comment

> Feminism is a reason to object to flibanserin. How can it be feminist for doctors to tell women what's normal and prescribe pills to control their sexual desire?

NO HOLDS BARRED Margaret McCartney

Flibanserin is not feminism

The UK Medicines and Healthcare Products Regulatory Agency will neither confirm nor deny it, but flibanserin is likely to be coming to British shores. Its maker, Sprout Pharmaceuticals, told me that it is "committed to working closely with other regulatory bodies outside the US . . . to bring to market a safe and effective treatment for the millions of women around the world affected by distressing low sexual desire." The drug was licensed at the third attempt in the United States for the treatment of hypoactive sexual desire in premenopausal women.[1]

Ironically, a pressure group used the feminism argument to push for the US Food and Drug Administration's approval on grounds of equality (men have their drugs; we want ours), when feminism is in fact a reason to object to flibanserin. How can it be feminist for doctors to tell women what's normal and prescribe pills to control their sexual desire?

We are told that 43% of women have low libido.[2] But women in this study were not asked whether their lack of interest was a problem for them—let alone an illness. Is experiencing no pleasure during sex a medical problem to be solved? What about a woman's relationship or the culture that surrounds her?

The intersection of psychiatry, feminism, and pharma has an uncomfortable history. The *Diagnostic and Statistical Manual of Mental Disorders* in 1952 described the "frigidity" of women,[3] which was expanded and differentiated over time. By 2013 the manual described "female sexual interest/arousal disorder."[4]

Some researchers have called on doctors to take responsibility for maintaining "sexual health," decrying "underdiagnosis and undertreatment" and noting pharmaceutical solutions (as well as declaring interests of consultancy to Sprout).[5]

But does flibanserin work? The FDA turned it down because one of two primary endpoints studied in two phase III studies, a daily diary of sexual desire, did not reach statistical significance.

A third trial asked women retrospectively about their sexual desire in the previous four weeks. Across the trials, 0.5 to 1 more "satisfactory sexual events" a month occurred with flibanserin than with placebo. Even if real life use reflects this, is it clinically significant? And is it worth the side effects: low blood pressure, fatigue, and somnolence?

Interaction with alcohol was assessed for side effects among only 23 men and two women.[6 7] Flibanserin is taken daily, and alcohol is contraindicated because of concerns about hypotension. This suggests that women can never drink while taking it.

The message on Sprout's voicemail says that it needs no further investors at this time. Save your money: the drug may be only slightly better than placebo. This is a medical "solution" offered for the huge complexity of female sexuality. It short-changes women. Flibanserin is not feminism.

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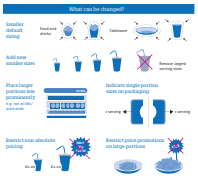

ANALYSIS

How smaller portion sizes might help tackle obesity

Larger portions of food increase consumption. **Theresa Marteau and colleagues** suggest ways to reduce their size, availability, and appeal

The size of portions, packages, and tableware has increased over the past 50 years (fig 1, opposite). Our recent Cochrane review shows that people consistently consume more food or non-alcoholic drinks when offered larger sized portions or packages, or when using larger items of tableware.[4] The size of this effect suggests that eliminating larger portions from the diet could reduce average daily energy consumed by 12-16% among UK adults and by 22-29% among US adults. Our estimates are in line with those generated in another review on portion size using different methods.[5]

Crucially, portion size is a modifiable determinant of dietary energy intake and most national and international policies to prevent obesity highlight a need to reduce portion sizes.[7 8] Indeed, a recent economic analysis ranked reduced portion size as having the highest potential to reduce the population health burden of obesity.[9]

It seems that the norms for what constitutes a suitable amount to consume are shaped by food portions we routinely encounter in supermarkets, restaurants, or the home, including images used in marketing. As exposure to larger portions has become more common, these sizes have come to be viewed as appropriate, with consumption correspondingly increasing. This suggests that reductions in portion size might, over time, recalibrate consumption norms, even if there were initial resistance from consumers and industry.

Policy options

Change will require active intervention. Achieving such change will require support from the public, industry, and politicians. We consider what interventions might work, where and how they can be made, and who needs to act.

