conservative, erring on the side of generosity, so the likely proportion of reactivation is even lower.

Many apparent reactivation cases are the result of reinfection or are from underlying drug resistant strains not cured by the primary regimen. One prophylaxis study showed that after cessation of isoniazid, incidence quickly returned to that seen before treatment, confirming the importance of transmission as the driving force of the TB epidemic.

In high prevalence HIV and TB settings, many adults with HIV test positive on a tuberculin skin test but have never had active TB. This supports the idea that they are either innately highly resistant to TB or were infected by TB before HIV infection and eliminated the TB infection.

As a research community, we need to re-evaluate the investment made in trying to understand persistence or latency, given the priorities of diagnosis, cure, and eradication. We need far better diagnostics to identify cases that present as reactivation disease. We need a careful rethink of wide scale prophylaxis. This paper provides good news for eradication, as it indicates that reactivation cases are relatively rare. By concentrating resources on recent infection, we should be able to achieve more in TB control and faster than we thought possible.

Paul D van Helden, professor emeritus; Eileen G Hoal, professor emerita, Cape Town

Cite this as: *BMJ* 2019;367:l6485

RISE IN OPIOID PRESCRIBING

No opioid crisis in Germany

Smith and colleagues describe widespread opioid prescribing and use in European and North American countries (Editorial, 26 October). But they neglect some important factors, such as the contribution of illicit opioids, that play a major role in the US opioid crisis.

The authors mention Germany as having prescription rates resembling those of the US most closely but fail to mention that Germany does not have a problem with overdose deaths. Data from the German Federal Statistical Office show 3.2 opioid related deaths per million inhabitants in 2015, compared with 144.6 in the US in the same year.

In Germany, good clinical guidance, widespread education, and balanced regulations ensuring adequate access to opioids for those who need them seem to prevent the developments seen in the US. Guidelines on the long term use of opioids for non-cancer pain were published in 2010 and 2015 and are currently being updated.

Lukas Radbruch, physician, Bonn

Cite this as: *BMJ* 2019;367:l6452

Most of the world lacks opiate pain relief

Opioid use might be "widespread" in some high income countries, but we must remember that lack of appropriate opiate pain relief is a continuing crisis in low and middle income countries, especially for those at the end of life.

The Global Atlas of Palliative Care (2014) says that 80% of the world's population lacks adequate access to opioid drugs for pain control. This contributes to the ongoing burden of serious health related suffering for those at the end of life.

Any debate on opiate misuse and overprescribing should be clearly situated in the context of high income countries. Otherwise we risk further exacerbating the many barriers that already exist to increased uptake of opiates in low and middle income countries.

Clare Gardiner, senior research fellow, Sheffield

Cite this as: *BMJ* 2019;367:l6448

STATINS AND PREVENTION

Financial abuse of general practice

A key message from the article on statins for the primary prevention of cardiovascular disease is that "uncertainty remains about the benefits of their use for primary prevention" (Analysis, 19 October). This is worrying, as implementing NICE guidance takes up an enormous amount of resources for general practice.

The 2014 NICE costing report looks at the evidence of benefit on mortality and morbidity and at the cost of drugs and blood tests to monitor lipid modification. It allows £34 a year for GP appointments to undertake monitoring, then discounts this altogether by stating that "it is assumed that any additional GP appointments will be managed within existing resources."

This amounts to the financial abuse of general practice's goodwill to implement "evidence based" guidance.

As Peter Drucker said: "The most serious mistakes are not being made as a result of wrong answers. The truly dangerous thing is asking the wrong questions."

Amrit Takhar, GP, Wansford

Cite this as: *BMJ* 2019;367:l6602

CHILD OBESITY

Bold and decisive action needed

The chief medical officer's report has raised awareness of childhood obesity (Seven Days in Medicine, 19 October). No single intervention (better labelling, altering portion size, increasing taxation) can tackle this issue on its own. We need a positive, comprehensive healthy eating strategy that supports children and their families and tackles obesogenic environments.

Whole school approaches are likely to be more effective than isolated education—providing healthy food and drink options and enlisting the support of school nurses and catering staff in a coordinated way. A whole systems approach is necessary in the NHS too, with heathy food options available for patients and staff.

Public health specialists are key to tackling this epidemic by stimulating, coordinating, and supporting action in different settings. But they will only be successful if they are given sufficient resources. We urge the government to scale up activities and to produce a robust positive healthy eating strategy.

