

**NO HOLDS BARRED** Margaret McCartney

## Why I love Parkrun

Long ago, at a riverside hotel, my betrothed and I went for a walk. We were joined by the hotel's dogs, yelping their delight. We had found ourselves a couple of companions who recognised the gleeful combination of social interaction and exercise.

This is the winning combination that we find in Parkrun ([www.parkrun.org.uk](http://www.parkrun.org.uk)). Every Saturday at 9 am, or 9.30 am in the darker northern climes of Scotland, people gather together in parks to run 5 km around them. It's entirely free. If you want to know your time, register online and print out a barcode. That's all you need to bring. The events are run by volunteers, who usually run on other weeks themselves. In other words, the events are self sustaining.

There are commercial sponsors, but the organisation is not run for profit and is supported by only a handful of paid employees. The number of runs in the United Kingdom has grown from one in 2004 to about 300, and now more than 50 000 runners are out "parkrunning" each Saturday.

**Social interaction is associated with longer life, and exercise is associated with reduced mortality**

And shorter runs for under 14 year olds are beginning on Sundays in many areas.

Running in a park involves none of the vile mirrors that haunt me in gyms; instead, you are surrounded by trees and grass and encouraged by marshals to keep going. Because runners are asked to do a little volunteering if possible, it's easy to get to know the regulars, and the resulting atmosphere is cheery.

I take great pleasure in seeing Lycra clad, sub-20 minute runners at the front later clapping the folk at the back as they cross the finish line, and anyone is welcome to walk for some or all of the course or to take part in a wheelchair. Parkrun includes old and young runners.

Personal statistics are available for even the slowest runner to analyse on the website—total runs, volunteering, age grading, fastest time this year—meaning that runners always



The *BMJ* readers can buy Margaret's new book, *Living with Dying*, for £7.99 (RRP £11.99) from [www.pinterandmartin.com](http://www.pinterandmartin.com) with code BMJ799

have something to aim for (including covered T shirts for people who complete 50, 100, or 250 runs). And what delights me most is that a quarter of people taking part don't describe themselves as runners; overweight and middle aged people are well represented, as are people with limiting disabilities.<sup>1</sup>

I have a bias: I love Parkrun. You might, too. Social interaction is associated with longer life,<sup>2</sup> and exercise is associated with reduced mortality.<sup>3</sup> The Olympics were never going to get the nation doing a decent amount of exercise.<sup>4</sup> But community running—inclusive, interactive, and regular runs for ordinary people—is something that might actually make a difference.

Margaret McCartney is a general practitioner, Glasgow  
[margaret@margaretmccartney.com](mailto:margaret@margaretmccartney.com)

Cite this as: *BMJ* 2015;350:h230

Twitter @mgmccartney

**IF I RULED THE NHS** Mayur Lakhani

## Promote a massive cultural shift in attitudes to dying

In a 2008 poll *BMJ* readers voted "palliative care in conditions other than cancer" as the intervention that would make the "greatest difference to healthcare." If I ruled the NHS I would make this a reality. All people with advanced progressive incurable illnesses would receive palliative care regardless of diagnosis or postcode.

By doing this, we would make good care for all at the end of life the norm. People in the last years of their life or with life limiting diagnoses would be encouraged to think ahead and make advance care plans. Quality and value would improve dramatically. Moreover, it could tackle the problem of "overinvestigation" and futile treatments by shared decision making, which is the central tenet of care planning.

The case for change is strong. Although Britain's palliative care services are among the best in the world, we are only scratching the surface. Most deaths still occur in hospital. Wards are full of people who do not need to be there, simply because no one has discussed their choices with them for what lies ahead. At least 92 000 people at the end of life do not get the care they need. The default of an ambulance taking a patient at the end of life from a care



**Although Britain's palliative care services are among the best in the world, we are only scratching the surface**

home to a hospital needs to be a thing of the past. The situation is pressing, the numbers of deaths are expected to rise.

I would promote a massive cultural shift in professional and public attitudes to death and dying. Transformational plans would be demanded from commissioners. Specifically I would co-locate palliative care doctors with relevant secondary care physicians such as oncologists and geriatricians.

This model would require a robust infrastructure with strengthened and accessible services outside hospitals, 24 hours a day, seven days a week. I would build this around general practice and its registered list. Advanced general practice with lower list sizes would provide continuity of care for patients with multimorbidity and

polypharmacy. End of life care planning would be integrated into management of long term conditions. I would combine community nursing with general practice to make one unified team.

At the heart of this new holistic model of care would be federations of general practices. The federation, on a hub and spoke model, would be people's "medical home." I would ensure that federations were "stamped" on the NHS map of England. There should be a national building programme of health and care campuses so that they became centres of excellence linked to universities. I would ensure that mentoring and support were of the highest standard for all staff and that an incentivised and progressive career structure was in place for all GPs, including sessional GPs.

If I ruled the NHS specialists and generalists would work together in "teams without walls" to promote the highest possible clinical standards.

Mayur Lakhani is chairman, National Council for Palliative Care, UK [mk.lakhani@gp-c82644.nhs.uk](mailto:mk.lakhani@gp-c82644.nhs.uk)

Cite this as: *BMJ* 2015;350:h605

thebmj.com

Read previous articles in this series at <http://www.bmj.com/specialties/if-i-ruled-nhs>

# Saatchi is right to promote medical innovation but his bill is wrong way to do it

Medical innovation in the UK is thriving already, writes **Michael Baum**. A commission to consider obstacles to progress would be more useful and safer for patients than the Medical Innovation Bill

**T**he peer Maurice Saatchi's Medical Innovation Bill has just passed its third reading in the House of Lords and will shortly be debated in the Commons.<sup>1</sup> I oppose the bill and believe that it is based on a false premise that innovation in medical practice is inhibited through fear of litigation, but whatever the outcome for the bill some things must change so that real impediments to medical innovation are recognised and dealt with.