What interventions might work?

The box (right) shows interventions with the potential to reduce portion sizes. While the evidence for the effectiveness of changes in physical and economic environments in relation to portion size is limited, there is strong evidence that interventions that reduce availability and increase price reduce tobacco and alcohol consumption.[18 19]

Reducing portion sizes across the whole diet to realise large reductions in consumption may mean reverting to sizes of portions and tableware similar to those in the 1950s (fig 1). This would involve reductions of over 50% for some energy dense products, far greater than the typical 5% reductions currently offered and negotiated with the food industry.[20]

Key uncertainties

Most of the existing evidence on the effects of reducing portion size comes from studies of very large portions. We therefore cannot be certain that reducing smaller portions would be as effective in reducing food consumption. In addition, we do not know by how much large portion sizes can be reduced before becoming unacceptably small. While

People consistently consume more food or non-alcoholic drinks when offered larger sized portions or packages

INTERVENTIONS

Physical environment*

Food and drink

Sizing—Make default serving sizes smaller for energy dense foods and drinks—eg, reduce size of single serve confectionery and serving size of chips and cakes in canteens

Availability—Reduce availability of larger portion and package sizes†—eg, remove largest serving size of drinks; increase availability of smaller portion and package sizes—eg, offer option of smaller portions to diners in restaurants

Placement—Place larger portion sizes in stores and cafes less accessibly†—eg, portion size limits at checkouts, aisle ends, and special displays

Design—Demarcate single portion sizes in packaging through wrapping or visual cues†—eg, individual wrapping of biscuits

Marketing—Restrict portion and package sizes used in advertisements and other marketing

Tableware (plates, cups, glasses, and cutlery)

Sizing—Make smaller tableware the default for self service and served foods and drinks†

Availability—Increase availability of smaller tableware and reduce availability of larger tableware for home use

Design—Develop tableware that maximises the mechanisms underlying the portion size effect—eg, shallow plates, straight sided glasses, cutlery that holds smaller mouthfuls

Economic environment

Restrict pricing practices whereby larger portion and package sizes cost less in relative (and sometimes absolute) monetary terms than smaller sizes†

Restrict price promotions on larger portion and package sizes†

Price tableware in relation to size

*Subheadings taken from a typology for interventions in physical microenvironments[16]
†Actions most consistent with evidence from our systematic review[4]

WHAT YOU NEED TO KNOW

- People consistently consume more food or non-alcoholic drinks when offered larger sized portions or when they use larger tableware
- Actions in public and private sectors to reduce the size, availability, and appeal of larger portion sizes might help prevent obesity
- Some interventions will probably require regulation and legislation
- Independent and rigorous evaluation is essential to ensure actions are effective

PERSONAL VIEW Ashley Graham Kennedy

The title Doctor disrespects patients

Deference is incompatible with person centred care

Medical titles reinforce a clinical hierarchy and frame the physician-patient relationship as a deferential one, which is hardly appropriate in person centred care.

A while ago I spent some time shadowing hospital doctors. On one of my shifts, a woman was brought to the emergency department. A physician entered the patient's room and introduced himself in the usual way.

"Hello, Ms Smith," he said, "I'm Dr Jones. I will be taking care of you." The woman visibly stiffened. This seemed odd, until I heard her reply: "Well, isn't that nice? I'm Dr Smith," she said. It turned out that she held a doctorate in clinical psychology.

Treated with respect

The woman's point was clear: she introduced herself to the physician with her title because she wanted to be treated as his equal; she wanted to be treated with respect. This, of course, is what all patients want, and it's what they deserve.

Titles have the power to shape interpersonal relationships. By using the title "Doctor" (from the Latin docere—"to teach") when addressing physicians, we are saying that the physician is the one in charge. And by introducing themselves with this title, physicians implicitly reinforce the same idea. These practices do not encourage them to respect their patients.

Unlike degrees, titles can't be earned: they can only be bestowed. A degree is a mark of education; a title is symbolic of money, power, and prestige.[1] By bestowing the title "Doctor" on physicians we, as clinicians and patients, have chosen to set them apart from everyone else. But physicians no longer call the tune in clinic as they did 50 years ago. Titles that signify who is in charge are anathema to today's interprofessional, team based approach to healthcare delivery.