Michael Craig Watson, trustee, Institute of Health Promotion and Education; John Lloyd, honorary vice president, Institute of Health Promotion and Education

Cite this as: *BMJ* 2019;367:l6396

MIGRANT HEALTH

All patients with a GP are eligible for free care

Trusts responsible for charging overseas patients for NHS care have asked GPs to help them to identify patients who are ineligible for free care (This Week, 19 October). BMA policy on this is clear: "Doctors should not become agents of the UK Border Agency."

Furthermore, it is almost completely pointless. Since changes a few years ago, everybody is entitled to register with a GP in the UK. Doing so—coupled with having been or expecting to be resident in the UK—makes you "ordinarily resident." Unless there are reasons to suspect that an individual has come to the country for the express and main purpose of seeking NHS treatment, any patient registered with a GP should be assumed eligible for secondary care.

GPs should not agree to act as border agency staff in this way.

Peter M B English, public health physician, Epsom

Cite this as: *BMJ* 2019;367:l6383

CONVERSATIONS AROUND DEATH

A privilege and responsibility

Oliver discusses the importance of end-of-life conversations (David Oliver, 19 October). We have a duty of care to keep relatives informed of patients' potentially poor outcomes. At times I find myself saying things like, "I don't mind I if am wrong, but I do not think your loved one will survive this admission." Effectively saying the same as recommended—"sick enough to die."

We are privileged to support patients and their relatives at this stage of life, and we must make every effort to undertake this task with tact and humility. Training for these conversations should go beyond simulations and breaking bad news sessions. Medical students should witness this type of conversation with patients and relatives so that they can appreciate and respect the enormity of the task and its responsibility. This is so that when they become the dispensers of care, they act with due care and attention.

Aruna Maharaj, acute physician, Worcester

Cite this as: *BMJ* 2019;367:l6393

PATIENT CENTRED CARE

How does the Bernhoven programme work?

Venhuizen writes about Bernhoven Hospital's patient centred approach (Patient Centred Care, 26 October).

Saying that "money is no longer an important incentive" seems at odds with the rest of the article and reinforces an unhelpful narrative about money. Admitting that money is important could shift our conversations: are these essential components of good practice or might we ditch them if they don't save money?

Bernhoven's achievements were associated with a highly complex, multicomponent intervention. We cannot tell whether any single component of this programme (which included doctors as hospital directors; patients and doctors as shareholders; removing incentives for doctors to do "more treatment"; increased senior clinical cover; and task shifting to optometrists) lowered the cost nor whether it would work without all the other components.

Before trying to learn from the Bernhoven programme, we need a mixed methods study to provide a robust account of how it works.

Louisa Polak, GP, Bury St Edmunds

Cite this as: *BMJ* 2019;367:l6560

Avoid grey areas with better communication

To be involved in management decisions, patients need guidance from a well informed clinician.

Proven histopathological prognostic parameters are not always effectively used in contemporary practice. Clinicians generally don't view histopathology material and are dependent on the pathology report, making pathologists responsible for effectively communicating these data.

Tumour grade is a biological continuum. A tumour at the better end of the high grade spectrum is not biologically different from one at the worse end of the low grade spectrum, but a "bad" high grade tumour has a significantly higher risk than a "good" one. If the pathology report simply states "high grade," the clinician can't decipher where the tumour lies on the spectrum, hindering the patient's ability to make a truly informed decision.

Ladher states that "learning to operate in grey areas is part of the science and art of medicine." The medical profession should strive to avoid creating grey zones through suboptimal communication.

Murali Varma, consultant histopathologist, Cardiff

Varsha Shah, consultant histopathologist, Newport

Cite this as: *BMJ* 2019;367:l6561

Henry Bernard Pollock

General practitioner Morecambe Health Centre (b 1926; q King's College London 1952; DObst RCOG), died from renal and cardiac failure secondary to diabetes on 29 May 2014

Henry Bernard Pollock became a GP partner at Morecambe Health Centre in 1971 and stayed until his retirement in 1988. He steered the practice into new buildings and enjoyed the role of family doctor and continuity of care. Bernard and Ruth (a fellow doctor) were married 55 years and had four children and 13 grandchildren. Two of their children—Douglas Pollock (retired GP in Leeds) and Graham Pollock (consultant radiologist in Derby)—and three of their grandchildren have also established or started medical careers. Bernard's main joys were his family, his labradors, classical music, birdwatching, and the natural world. In later years Bernard and Ruth retired to Warton, Carnforth, where he died peacefully at home with his family present.

