World Cup’s extended pub opening hours make no sense

The drinks industry sees longer opening hours for the World Cup as a victory for common sense—but this sets an unwelcome precedent, says Clifford Mann

Alcohol is rightly both praised and vilified. An accompaniment to food, an adjunct to celebration, and a subject of much expertise and ignorance, it is an accepted part of many cultures. Used responsibly, it seldom causes problems, but my concerns relate to government action that could encourage the opposite. The forthcoming 2014 FIFA World Cup and the related amendments to licensing regulations in England and Wales have brought these issues into focus.

On 24 November 2005 the licensing laws for England and Wales were relaxed. The arguments at that time for amending the legislation, which had been largely unchanged since the first world war, emphasised the benefits of the “cafe society” described in much of continental Europe. It is difficult to imagine a more egregious example of confusing cause and effect.

Those of us who objected at the time were regarded as out of touch and anti-libertarian. Imagine my surprise, then, and that of my colleagues in the emergency departments of England and Wales, when we began to see ever more victims of these “cafes” and the beverages they sold.1 The UK experience of “cafe culture” was turning out to be rather different from a small glass of beer or cognac delivered to your table. Contrary to expectation, people did not saunter into their local hostelry for one or two drinks during the course of a day or evening—they simply stayed later and drank more.

The UK experience became one of queuing uncomfortably in a venue where dim lighting was as much about masking reality as about setting the mood, and where any unpleasantness was supplanted in the minds of the participants by the offer of “two for one” drinks. At the same time, some alcoholic drinks were now priced more cheaply than water at the local supermarket, and the financially astute led the way by “preloading” with cut price alcohol at home before hitting the town.

And so we turn to the 2014 World Cup, opening in Brazil this week, and the announcement that the UK licensing laws will be temporarily amended to allow pubs in England and Wales longer opening hours during certain England games.2 A government move that was originally rejected by the Home Office, this is seen as a “victory for common sense” by the drinks industry. Popular, it may be, but sensible? I beg to differ.

Firstly, I don’t accept that the first round, pool stage matches of any competition can be deemed to be of “national importance.” Would the same actions have been taken if Wales had qualified and England had not?

Secondly, if one accepts that many people would choose to “drink and watch” in a pub, then an argument for longer hours can certainly be made for the first England match against Italy on 14 June, with its start time of 11 pm; however, the same rationale applied to subsequent games that start at 8 pm is surely flawed.

Alcohol drunk in excess is not a zero sum game: while its benefits are transient and reside mostly in the memory, its adverse effects are all too long term, persistent, and physical. British society does not deal well with alcohol, and as a consequence it pays a very high price in terms of lives damaged and healthcare costs.

The consequences of alcohol abuse are seen daily in the country’s emergency departments and manifest themselves as injuries, as well as acute and chronic illnesses. Substantial sums are spent on repairing bodies and property; and sadly, the costs of lost opportunities, shattered relationships, violence, and abusive behaviour are even more substantial.3-6

This temporary relaxation of the licensing laws is unwelcome, as it sets a precedent that those with vested interests can use to encourage the exception to become the norm. Those vested interests have held sway on this occasion—but they must not be allowed to peddle the notion that sporting events are best enjoyed with alcohol, and we must certainly reject the argument that licensing laws should reflect sporting timetables and television schedules. Next month Glasgow will host the Commonwealth Games, and next year the Rugby World Cup will come to England and Wales. These will be fantastic sporting events, but they will not be “improved” by a relaxation of licensing laws.

I hope that all football supporters have the opportunity to enjoy the World Cup. It is unlikely that their enjoyment will be proportional to the amount of alcohol consumed.

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References are in the version on bmj.com.

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FEATURE, p 15; ANALYSIS, p 18
Coffee time is about much more than coffee

The days I don’t make it to morning coffee are the worst days. On these too-busy days the time after surgery haemorrhages into house visits and urgent telephone calls. I’ll be trying to get hold of someone at the hospital—while that someone is trying to get hold of me. I’ll have received badly abnormal blood results but no phone number for the patient. And, of course, I’ll have forgotten the latest computer password that I’ll have written down in several notebooks, none of which I can find.

Coffee time is about succour. I am blessed to work at a practice where it is a time to debate clinical decisions, to seek solace about deaths and disease, and to discuss and learn from difficult encounters. It is a few moments to exchange information about the families that our district nurses are caring for, to share dismay over the latest ludicrous requirement of the general practice contract, and to laugh at the idiot who injured her ear canal because she didn’t notice that the rubber bung was missing from the aural end of her stethoscope. (Yes, that was me.)

In formal educationalist terms, coffee time might be described as professional reflection, peer review, team building, and moral support. Time to talk with your colleagues is like gold. Some organisations pay thousands for this kind of interaction, whisking their employees off for corporate away days of raft building or zorbing.

So what have we done to facilitate this cheap, easily available time that enables collegial bonds to flourish? Rather than being the cornerstone of the day, precious coffee times are disappearing, squeezed by the ever evolving demands of today’s general practice.

The software we now use means that letters from the hospital are acting on by each doctor alone in a consulting room, staring at screen, rather than in the communal space. The tickbox pressure of the quality and outcomes framework, and the need to note every bit of learning for appraisal, ties us to computers, contributing not merely to solitude but also to risks of isolation and loneliness—even in large group practices.

Mandating time to chat with colleagues would be silly. But for every new QOF point, every new innovation, and every new activity that someone presupposes is good for doctors to do, first answer me this: Will it mean that I am more likely to miss coffee time? And because of this might my patients lose out?