Who is in charge?

But how, without using a title, can we identify physicians in the clinical setting? This question implies that, without the title, patients won't know who is in charge. This is similar to the objection posed by those who disagree with calls for clinicians to stop wearing white coats.[2] In both cases, potential problems can be easily circumvented—for example, "Hello, my name is Joan Smith, and I'll be the physician on your healthcare team today."[3] Badges could still be used with the care provider's name and role.

Titles that signify who is in charge are anathema to today's inter-professional, team based approach to healthcare delivery

But won't the physician-patient relationship be misconstrued without the separation that a title creates? In medicine, appropriate boundaries need to be drawn—but the title "Doctor" draws this line in the wrong way.

PATIENT COMMENTARY Dave deBronkart

Empowered patients aren't belittled by doctors' titles

Doctors' trappings of power—white coats, diplomas, titles—are a mixed blessing. I'm an empowered, egalitarian, and free thinking patient, but still I've known the desperate desire to have my life saved by brilliant, god-like, highly educated, experienced wizards.

I've known the healing sensation of feeling that I'm in the best place possible and in the hands of someone who can save me. And I'm all for it if these trappings sometimes have some kind of placebo effect.

But power can also be used, intentionally or not, to control others. Some physicians have told me they were taught that these trappings were part of their earned authority: for them, any questioning of their trappings' validity can seem to be an insult.

Other doctors have told me that it's their sacred responsibility to use these trappings, to display confidence even when not confident, to help boost the patient's therapeutic response. Once a physician has seen a patient benefit in this way, to question the method or to suggest taking it away is to threaten to remove an established tool from the doctor's black bag.

"Doctor, what should I do?"—what does this question mean? Is it oppression? Does it reflect

Awakened patients simply don't participate in the pre-transformation discourse in which "Doctor" connotes, "better than you"

helplessness? To me, it's an emblem of partnership. But many hear it differently.

The culture of medicine is in the early stages of a redistribution of power, in reality as well as in the beliefs of patients, providers, and policy makers. Many patients want their clinicians to know exactly what should be done; they want the feeling that they've found

AF ARCHIVE/ALAMY

A professional boundary should respect an appropriate distance between the two parties. The hierarchical title "Doctor" instead creates a distinction that the patient is lesser than, and should defer to, the physician. It is exactly the sort of message that we ought not to send in clinic.

Professional skills

An implicit assumption is that using a title fosters patients' trust in physicians. But we can't ascertain others' professional skills from things such as clothing or titles.[4] Instead, physicians should encourage patients to learn to evaluate clinicians on their competence in medical practice.

But might patients be uncomfortable addressing physicians without a title? Perhaps at first: patients once had to learn that female or non-white professionals were as fit for medical practice as their white, male counterparts.[4]

Patients' rights have reshaped the physician-patient relationship in recent years. Re-educating patients about the importance of practice over titles would be worth the effort to achieve truly shared decision making in healthcare.

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expertise. Yet other patients feel belittled by the trappings of power. In some cases they've experienced belittling remarks from doctors ("When did you get your medical degree?") or disempowering orders ("Stop Googling"). Remarks such as these are oppressive, regardless of whether the speaker is called "Doctor" or "Jimmy."

Culture change

Today, activated "e-patients" are leading a culture change in medicine and expressing what they value, which includes the skills of the best clinicians. No physician could oppress these patients' sense of self worth, even if they conspired to. These awakened patients simply don't participate in the pre-transformation discourse in which "Doctor" connotes "better than you."

As empowered as I am with plenty of self respect, I admire my clinicians' training and experience. They know more than I do; that's why I come to them. At the same time, my values matter to me, and I'd better not have any clinician say, "You shouldn't want that." As the social activist Eleanor Roosevelt said, "Nobody can make you feel inferior without your consent."

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ACUTE PERSPECTIVE

David Oliver

Stop blaming patients for A&E visits

The NHS Wales chief is urging patients "not to clog up accident and emergency units," the BBC recently reported.[1] The story? Four fifths of patients using emergency departments didn't need hospital admission or treatment. The inference? Such attendances were frivolous, entirely avoidable, or irresponsible.