Graham Pollock

Cite this as: *BMJ* 2019;367:l6514

Ruth Pollock

Senior clinical medical officer Longlands Child Development Centre, Lancaster (b 1933; q St Andrews 1957), died from pancreatic cancer on 10 May 2019

Ruth Lewty met Bernard Pollock, who was acting as her locum during a casualty job in Dundee. They married in 1958 and she supported his GP career in north London, Gillingham, and Lutterworth. In 1968 they moved to Lancashire, where Ruth restarted her career in child health and community paediatrics in Lancaster. She was a dedicated, industrious, and well liked paediatrician, dealing with often complex child developmental and social needs. In retirement the couple relocated to Warton, Carnforth, and Ruth pursued hobbies of botany, ornithology, and walking. She nursed Bernard through his terminal illness and stayed in Warton until her own death from pancreatic cancer that developed rapidly. She died with her family present at St John's Hospice, Lancaster. She leaves her four children and 13 grandchildren.

Graham Pollock

Cite this as: *BMJ* 2019;367:l6516

John Broomhall

Consultant paediatrician (b 1950; q London Hospital 1975; BSc, FRCP, FRCPH), d 8 June 2019

John Broomhall was appointed jointly between Torbay Hospital and the Royal Devon and Exeter Hospital, where he was the clinical lead for the neonatal intensive care unit. With the introductions of clinical directorates, John was appointed the clinical director for paediatrics and child health and worked to progress the development of the whole child health service, while working as a full time consultant paediatrician. In 1996 he was appointed trust medical director, again a post that he fulfilled with no reduction in his clinical responsibilities and workload. In retirement he trained as a walking guide and was active in this role, leading walks and giving talks, even after his diagnosis with advanced prostatic cancer. John leaves his wife, Vivienne; three children; and four grandchildren.

David Pring

Cite this as: *BMJ* 2019;367:l6619

Maurice Wilson Fowles

Consultant forensic psychiatrist (b 1927; q Liverpool 1954; DPM, MRCPsych), died from several subdural bleeds on 21 June 2019

Maurice Wilson Fowles met Claudine Louise-Marie when she was undertaking nurse training on the Isle of Man. They married in 1955. Fowles trained in psychiatry and became a founder member of the Royal College of Psychiatrists in 1973. After lengthy positions at the Prison Medical Service and Rampton Hospital, he was appointed as regional consultant forensic psychiatrist to East Anglia in 1979. He led the development and establishing of the Norvic Clinic in Norwich, East Anglia's regional secure unit and response to the 1975 Butler report. He was considered an experienced and wise clinician within the developing specialism of forensic psychiatry. Fowles retired from the NHS in 1992. He leaves his three children and five grandchildren.

Hadrian Ball

Cite this as: *BMJ* 2019;367:l6454

Shashi Prabha Gupta

General practitioner Hackney, London (b 1937; q King George's Medical University, Lucknow, India, 1961), died after a long illness with Alzheimer's disease on 20 July 2019

Shashi Prabha Gupta moved to the UK in 1963, initially working in all four corners of the country in junior level posts. She finally settled in London, as an elderly care physician at the Homerton Hospital. She published many articles relating to the health of elderly people, notably a paper in the *Lancet* in 1976, assessing the vitamin D status in elderly patients. Shashi joined her husband to work in primary care and became a forensic medical examiner specialising in sexual assault cases. She started to show signs of memory loss after retiring in 2000 but managed to maintain an active life for many years, travelling and spending time with her grandchildren. She leaves her husband and two daughters, who followed her into medicine.

Mina Gupta, Nishi Gupta

Cite this as: *BMJ* 2019;367:l6511

Judith Mary Hockaday

Consultant paediatric neurologist (b 1929; q St Mary's Hospital, London, 1953; MD Cantab, FRCP), died from peritoneal carcinoma on 24 May 2019

Judith Mary Hockaday (née Fitzsimons) was accredited in both neurology and paediatric neurology by the Joint Committee on Higher Medical Training in 1977. In 1981 she became consultant paediatric neurologist in Oxford. She collaborated with the university's psychology department on problems of language disorder. She saw the need for Oxford based regional services for parts of the Thames Valley, Wiltshire, and Northamptonshire. Judith valued her role as a mentor to clinical students and junior colleagues. In retirement, with her flair for design, she greatly enjoyed restoring an old house and its garden and trained in Oxford as a botanical artist. She leaves her husband, Derek; three children; and six grandchildren.

