The flowers in my garden sprouted before the Christmas tree was taken down. Australia welcomed the New Year ablaze. The year has hardly begun, but the climate emergency is set to be the story of the next decade.

It’s hard to raise a glass to the next decade while the crisis causes more deaths than smoking, AIDS, diabetes, and road accidents combined, putting increased pressure on healthcare services. Climate related illness and injury disproportionately affect low income communities—another example of the most vulnerable people bearing the largest burden of ill health. And yet, while health providers are busy treating the effects of climate related illness, the healthcare sector’s carbon dioxide output is equivalent to 4.4% of global greenhouse gas emissions. If healthcare were a country it would be the fifth largest polluter.

Alarm is all very well, but what about solutions? As I fly home from another overseas conference it’s embarrassing that my talk about respiratory disease was powered by jet fuel, while the calories provided by the conference were delivered through meat. The lights that brought my colourful slides of battered lungs to life took their energy from the coal that coated the insides of the patient I was trying to save.

Help me to start a movement at our conferences: I want organisers to commit to providing food that doesn’t bloat the atmosphere as well as those eating it. A meat-free lunch would do little to dampen spirits but could be a start to dampening forest fires. A quarter of global emissions come from food production—half of them from animal product emissions, chiefly beef and lamb. Livestock contributes to global warming not only through methane production but through deforestation linked to expanded pastures, and the Intergovernmental Panel on Climate Change is pleading for us to switch to a plant based diet.

If air travel is unavoidable in allowing human connections at conferences, we should nudge speakers to use honorariums or travel costs to cover ethical carbon offsetting projects, and this should be built into the travel expenses policy.

However, even not-for-profit companies providing ethical carbon offsetting are not the whole solution. Organisers could cover travel costs of only the most efficient airlines or advocate train travel for short haul alternatives. With online streaming and virtual connections, travelling halfway around the world to watch someone present slides and to check your emails at the back of a lecture theatre seems a little odd.

Finally, venues should be chosen not only for delegates’ convenience but also to improve our lives now and those of future generations. Selecting facilities that commit to renewable energy is a price worth paying for organisers, delegates, and the planet.

Matt Morgan, intensive care consultant, University Hospital of Wales
mmorgan@bmj.com
Twitter @dr_mattmorgan

Cite this as: BMJ 2020;368:m239

Travelling halfway around the world to watch someone’s slides seems a little odd
The psychological effects of living in a quarantined city

Do the epidemiological benefits of mandatory mass lockdown of urban areas outweigh the mental health costs?

The emergence of a novel form of coronavirus in Wuhan, China, is creating a confused and rapidly evolving situation. As ever in the early stages of a major incident, facts are unclear. We're not sure how many people have caught the disease, the fatality rate, the incubation period, how far it's spread—or how worried we should be.

The imposition of travel restrictions on Wuhan—and a growing number of other cities—has surprised many. The move has left more than 20 million people caught in a modern form of quarantine. Regardless of whether it succeeds in controlling the outbreak, the widespread lockdown will inevitably have a psychological effect.

Residents are reported to be comparing the situation to “the end of the world,” hospitals are “overwhelmed,” and there are concerns about food shortages.

We must be careful of reading too much into this. Journalists regularly assume panic based on little evidence and, in our experience, the further away a reporter is from an incident, the more likely they are to claim panic. Yet words have power. Portraying public responses as panic can lead policymakers to conclude that people should be controlled for their own wellbeing, or that information that might worsen the situation should be withheld.

But while history reminds us that outright panic is unlikely, fear seems an almost certain consequence of mass quarantine. Anxiety in Wuhan is to be expected, even without quarantine. During disease outbreaks, community anxiety can rise following the first death, increased media reporting, and an escalating number of new cases. Mass quarantine is likely to raise that substantially, for many reasons.

Loss of control
First, the measure shows that authorities believe the situation to be severe and liable to worsen. Second, the imposition of the measure primarily for the benefit of those outside the affected cities reduces trust for those within. Third, quarantine means a loss of control and a sense of being trapped, which will be heightened if families have become separated. Fourth, the impact of the rumour mill must not be underestimated. The desire for facts will escalate and an absence of clear messages will increase fear and push people to seek information from less reliable sources.

The cumulative effect can be severe—after SARS cases were identified at the Taipei Municipal Hoping Hospital, all staff, patients, and visitors were restricted to the building for two weeks. An account of the chaos that followed described how the confinement “caused a sense of collective hysteria, driving the staff to desperate measures.” Elevated anxiety may also have implications for other health measures. While reports of Wuhan hospitals being overwhelmed might reflect high levels of disease activity, most patients in previous incidents were found to be free of the disease in question. Surges of such low risk patients are often precipitated by high levels of anxiety, leading patients to identify, catastrophise, and seek help for symptoms that might otherwise have been of little concern.

Perhaps the most pernicious effect is on how those outside the cordon come to view those inside. Previous incidents have seen affected residents shunned and face workplace discrimination. Unless steps are taken to avoid stigmatising those who have been quarantined, the official imposition of a cordon may aggravate such effects. Isolation imposed by vigilantes can follow, or even run ahead of, official quarantine.