The law is a blunt instrument, and we risk serious unintended consequences in changing the status quo. A "bill to cure cancer," however well meaning, would remove current safeguards and be likely to add another layer of bureaucracy that would inhibit progress. And it reflects a naive understanding of the logic of scientific discovery.

## Forty years of innovation

Contrary to Saatchi's claims, medical innovation is thriving in the United Kingdom, perhaps more than anywhere else in the world. In surgery we have witnessed phenomenal successes with organ transplantation, joint replacement, and minimally invasive procedures. My life was probably saved a couple of years ago by the insertion of two coronary artery stents through my right radial artery. To deny that progress has resulted from medical innovation is disingenuous in the extreme.

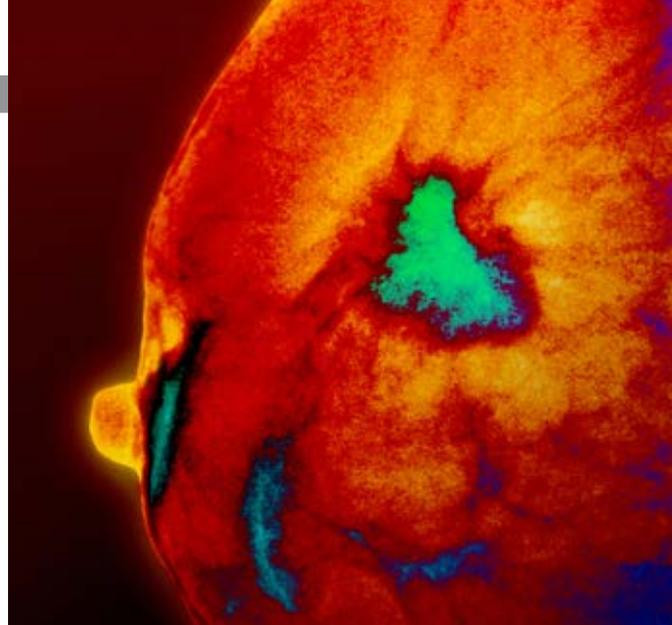
I can provide examples from my own career regarding innovation in the treatment of breast cancer. Along with groups in the United States and Italy, clinical scientists in the UK lead the revolution in breast cancer treatment, from radical mastectomy to breast conserving surgery, improving patients' quality of life.<sup>2</sup> Of equal importance was our pioneering work on adjuvant endocrine therapy with anti-oestrogens (tamoxifen) and aromatase inhibitors.<sup>3-4</sup> These approaches have contributed to a 37% fall in breast cancer mortality in the UK in the past 40 years (from 40 deaths per 100 000 women to about 25 per 100 000), the best outcome in Europe.<sup>5</sup>

Never once have oncologists in the UK encountered interference or obstruction because of fear of litigation.<sup>6</sup> There are, though, many other obstacles to progress. Changing the law with this bill would not accelerate innovation in cancer therapy—but it might well endanger our patients through uncontrolled experimentation.

## Myth of "nothing to lose"

There is a myth that patients with terminal cancer have nothing to lose, so what's wrong with

**Changing the law with this bill would not accelerate innovation in cancer therapy—but it might well endanger our patients through uncontrolled experimentation**



ZEPHYR/SPL

## We already innovate in breast cancer treatment

"suck it and see"? Well, firstly, we will learn nothing from such anecdotal reports. Secondly, they could mislead us.

The expectation of life in "terminal" cases is unpredictable. It is nothing but urban myth to claim that "the patient was given only six months to live." If through "innovation" at Hogwarts School of Medicine she lives for nine months, this will be trumpeted as proof of success of the bill. If she dies at three months, it will be written off as the patient's fault for not having sought treatment earlier.

"Unproved" treatments already blight the lives of many; bizarre diets often take time to prepare, and they deny patients the pleasure of self indulgence in choice of food and drinks. Money can be squandered on trips to healers, and, in the desperate search for a miracle cure, patients can be denied a dignified and decent death in the comfort of their own homes and in the embrace of their families.

Hope is always important, but it must not be betrayed. Freelance "innovation" will almost always bring false hope because it will rarely—vanishingly rarely—stumble on a cure. There will often be a tipping point when doctors in charge may judge that their role has changed "from curers to carers." Patients must never be abandoned, and so at this point supportive and palliative care kicks in. Adequate control of symptoms can in

itself prolong life.<sup>7</sup> In addition to medical and palliative care, many patients should be offered spiritual support as their time runs out. So called "holistic medicine" is but a poor alternative to the appropriate rite of passage of most of humankind's tribes and faith groups.

## We need no-fault compensation

I must congratulate Saatchi for opening up this debate, which in its own way has provoked a period of reflection among lawyers and clinical academics such as myself. Nevertheless, I beseech members of the House of Commons to reject this bill.

The problem of excess litigation in healthcare might be tackled by no-fault compensation. But as the NHS Litigation Authority points out, no case has been documented where a doctor has ever been sued for responsible innovation. I appeal to Saatchi's team to redirect its efforts and resources to initiate a commission that will investigate the real obstacles to progress in medical innovation and not unintentionally provide cover for charlatans, nor muddy the waters of common law where there is now clarity. Yes, we need change, but not this bill.

Michael Baum is professor emeritus of surgery and visiting professor of medical humanities, University College London  
baum.michael3@gmail.com  
Cite this as: *BMJ* 2015;350:h351

► thebmj.com poll  
See this week's online highlights page