The Welsh "Choose Well" programme aims to steer patients to appropriate services.[2] But the message that stuck from the BBC's story was one of blaming patients.

NHS England's review of urgent care also described options for patients, from "self care" upwards.[3] But the mass media focused on Bruce Keogh, medical director of NHS England, saying that 40% of patients leave emergency departments without treatment.[4]

A report from the Royal College of Emergency Medicine and the Patients Association, *Time to Act*, surveyed 924 emergency patients.[8] It concluded, "The judgement of urgent and emergency is made by the patient and not by the clinician." Patients' highest preference was still the hospital emergency department: as one said, "When in doubt, frightened or worried, I'd use A&E."

Many patients attended through personal choice, but 40% had been advised to attend by a healthcare provider such as a GP

Many patients attended the emergency department through personal choice, but 40% had been advised to attend by a healthcare provider such as a GP. One third had already consulted another service before resorting to an emergency department. About two thirds were well aware of other services such as general practice, out of hours, or pharmacists.

The Department of Health is pushing an agenda of choice.[9] The public are intelligent. They know that they're likely to be seen and treated within four hours in emergency departments, 24/7. Many have less confidence in alternative community services, often from personal experience. And many people, frightened that they are seriously ill, want reassurance—also known as leaving with no medical treatment.

Blaming the public for using a service that they value, when they think it's needed, is the antithesis of patient centredness. Punishing emergency departments for demand is unhelpful.

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the portion size effect seems to operate without awareness,[10 12] overt actions to reduce portion sizes, particularly when prices do not also decrease, may prompt consumer resistance.[21] This may not recede until social norms are recalibrated and pricing is adjusted to reflect a smaller size.[22]

Reducing exposure to larger portion sizes could also have unintended compensatory effects, encouraging consumption of multiple smaller portions or additional foods. At present there is no strong evidence for this.

Where can interventions be made?

Public sector environments

Implementation of portion size interventions will be easier in public sector organisations, such as schools, hospitals, military bases, and prisons, than in commercial environments. Intervening in health related environments could have a particular potency, removing the "health halo" that comes from providing less healthy foods, including larger portions, in these environments.[24]

Commercial sector environments

Interventions in commercial environments pose major challenges. For example, the attempt to introduce a 16 ounce (454 mL) limit on the size of sugar sweetened beverages sold in food outlets in New York City met much resistance and has been unsuccessful.[26] There has been an effort to reduce portion size in England through voluntary agreements as part of the Public Health Responsibility Deal. For example, Mars, Nestlé, and Mondelez, the three largest chocolate manufacturers, have committed to limiting the energy content of single serve confectionery to 250 kcal. However, broader change across companies and products is fragmented. Some cinema chains in England have voluntarily removed their largest cup size of soft drinks so that the maximum is now 32 ounces, but this is still a large amount and the fact that not all cinemas have signed up illustrates the limits of a voluntary approach.

How can interventions be achieved?

A combination of regulatory and non-regulatory measures is likely to be needed.[27] Indeed, the food industry may find it difficult to act without regulation given "first mover disadvantage."[28] Including disincentives or sanctions for non-participation in voluntary agreements may also help.[29]