Who is legally liable when patients are discharged early?

The Royal Cornwall Hospitals NHS Trust has reportedly advised staff to help relieve pressure on resources by considering discharging patients “earlier than some clinicians would like.” If a trust adopts such a policy, where does legal responsibility lie?

A patient who suffers injury because of a negligent discharge decision is entitled to bring a compensation claim against the responsible trust, not individual clinicians. If a trust adopts a policy that exposes patients to an increased risk of avoidable harm, then it is liable to face more, rather than fewer, claims.

When assessing whether a patient’s management or treatment has been negligent, the courts know most clinical decisions carry an element of risk. They also recognise resources are not limitless.

Whatever it says in a memo, only the clinician can make a judgment, at a particular time, for a particular patient

The law acknowledges that the allocation of scarce NHS resources is not properly a matter for clinical negligence litigation, and that professionals work within structures that are determined, in part, by managerial decisions. However, the pressure on resources would rarely constitute an absolute defence. The Cornwall memo raises the concern that it will influence staff to act against their clinical judgment. Why else send it other than to change clinical decision making?

For a clinician to discharge a patient early when they consider it unsafe or unreasonable, might not only expose the trust to a negligence
The costs of conveyor belt medicine

Over the New Year I worked three 12 hour stints on the acute medical unit. What I saw over those days was nothing unusual for colleagues in NHS acute care. It resembled an out-of-control conveyor belt, used to tragicomic effect by Charlie Chaplin in the 1936 film *Modern Times*. This one wasn’t carrying parts needing screws, however, but sick patients and their worried relatives. The operators weren’t depression era factory workers but clinical staff, struggling to deal with the relentless procession.

Each clinical encounter matters to patients and their relatives. It will be remembered and discussed, not least if things go wrong. We know that decisions, omissions, demeanour, and the time we give people can help or harm—often fraught with managed or balanced risks.

We seem to have several conveyor belts to manage as we run from one to the other in a forlorn attempt to stay on top of the work. We get phone calls for referral or advice, or emergency crash calls that drag people away, mid-task. Patients can deteriorate or require further assessment or admin. Updates remind us of negative bed capacity and our imperative to find more patients to send home sooner. Bed shortages have turned decisions to admit people overnight into a thought crime.

Data on hospital attendances and admissions tell us that none of these pressures is unique to winter. But a slowdown in community health and care services over Christmas and New Year can mean even more beds being taken out of commission by stranded patients, with backlogs taking weeks to clear.

Bed shortages have turned decisions to admit people overnight into a thought crime

We do much of our work in very public areas, trying to maintain a semblance of confidentiality but feeling the pressure of dozens of eyes burning into us in the hope that we’ll be coming to them next. We’re interrupted by people keen for reassurance and updates; even when they’re not our patients we’re seen as interchangeable. Concentration is broken, and errors become more likely. If we assert ourselves we risk complaints that we’ve been rude or dismissive. Our minds are often partly on the next, or sicker, patient as we try to stop the conveyor belt from swamping us. We can’t give people the individual time and attention we’ve been trained for.

There are compensations. When I go home I’m never in doubt that I’ve done something of value. There can be tremendous camaraderie, mutual support, and gallows humour among clinical staff and operational managers, bonded by circumstances in a common purpose. And there’s real skill in being able to work at pace, accept risk, and coordinate workflow.

But I’ve seen too many staff at their human limits—not because of the inherent nature of clinical work but because of a system and workforce not designed for this volume of activity, expectation, or pressure.

When items on Chaplin’s conveyor belt started to fall off, his line manager just drove him harder. He had a nervous breakdown and ended up being swallowed by the machine—only in his case it was fictional, and funny.

Cite this as: *BMJ* 2020;368:m162

David Oliver, consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com
Twitter @mancunianmedic
Cite this as: *BMJ* 2020;368:m162

Perhaps the most pernicious effect is on how those outside the cordon come to view those inside

Social disruption

Longer term effects are also possible. The potential exists for anger, exacerbated by the impact on the economy, to set in train social disruption that might linger for years.

Ever since the Roman plague of Justinian, imposed quarantine has remained part of our public health arsenal. But as with every medical intervention, there are side effects that must be weighed in the balance and alternatives that must be considered.

Voluntary quarantine, for example, may be associated with good compliance and less psychological impact.

Whether the uncertain epidemiological benefits of mandatory mass quarantine outweigh the uncertain psychological costs is a judgment that should not be made lightly.

G James Rubin, reader in the psychology of emerging health risks gideon.rubin@kcl.ac.uk
Simon Wessely, Regius professor of psychiatry, King’s College London
Cite this as: *BMJ* 2020;368:m313

claim, but also put themselves at risk of sanction from their professional regulator. Accordingly, clinicians will want to make a clear record of their view about the discharge, of any instruction or policy to the contrary, and of what advice given to the patient.

Clinicians owe legal and professional duties of care to patients. Managers do not know the specifics of each patient—their condition, the care available at home, or the consequences if they were to deteriorate—but clinicians do. Whatever it says in a memo, only the clinician can make a judgment, at a particular time, for a particular patient. Whatever risks “the health community” are prepared to take, a duty of care and professional responsibility remains with the clinician.