Derek Hockaday

Cite this as: *BMJ* 2019;367:l6512

Eric Robert Beck

Cofounder of the Doctors Award Redistribution Scheme and major contributor to medical education

Eric Robert Beck consultant physician with an interest in gastroenterology, Whittington Hospital (b 1934; q University College London/UCH, 1958) BSc FRCP, died from sepsis complicating an embolic stroke 16 months previously, on 4 August 2019

In 1983, after a pay award to doctors that was far greater than that for non-medical NHS workers, Eric Beck was the senior author of a letter in the *Times* decrying the award as divisive.

The letter went on to say that the signatories would donate the difference, some 4.1% of the rise, to a fund to be called the Doctors Award Redistribution Enterprise (DARE) that would be used to fund projects not covered by the NHS and for an annual lecture at the Faculty of Public Health Medicine. The latter continues to this day as the DARE lecture.

Principles

Beck was passionate about social justice and equality and the principles of the NHS, attitudes to which his refugee background probably contributed. His German speaking father, Adolph Beck, was born in Austro-Hungarian Prague. He qualified in medicine in Frankfurt, where he had met and married, while still a student, Leni, a nurse and a Catholic.

Shortly after Hitler came to power Adolph was sacked from his university post for being Jewish. He and Leni fled to Paris, where Beck was conceived but, as they moved on, he was born in England. Fear of a Nazi invasion led to Beck being baptised, but the family was resolutely secular. Beck lost most of his paternal relatives in the holocaust, and a maternal uncle in a U-boat.

After requalifying, Adolph secured a post as pathologist in Burnley, where Beck acquired his love of Burnley Football Club. This remained undiminished by the family's move to north west London for Adolph's new consultant bacteriologist job. At St Paul's School, Beck was a contemporary of Jonathan Miller and Oliver Sacks.

Eric Beck was passionate about social justice and equality and the principles of the NHS

Beck followed his father's example and married a nurse, Pat, while still a medical student, but in his final year, she developed Hodgkin's disease, from which she died 20 years later. Their daughter, Helen, was also diagnosed with lymphoma at about the same age as her mother and died from radiation induced cardiac failure in 2014.

Despite his grief, Beck's life was one of lasting achievement. He recognised, while a registrar, the lack of appropriate teaching for the examination for membership of the Royal College of Physicians (MRCP), an essential gateway-cum-barrier to higher training and, at that time, exclusive and a lottery. There were just 23 passes when he obtained his MRCP.

As medical registrar at London's University College Hospital, Beck, with two colleagues, devised a correspondence course and subsequently a book, *Tutorials in Differential Diagnosis*, introducing a problem solving approach to the diagnostic process. Both proved very popular.

Medical diplomat and teacher

The RCP was planning reforms and appreciated the relevance of the teaching material produced by Beck and his colleagues. He was recruited to the membership exam committees, of which he duly became chairman of the Part 2 board and a driving force for achieving change.

A skilled medical diplomat, Beck helped establish exam and local postgraduate diplomas in several centres in Asia, Africa, and the Middle East.

His diplomatic skills also proved invaluable at Whittington Hospital. When UCH Medical School approached the hospital for help with undergraduate teaching, Beck was tasked with negotiating the arrangements. There was no problem with the physicians; however, the surgeons were not on easy terms with their opposite numbers. There was also the need to ensure the Whittington was not being used as a temporary expedient. Beck helped establish an undergraduate centre and professorial academic units of medicine and surgery so Whittington came to be a third campus, with UCH and the Royal Free, of the UCLH medical school.

Beck was teaching communication skills to first year students at the Whittington three days before his stroke in March 2018. His achievements in medical education have been publicly recognised by the fellowship of University College London and the President's Medal at the Royal College of Physicians in 1999—only the second to be awarded.

Beck's non-medical interests were opera, notably Wagner, squash, long distance footpath walking, and football, with two United Hospitals' cup winner medals to his credit. He died peacefully, wearing a T shirt bearing a quote from former Liverpool manager Bill Shankly: "The socialism I believe in is everyone working for each other, everyone having a share of the rewards. It's the way I see football, the way I see life."

Beck leaves his second wife, Pam; their daughter; Martin, his son with Pat; and two grandsons.

Barry Hoffbrand, retired consultant physician, London barry.hoffbrand@outlook.com

Cite this as: *BMJ* 2019;367:l6220