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BMJ BLOG OF THE WEEK Ceinwen Giles

Patient leaders at the NHS Confederation Conference

As readers of The BMJ will know, leadership is a hotly debated topic across the NHS at the moment. It’s also a theme that permeated the NHS Confederation Conference in Liverpool last week. Of particular interest to me was the issue of patient leadership, as I was asked to speak at a plenary session called “Patients in the Driving Seat” on the last day of the conference.

As I walked around the conference, I heard much talk of the need to involve patients and work with them—some of it tokenistic, but much of it well meaning. Various sessions highlighted the value of working with patients in different ways, and provided examples of patients who had managed to bring about new services, or shape old services in a new way.

There was, however, a lot of confusion about the concept of “patient leaders.” It sometimes felt like people were using the term “patient leaders” as a politically correct word for “patients,” without understanding that the concept should really force us all to think differently.

The Centre for Patient Leadership defines patient leaders as “patients, service users, and carers who work with others at strategic levels to influence change in health and healthcare.” It also notes that patient leadership is more than patient and public involvement (PPI), and that patients are a vast, untapped asset within the healthcare system. But if that’s true, what does it mean for the NHS?

One thing discussed during the plenary session was the need to create an environment in which patients, managers, and clinicians can work together—to move beyond the “us v them” dichotomy that often permeates PPI work. One frequent criticism of patient involvement work is that patients seldom see past their own experience, and too often focus on things like parking and poor quality food.

It would help both the patients and managers enormously if the way in which patients are involved was better designed, with outcomes for success better defined. But it is also vital to provide training and support, which enables patients to understand how their experiences of the health system can inform thinking on a wider range of issues. Even those who have previous experience that they can draw from need support to understand the structure and culture of the behemoth that is the NHS.

The “Patients in the Driving Seat” session was, as one attendee remarked, excellent—but it was a huge shame that more people weren’t in the audience. That discussions on patient leadership are taking place is a good step forward, and it felt like there was real momentum behind some of the ideas we discussed. Even greater change might occur when sessions like this are better attended.

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Non-palliative care staff need to deliver generalist end of life care

Leeroy William reflects on end of life care from Australia, one of several countries where the Liverpool care pathway is still in use.

The recent demise of the Liverpool care pathway (LCP) in England has shocked many healthcare professionals. There had been poor use of the pathway in the beleaguered English NHS, and similar controversies could occur in any of the 21 countries still using it, or anywhere using a derivative of the pathway. How did this model of end of life care—perceived as best practice—fall from grace? The LCP was developed in the late 1990s. It aimed to transfer the hospices’ approach to end of life care to people dying in other settings. In 2013, however, in the aftermath of media fuelled criticism, the UK government commissioned an independent review. The panel’s report, More Care, Less Pathway, made comprehensive recommendations, including the phasing out of the pathway within a year. With or without a pathway, how can we ensure consistently good care of dying people?

What do we mean by care? The words of the Harvard educator Francis W Peabody remain pertinent: “The secret of the care of the patient is in caring for the patient.” This involves moral, social, and professional obligations, summarised in the five Cs: caring is expressed in compassionate and competent acts in relationships qualified by confidence through an informed sensitive conscience and through commitment and fidelity. One motivator is true empathy—that is, “a concern for the patient’s well-being that comes from a sensitive identification with the patient’s situation.”

And how is this care delivered? The specialisation of modern medicine has fragmented clinical teams. These specialist teams share common goals and learn to achieve this better through regular interaction. They develop a repertoire of skills within their own cultures of care.

Palliative care teams work towards holistic patient centred goals. Their practices have evolved to guide how end of life care is given, and patients’ narratives are important. In many non-palliative care teams, however, end of life care is no longer deemed part of their practice. Even with guidance, the experience of, attitudes towards, and pressures on teams determine how they deliver end of life care. Professional and societal standards, such as those proposed by the LCP, may govern end of life care in general, but the actual care given to patients depends on the particular community of clinical practice.

Most deaths do not occur in hospices. Non-palliative care staff therefore need to deliver “generalist” end of life care. Undergraduate education should lay the foundations, with opportunities for experiential and academic learning. It should facilitate transformative education that changes the way we practice or view our work. However, an inability to participate in, and reflect on, good end of life care perpetuates misunderstandings about how to care for the dying. To this end the palliative care community should continue to collaborate with other teams. In so doing, end of life care may inform other care by promoting attentive human relationships rather than detached interactions.

For many, the LCP, one of several integrated care pathways used in healthcare, became the tool by which end of life care was delivered. Such pathways aim to standardise care, whether viewed as protocols to be followed or guides to prompt appropriate care. These pathways may be defined as “structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem.” These “problems” were ideally well defined diagnoses or procedures—for example, myocardial infarction and colectomy. With multiple pathologies or variable clinical management, cautious use of such pathways remains advisable.

How appropriate is the concept of standardisation of care in the context of death and dying? The diagnosis of dying is far from straightforward and rarely involves a single pathology, making it a less well defined problem for an integrated care pathway. People who are dying, and their families, also require variable management plans that enable the delivery of personalised end of life care.

It is not clear whether use of integrated care pathways has improved patient care. Better end of life care is a focus for ongoing research. Whatever replaces the LCP cannot and must not be a substitute for good clinical practice, professionalism, and compassionate care. We need to create spaces for families to unite, grieve, reminisce, say farewell, and support each other. Palliative care services are available to facilitate better end of life care, but the need for change must be clear.

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