**Nigel Poole QC, head of chambers, Kings Chambers**
Is transactional care enough?

I’m lucky enough to have been in the same practice since 2002, and I’m still discovering things about the patients I look after, making connections that deepen my understanding of who they are and how illness affects them. Terms that have been used to describe me, or the kind of general practice that I think all patients should have, include old fashioned, nostalgic, or hopelessly unrealistic.

A distinction has been drawn between transactional and relationship based (or relational) care. In transactional care the patient has a specific need, a condition is diagnosed and treated, a risk factor is controlled, or a referral made. The quality of the medicine is judged by the efficiency of the transaction: we’re “good” doctors if we can tick the boxes in the Quality and Outcomes Framework, follow guidelines, and keep within our prescribing budgets.

Relationship based care focuses on the patient and doctor interaction. Although the medical activity may be similar, there’s another dimension to consider, which is the quality of that interaction. Relationships and trust develop over time, and we know continuity of care brings a reduction in medical activity—fewer investigations performed, fewer medicines prescribed and referrals made—and longevity increases.

Given the shortage of doctors in UK general practice, there have been suggestions we should work out which patients need continuity and would benefit most from an ongoing relationship with a single doctor. In the case of complex patients with multimorbidity, this could be a familiar team including a nurse and a pharmacist. We could then prioritise these patients to receive continuity, while everyone else would be offered an efficient transaction with a suitable practitioner.

I see two immediate problems with the proposed division of patients. The first is that we really don’t know, before we’ve met the patients, which category they fall into. Neither age nor the number of diagnoses are reliable indicators of complexity, in my experience.

The second is what sort of service patients want. Some would no doubt prefer to see an unknown doctor remotely at a convenient time than wait to see their named GP. For many others, starting afresh with a new GP is daunting, and they prefer to wait weeks to see one they know. In reality I suspect most people don’t want a choice between access and continuity—they want both: a timely appointment with a doctor they know and trust.

If we’re to avoid a future where the one-off, transactional encounter is the default, with continuity reserved for the lucky few, we need more GPs in stable practices. To achieve this, we need more resources and better support for primary care to make it the attractive specialty it was when I joined.

I suspect most people don’t want a choice between access and continuity—they want both

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**LATEST PODCASTS**

Working with the multidisciplinary team

A host of professionals work together to make patient care safe and effective; this latest episode of Sharp Scratch looks at how you can work well with all of them. Here, we hear from Carolyn Cairns who was previously a manager in the NHS but is now a second year medical student:

“It’s so important that the workforce in the NHS get along, and it’s really important to recognise that is clinical and non-clinical. It’s every grade and level, and it’s inside and outside hospitals. We cross over all the time. There are definitely reported points of friction and I challenge people to think about the frictions in their day versus what they read about, because I think it’s easy to fall for the stereotypes about us and them. Generally, I think people work together really well, but different teams have different pressures.”

**Talk Evidence: Sepsis, talc, and blindsided by blinding**

Our first Talk Evidence podcast of the year sees regular hosts Helen Macdonald, Duncan Jarvies, and Carl Heneghan talk about what’s new in the world of evidence based medicine. They cover research on treating sepsis with steroids, whether blinding participants in a randomised control trial is all it’s cracked up to be, and widespread media coverage of a study about the risk of ovarian cancer with the use of talcum powder. Carl Heneghan talks about how this last study reached a conclusion that was the exact opposite of a similar study published in 2016 and how this lands with the public:

“What’s happening here is we are confusing the public by producing single studies that get picked up. They have significant Altmetric scores. The news loves them, but nobody then places them in the context of pre-existing evidence.”

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
Quality improvement approaches drawn from industry can go beyond traditional concepts of value and deliver health service improvements, argue Iain Smith and colleagues.

Healthcare systems internationally face quality and productivity challenges and calls have been made for them to focus on delivering better value. However, in healthcare, value is a debated concept. Value is often viewed in terms of health outcomes per spend for a given population or in terms of clinical efficacy, focusing on interventions with a robust evidence base and reducing the use of interventions of low benefit. But it can also be considered at the level of the microsystem, and systematic quality improvement (QI) approaches can help provide better value through action on quality, safety, and productivity.

The Lean method is one approach that is being increasingly used to enhance value in healthcare. In the UK, for example, NHS Improvement has embarked on a programme to embed Lean in English NHS trusts—some with support from the Virginia Mason Institute, a US based healthcare consultancy, and others with support from an NHS Improvement consulting team.

Lean has drawn criticism for assuming that production efficiency techniques can apply directly to healthcare and for lacking methods to integrate clinical knowledge and expertise with patients’ preferences and needs in defining value. We examine how it can be used to engage stakeholders in both defining value and designing systems and processes to deliver value.

The Lean ideal is to design systems and processes that deliver customer value without waste, delay, or errors.

What is Lean?

Lean is derived from the production process of Toyota, the Japanese carmaker. Lean is a systematic improvement approach that conceptualises work as processes that can be continuously improved by emphasising customer value and eliminating waste. Although it was developed for industry, it has been used successfully to improve quality and safety in acute, primary, and mental healthcare contexts. The goal of Lean is to improve customer value. Defining value in customer terms is the first step.

Box 1: Examples of Lean in healthcare

Western Sussex Hospitals NHS Foundation Trust has developed its patient first improvement system based on Lean principles. The system has been credited as contributing to the trust being rated outstanding by the Care Quality Commission. It is also credited with improving timeliness of patient observations, fall rates, response rates for friends and family tests, and theatre start times, as well as many more small improvements that make a difference to the everyday experience of patients or staff.

NHS England’s General Practice Development Programme has saved thousands of hours of clinical time by applying Lean principles through its “time for care” and “productive general practice” programmes. This involved identifying and implementing high impact changes to reduce waiting times and increase available GP time. Examples include redirecting patients not requiring a GP appointment to see other healthcare professionals such as nurse prescribers.

A cross-organisational collaborative in North East England used Lean methods to improve dementia care and nurse-led liaison mental health services for older adults. This included rapid improvement events that resulted in changes that reduced wait times, readmission rates, and length of hospital stay and made qualitative improvements such as increased confidence of staff and calmer ward environments.
The Lean ideal is then to design systems and processes that deliver customer value without waste, delay, or errors. This is achieved through iterative application of the Lean principles (box 2), which set out the steps for continuous improvement towards the ideal. Differences are well understood to adapt the approach to the specific requirements of the new context. Therefore, delivering value for healthcare using a Lean approach requires understanding of how Lean views customer value, how this concept should be translated to the healthcare context, and practical methods for engaging stakeholders in defining and delivering value.

**Translate Lean value principle to healthcare**

Lean value definitions typically emphasise a commercial, production perspective. Customer value is related to manufacturing processes that convert raw materials into finished products, such as a car, ready for sale. Customers will not pay for defective vehicles, so to deliver value these processes must be performed correctly first time. Production activities that are not adding value are deemed to be waste and targeted for elimination.

US advocates applying Lean to healthcare have tended towards definitions of value in terms of the customer’s willingness to pay and its corollary that “anything in the process that the customer would be unwilling to pay for is waste.” Although this logic may be appropriate for the US system of hybrid payment healthcare, it is less relevant in national health insurance systems like the NHS. Translating Lean value to healthcare services are generally intangible and are characterised by simultaneous production and consumption.

Value is not created through transformative production steps in a remote factory. Rather, the value of the service is co-created with the customer (or end user); patients are not customers at the end of a production process but right in the middle of it throughout their pathways of care. Some believe that the principles of Lean have therefore been misunderstood and a more service-oriented view is required that assumes value in healthcare is co-produced with patients.

Although it may seem obvious that the patient should be considered the customer and value defined from their perspective, there are other customers and stakeholders in healthcare whose needs and value perspectives must also be considered. Young and McLean proposed a framework to help do this by defining three critical dimensions to healthcare value—clinical, operational, and experiential. The clinical dimension of value relates to delivering effective care that achieves the best clinical outcome. The operational dimension relates to the effectiveness of care relative to the cost of care.

The experiential dimension relates to how patients experience the care they receive and can be related to their interactions with staff as well as the care environment. The various healthcare stakeholders (such as patients and carers, clinical and non-clinical staff, managers, and regulators) may place different emphasis on these dimensions of value.

**Lean QI methods to engage healthcare stakeholders**

Arguably, most applications of Lean to healthcare have been limited by a largely operational view of value, where the focus has been on reducing costs rather than a more holistic, multitakeholder view. However, through various workshop formats, Lean does have methods that enable definition of value and enhance customer participation.

Lean rapid improvement events are already commonly used in healthcare to make incremental changes to processes. Other Lean workshops include value stream analysis, which focuses on end-to-end pathways at high level to define strategic improvement plans, and the production preparation process (3P), which focuses on developing new products and production facilities. These Lean workshop formats differ in emphasis but all offer the opportunity to involve patients and service users in identifying value adding activities and eliminating waste. The question is how can people leading health service improvement use these methods in practice?

Box 3 presents an example from the NHS in North East England, which adopted Lean using knowledge from Virginia Mason. The Lean 3P method was used to involve stakeholders in simultaneously designing healthcare facilities and service systems. The example illustrates challenges to participation that may be generally applicable (specifically the perception that patients are unable to contribute because of a lack of knowledge or ability).

**Box 2| Five core principles of Lean in healthcare**

Value—Understanding value from the customer’s perspective (usually the patient)

Value streams—Identifying all the steps (both helpful and unhelpful) in the pathways of care that patients experience as they move through the system

Flow—Working along care pathways to align healthcare processes to facilitate the smooth flow of patients and information

Pull—Creating processes that direct value towards the patient such that every step in the patient journey pulls people, skills, materials, and information towards it, as needed

Perfection—an ideal to be pursued through the ongoing continuous improvement of processes
The 3P method engaged stakeholders to articulate and share their value perspectives. Most importantly, this included service users, who shared their experiences and views on how these could be improved. Their experience was combined with staff experience to design care pathways (value streams) to deliver the desired user value. Staff contributed clinical experience and professional knowledge to ensure this could be done safely and effectively. The treatment rooms and other facilities were located to ensure steps in the pathway lined up with the physical layout to facilitate good flow. The service user, carer, and staff flows were mapped and simulated at each cycle of the design process. Information on how pathways would work was discussed by stakeholders, which helped facilitate improvement.

To improve the overall experiences of care, participants applied a service oriented approach in which “every step in the patient journey [pulls] people, skills, materials and information towards it, one at a time, when needed.” This helped stakeholders design more innovative models of care that could respond flexibly to changing circumstances. Services could then be “pulled” towards patients as required (for example, by bringing a clinician to a patient in a treatment room rather than moving the patient to the clinician in a different location, reducing patient movement). Through multiple cycles of design, the Lean 3P method helped participants move towards an optimised service model and design.

### Effective collaboration

The example shows that QI approaches such as Lean can be adapted to include important dimensions of service led value and quality, such as patient experience and satisfaction. In translating such methods to healthcare, it is important to identify both the primary customer and other service stakeholders to define value and target improvement. The 3P method facilitated conversations across multiple stakeholder groups (including patients, clinicians, and managers) that considered value in a more holistic way. For example, the clinical dimension of value involved stakeholders considering the effectiveness of treatments; the operational dimension involved stakeholders considering the efficiency and productivity of service delivery; and the experiential dimension involved stakeholders considering patients’ preferences and needs.

Stakeholders, including patients, articulated and shared their value perspectives, tested their ideas, and co-designed healthcare facilities and systems to deliver users’ requirements. Stakeholder conversations about the different dimensions of value could also be facilitated in other workshop formats such as rapid improvement events and value stream analysis.

When patients are asked to participate in QI initiatives, their role needs to be relevant and have a practical impact. Proper collaboration early in the change process can help avoid the unintended consequences of overlooking experiential details that matter to patients. To achieve this, the qualitative nature of patient experience must be recognised and given equal priority to that of healthcare professionals.

It is therefore important to involve patients, clinicians, and managers early in the improvement initiative and select methods that allow them to work together on improvement. This includes facilitating conversations between stakeholders about what matters to them and creating opportunities for practical and tangible improvement activities such as small scale tests of change, working through the plan-do-study-act cycle, or creating prototypes together.

In this way, QI approaches such as Lean will begin to fulfil their potential to deliver greater value in healthcare.

Cite this as: BMJ 2020;368:m35
The need for evidence based transatlantic orthography

How reassuring that *The BMJ* allows authors to perpetuate myths, albeit whimsically, encouraging us all to do likewise, without fearing pedantic intervention from editors.

Kasten’s assertion that George Bernard Shaw said that the USA and the UK were “two nations, divided by a common language” is unsupported by evidence (Let It Be, 21 December–4 January). Oscar Wilde, however, in *The Canterville Ghost* (1887) wrote that Mrs Otis “was quite English, and was an excellent example of the fact that we have really everything in common with America nowadays, except, of course, language.”

As for Noah Webster, he encouraged spellings such as -or instead of -our and -er instead of -re long before the 1930s, as seen in his *Blue-Back Speller* (1783) and *A Compendious Dictionary of the English Language* (1806). Others reduced to e the digraphs (not diphthongs) ae and oe in words of Greek origin. Nor did the Americans introduce the z in verbs ending -ize, from Greek words ending -izaein (Latin -izare). They just kept it. The French changed it to -iser and the British to -ise. Kasten, I incidentally note, refers to “manoeuvres,” whereas Noah Webster introduced the US form “maneuvers” in 1783.

Why not spell according to etymology (without expecting etymology to necessarily reflect meanings)? The British would write “tumor” and “humor” and end verbs in -ize. The Americans would write “centre” and “theatre,” but retain “goiter” (Latin guttur, the throat). They would restore the digraphs ae and oe, but not in “fetus”; “foetus,” the incorrect form, was introduced in the 7th century by St Isidore of Seville, who derived it from foveo (Latin, I keep warm), instead of feto (I breed).

Myths about transatlantic linguistic differences abound. Lynne Murphy debunks them in *The Prodigal Tongue* (2018), required reading for those who would write on the subject.

Jeffrey K Aronson, consultant physician and clinical pharmacologist, Oxford

Cite this as: *BMJ* 2020;368:m282

### RIGHT BALANCE IN SEPSIS

#### Sepsis algorithms caused me anxiety

Morgan and Majeed raise valid points about the potential overdiagnosis of sepsis but ignore the effects of current sepsis recognition algorithms on doctors (Editorial, 14 December).

The main reason I stopped working in primary care was the anxiety caused by the “red alert for sepsis” system built into the clinical software we used. In winter, this alert would usually flash up once a day in a worrying red box and urge me to dial 999 “now.” I almost always ignored it and none of these patients came to harm. The few patients I did dial 999 for did not trigger the alert, and one proved to have sepsis.

This anecdotal evidence of clinical experience over untested algorithms was unlikely to save me if a patient did develop sepsis; this caused anxiety. But I was unwilling to flood an already overstretched emergency department with inappropriate admissions just to improve my mental health.

Susan Martin, GP (not practising), Oldham

Cite this as: *BMJ* 2020;368:m134

#### Authors’ reply

We thank Martin for her response to our editorial. Electronic health records bring many benefits for patients, health professionals, and the NHS. Health information technology, however, also contributes to stress and burnout among health professionals.

One aspect of electronic health records that many doctors do not like is the large number of electronic prompts and reminders that they generate. Software system suppliers must work closely with health professionals and patients to minimise the number of reminders and make them more useful (increase the “signal to noise” ratio). This has proved difficult to achieve but should be a priority for health systems if we are to maximise the value of electronic health records and reduce levels of stress and workload for health professionals.

Azeem Majeed, professor of primary care, London; Paul Morgan, consultant intensivist, Cardiff

Cite this as: *BMJ* 2020;368:m263

### GMC AND SAS DOCTORS

#### GMC is committed to supporting SAS doctors

Wield is right that staff grade, associate specialist, and specialty (SAS) doctors make a vital contribution to clinical care and that contribution is often overlooked (Letters, 11 January). The GMC does recognise their plight.

We recently published the initial findings from our 2019 survey of SAS and locally employed doctors (This Week, 18 January). The injustices faced by many of these doctors are unacceptable and, as Wield says, need to be put right. We are now working with others to identify what can be done to give these doctors the support they need.

The independent review of doctors’ wellbeing commissioned by us focused on doctors at all stages of their careers, including SAS doctors. Its recommendations for better support in the workplace will benefit all doctors, but the GMC understands that SAS doctors face particular challenges. We are committed to working with others to tackle them.

Colin Melville, medical director and director of education and standards, General Medical Council

Cite this as: *BMJ* 2020;368:m291

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Cite this as: *BMJ* 2020;368:m291
RISING ABOVE RACISM

Racism should have consequences
Mathew is right—our response to patients’ racism is not always straightforward and there cannot be a “one size fits all” approach (Rammya Mathew, 23 November). But she seems to suggest that everyone should be able to choose the race and skin colour of their doctor, even if there is no other reason for this view than bigotry.

We should offer high quality compassionate care to all people, but if a competent person chooses to decline care based only on the race of the doctor giving it, that’s their problem not ours. Rescheduling treatment to ensure that racist patients only get a white doctor will simply reinforce their bigotry, not “change the way people think.” It sends a powerful and dangerous message to black, Asian, and minority ethnic colleagues that their treatment is not as good as that of their white counterparts—something that should be challenged at every opportunity.

Steven Crane, consultant in emergency medicine, York
Cite this as: BMJ 2019;367:l6984

Author’s reply
My view is that it’s clearly wrong to ask for a white doctor, but our response shouldn’t be to shut patients down and call them racist. I do not think that patients should be given free choice regarding the colour of the skin of the doctor who sees them. But I do think that we should seek the opportunity to have a compassionate conversation when patients put forward such requests. Shuttling people down doesn’t make them any less racist, but evidence indicates that a compassionate conversation might.

In my experience, it is much harder to behave badly towards someone who is showing you kindness. It won’t always be an option of course, and there are always red lines, across which behaviour is unacceptable. In these cases, patients will unfortunately have to be denied care, even if it goes against our desire to provide equitable compassionate care to all.

Rammya Mathew, GP, London
Cite this as: BMJ 2019;367:l7004

Racism is still underplayed in the NHS
NHS clinical staff are under no ethical or legal obligation to provide pastoral care to overtly racist patients or to initiate the “open dialogue” that Mathew suggests. Dealing with unlawful acts is a matter for law enforcement agencies, but reporting such acts is a matter for all law abiding people, including clinical staff—we must not be passive observers.

Patients who commit unlawful acts against the staff who treat them must accept the lawful consequences. It is most unlikely that most of those who commit acts of racial abuse, racially motivated requests, or racially motivated violence against staff lack mental capacity. Even the health minister is telling us: “Don’t accept racist abuse.”

Racism still seems to be underplayed in the NHS. But I found it reassuring that a man was recently arrested on suspicion of a “racially aggravated” offence at a football match.

Jay Ilangaratne, founder, www.medical-journals.com
Cite this as: BMJ 2019;367:l7005

Prejudice within the profession
Perceiving racism is often easier than understanding the complex reasons behind it.

Communication has been a major problem. Some patients’ first contact with a black, Asian, or minority ethnic (BAME)—an acronym I find dismissive for such a disparate group—person might be when they are at their most vulnerable, are being subjected to an approach seen as authoritarian, and are possibly hard of hearing.

The importance of empathy is often emphasised in medical practice, but real empathy needs an understanding of relevant culture and religion, which many doctors lack. I have taken no offence when a Jewish patient has preferred to see a Jewish doctor—showing understanding can give adequate reassurance.

The worst examples of racial prejudice have come from within the profession: a good place to start any zero tolerance. Perhaps our self-righteousness towards racism from patients reflects a collective guilt for the past. Hopefully we are improving.

Simon Kenwright, retired physician, Stowring
Cite this as: BMJ 2019;367:l7008

Listen to ethnic minority staff
Mathew’s focus on patient centred, open access care is valid and important, but as BAME medical students, we think that more consideration could be given to the staff who are being discriminated against.

The NHS’s zero tolerance policy is based on its fundamental principle of equality; if we give a racist patient another choice of healthcare practitioner, we are deciding that one staff member is less equal than another. Radhakrishna Shanbhag, a senior surgeon experiencing exactly this, said that he felt “worthless”—what effect could this have on our less senior members of staff? Ethnic minority staff already face barriers to progression and satisfaction in their job—now is not the time to be overlooking this.

As an individual, rising above racism is gracious, but institutionally, it might be at the expense of our valued NHS workers.

Stephanie N D’Costa, final year medical student, Cambridge; Matthew S D’Costa, second year medical student, London
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RACIST PATIENTS

Abuse demoralises staff
Sokol discusses the Red Card to Racism campaign (Observations, 23 November). This sporting analogy has limited relevance to healthcare—playing a sport is not a basic human right, but access to treatment is.

Similarly, duty of care for players is much lower than for physically or mentally unwell people. We should stick to the NHS zero tolerance of abuse policy, and services should be withdrawn or incidents reported to the police as appropriate. A fair and proportionate response, however, must have two components—an element of oversight on such decisions by a group of people with relevant experience and ability to do an objective review; and a mechanism to ensure that affected staff members are listened to and supported.

Healthcare services are only sustainable as a public service if staff feel supported and valued. Racist abuse should not be tolerated—it not only demoralises staff but renders the NHS unsustainable.

Rais Ahmed, consultant psychiatrist, Derby
Cite this as: BMJ 2020;368:m23
Alfred Myer (John) Burnford

General practitioner Barley, Hertfordshire (b 1920; q Westminster Hospital, London, 1950; DCH Eng, DObst RCOG), died from old age on 8 July 2018

Alfred Myer Burnford (“John”) was born in New Zealand. He was a month short of 14 when the family moved to England and settled in Sussex, where his father, Alfred, was in general practice until his retirement. John’s medical training was deferred by war service with the Royal Marines from 1939 to 1946. After various hospital appointments he went into general practice in Norwich. He then spent six years in Australia as medical superintendent at the rehabilitation branch of the Royal Perth Hospital. On returning to the UK in 1964, he joined an expanding rural practice in the village of Barley, near Royston, from which he had to retire in 1986 because he developed macular cysts. He leaves his wife, Jean; their daughters; and grandchildren.

Philip Burnford

Cite this as: BMJ 2020;368:m43

Elwyn Tudor Jones

General practitioner Criccieth, Gwynedd, north Wales (b 1930, q Welsh National School of Medicine, Cardiff, 1955), died from disseminated carcinomatosis after a short illness on 16 November 2019

Elwyn Tudor Jones was a GP in rural north Wales for 30 years. He did national service in the Royal Army Medical Corps in Libya. While remaining what might be regarded as a traditional, “old fashioned” practitioner, who knew his families and whose interests were always paramount, he oversaw the transition locally from the legacy of two singlehanded practices to a modern multipartnered dispensing practice housed in purpose built premises. Tudor always maintained a progressive attitude, embraced modern technology, and was keen on training young doctors. He finally retired from all medical practice at the age of 78. He leaves Helen, his wife of 62 years; two children; four grandchildren; and one great grandchild, with a second due shortly.

Jeremy Allgrove

Cite this as: BMJ 2020;368:m47

Ernest Herbert Jellinek

Consultant neurologist (b 1922; q Oxford 1952; DM, FRCP, FRCPG), died from frailty of old age on 12 October 2019

Ernest Herbert Jellinek was interned in the Isle of Man as an enemy alien during the war. He enjoyed the atmosphere, but after only two months he had the opportunity of release by volunteering for the army. He was struck in the face by fragments of an antitank shell and recovered consciousness in an American field hospital. By October 1945 he had recovered sufficiently to take up his place at Worcester College, Oxford. He was appointed consultant neurologist at Mount Vernon Hospital in 1962, but in 1966 he moved to Edinburgh as consultant and senior lecturer in the Northern group of hospitals. Ernest was a cultured man, energetic, multilingual, and with a love of travel. Predeceased by his wife, Ruth, he leaves two children and six grandchildren.

Anthony Seaton

Cite this as: BMJ 2020;368:m45

John Bernard Michael Roberts

Consultant urological surgeon Bristol (b 1929; q Leeds 1952; FRCS, FRCPG), died after a few years of living with vascular dementia on 27 October 2019

John Bernard Michael Roberts (“Michael”) started work at Leeds General Infirmary, where he met Jill Foster, a theatre sister, whom he married in 1953. He went into the army to do his national service in Dorchester. In 1966 he started his first consultant post in urology at the Bristol Royal Infirmary. He was particularly proud of being awarded the Moynihan prize from the Royal College of Surgeons. Towards the end of his career, he gave up surgery to become postgraduate dean for Bristol and the south west of England. He developed vascular dementia, requiring full time care at home and then in a nursing home. Predeceased by Jill, Michael leaves five children, 11 grandchildren, six great grandchildren, and two great great grandchildren.

Nadia Roberts

Cite this as: BMJ 2020;368:m44

Calum Og MacRae

General practitioner Isle of Skye (b 1929; q 1956), died from multisystem failure after a long illness on 16 September 2019

Calum Og MacRae originally intended a career in obstetrics but took over his uncle’s general practice when the latter died unexpectedly. Deeply proud of his Highland heritage, he loved every aspect of community practice, from the challenges of remote care, through lifelong friendships and local arts, to fly fishing between house calls and even politics. He was on call continuously for over 20 years in singlehanded practice and gave this up only reluctantly, concerned that he would never again be able to know his patients well enough to be effective. He was never a fan of undue ceremony but a defender of medical tradition; his strongest belief was in the healing nature of human interaction. He leaves Sarah, his wife of 58 years, and six children.

Calum A MacRae

Cite this as: BMJ 2020;368:m48

Anthony Edgar Steel

Consultant ear, nose, and throat surgeon (b 1924; q St Mary’s Hospital Paddington 1949; FRCS), died from old age on 28 October 2019

Anthony Edgar Steel trained in London and held various positions, mainly at Hammersmith Hospital. In 1961 he was appointed to Southend and Rochford hospitals as a consultant ear, nose, and throat surgeon. He stayed in post until 1987 and also practised privately at his home in Leigh-on-Sea and at the (Spire) Wellesley Hospital in Westcliff-on-Sea. He had a particular interest in inner ear surgery. He retired to Burnham-on-Crouch, Essex, where he pursued his hobbies of sailing, including racing, and playing golf. Predeceased by his wife, Jo, in 2001, and one of his twin sons (Christopher), in 2015, Anthony died of travel. Predeceased by his wife, Jo, in 2001, and one of his twin sons (Robin) and two grandchildren. The service of thanksgiving for his life was attended by many former colleagues.

Robin Steel

Cite this as: BMJ 2020;368:m46

Anthony Seaton

Cite this as: BMJ 2020;368:m45

Consultant ear, nose, and throat surgeon (b 1924; q St Mary’s Hospital Paddington 1949; FRCS), died from old age on 28 October 2019

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Anthony Edgar Steel

Cite this as: BMJ 2020;368:m48
Endocrinologist who saved many short children from unnecessary growth hormone treatment

Peter Betts undertook his paediatric training at a time when the many current subspecialties were beginning to develop. He was drawn to endocrinology and in 1978 was appointed consultant in Winchester and Southampton; he moved to Southampton full time in 1989.

For children who were found to be short with growth hormone deficiency, human growth hormone was available to restore them to average height, but very strict criteria had been developed to make sure this precious resource was properly used. The advent of synthetic growth hormone led to the possibility that constitutionally short (that is, short, normal) children might be made taller. At the time it was thought that short children were at a social and educational disadvantage, based on the presumption that a lack of height was detrimental to a child’s development and, in particular, that personality and psychological functioning were adversely affected.

If this were true, then almost 3% of a typical population would be under the third centile for height and potentially might be helped to achieve greater height by regular injections of growth hormone during their childhood and teenage years. Betts took up the challenge to determine whether or not this supposed disadvantage was true and established the Wessex Growth Study, now internationally renowned for answering this important question.

Wessex Growth Study
The researchers recruited all children starting primary school in Winchester and Southampton (Wessex) in 1985 and 1986. Using standardised measurements, they identified all of those who were shorter than the then growth curves third centile. They excluded all those with a recognisable medical problem that contributed to their lack of height and were left with 140 children whom they followed up throughout their school years, along with a matched group of children of average stature.

They found that the shorter children (at least up to the age of 12 or 13) were no different from their average sized peers in terms of self esteem, self perception, and behaviour. Their conclusion was that it was fine to be short and that injections of growth hormone were not indicated in children who were not growth hormone deficient.

This was a hugely important finding, leading to seminal publications in *The BMJ, Lancet*, and other leading journals, and preventing many short children around the world being given unnecessary treatment. It also quashed the paradox that if you treat the smallest child in the class with growth hormone, you simply create another smallest child, who is then eligible for treatment, and this cycle repeats until you have a class of giants.

Peter Betts also cared for children with diabetes. His ideas helped make The Wessex Diabetic Service one of the best in the UK.

Career
Peter Betts trained in general medicine in Stoke-on-Trent and did his paediatric training at Birmingham Children’s Hospital. As a consultant he undertook teaching and research projects in the Caribbean, Jordan, and Russia. He aimed to improve the care of children with diabetes along the Wessex model in these countries, where both knowledge and insulin were scarce resources.

Betts was actively involved in fundraising for local diabetes charities and for patient, family, and carer education. He helped establish an MSc at Southampton University to train multidisciplinary practitioners who could work in small, resource poor communities, with children with disability. He was secretary for the British Society of Paediatric Endocrinology and Diabetes and in 2019, 14 years after retiring, was still co-author of original research.

Whatever he did, he threw himself into headlong. When he sailed, he took courses in navigation and crossed the Channel. When he walked up mountains in many countries he would carry a large pack and stay in refuges or camps. On retirement he threw himself into golf, cycling, photography, and gardening. All his interests were shared with his wife, Elizabeth, whom he had met when a student in London.

He leaves Elizabeth and their three children.