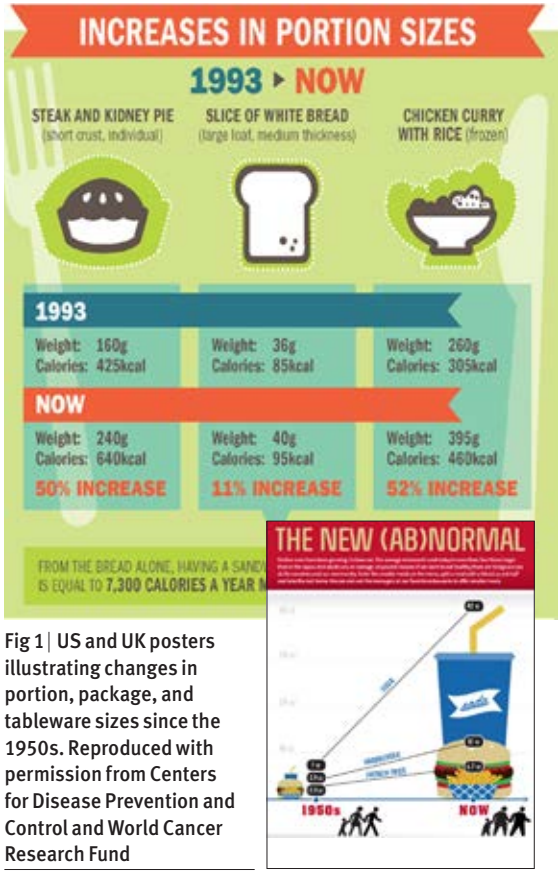

Fig 1 | US and UK posters illustrating changes in portion, package, and tableware sizes since the 1950s. Reproduced with permission from Centers for Disease Prevention and Control and World Cancer Research Fund

Effective interventions will also need to take into account industry innovations that may circumvent the intended effects of policy approaches. For example, the agreement of confectionery manufacturers to phase out king size chocolate bars in 2005 led to the introduction of bars containing multiple portions, ostensibly for sharing or consuming at different times. A 2015 poll reported that 40% of those aged under 25 regularly eat a whole 150 g "sharing bag" of crisps, which can contain up to a third of an adult's recommended daily intake of calories and salt and almost a quarter of the recommended intake of fat.[30]

A 2015 poll reported that 40% of those aged under 25 regularly eat a whole 150 g "sharing bag" of crisps

Who needs to act?

Although policy makers and the food industry have primary responsibility for action, public acceptability is likely to be an important facilitator. Public acceptance of government intervention to prevent obesity is mixed but stronger when it is focused on children.[31 32] More specifically, little is known about the acceptability of reducing portion or package sizes. A newspaper survey of New York residents in 2012 reported 60% opposed the proposed 16 ounce cap on sugary drinks.[33] This was during a media campaign, funded by soda manufacturers, highlighting the rights of citizens to purchase soda in sizes "without interference from bureaucrats." By contrast, a more recent survey of UK and US participants found greater support for this intervention, with 59.9% and 53.5%, respectively, finding it acceptable (unpublished data).

While public acceptance seems necessary for governments and the private sector to act, real progress may require more coordinated public demand.[35] The introduction of many tobacco control measures reflects the mobilisation of public support, not yet evident for obesity control.[36] Providing information about the effectiveness of interventions increases support for them.[37 38] Communities can also be enabled to act through stronger non-governmental organisations (NGOs) as seen in Mexico, where NGOs purchased prominent advertising space to effectively counter industry opposition to soda taxes.

Conclusion

The compelling evidence that larger portion sizes of food and non-alcoholic drinks increase consumption is currently unmatched by similarly strong evidence on how to reduce this effect. This requires independent and rigorous evaluation of interventions that aim to reduce the size, availability, and appeal of larger portions. Successful interventions, if implemented at sufficient scale, have the potential to help prevent obesity as part of a wider obesity strategy.[27] Aligning the will of the public, private industry, and political leadership is key to progress.

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Cite this as: *BMJ* 2015;351:h5863

OBITUARIES

Herbert Jonathan Kwaku-Mensah Mamattah

Consultant pathologist (microbiology) Leighton Hospital, Crewe (b 1932; q University of Ibadan 1962; Dip Bact Manch, MD Lond), died from a ruptured aortic aneurysm on 20 July 2015.

Herbert Jonathan Kwaku-Mensah Mamattah moved from his native Nigeria to the UK in 1966. At Leighton Hospital, Crewe, he was instrumental in setting up and establishing a robust microbiology department. He had to retire in 1994 after unsuccessful surgery for his chronic back problems. He leaves seven children and eight grandchildren.

Joseph O E Jones

Cite this as: *BMJ* 2015;351:h5222

Brian Anthony Wolfenden

General practitioner Preston (b 1925; q Manchester 1949), d 14 August 2015.

Brian Anthony Wolfenden moved to Preston in 1952 to join a small practice, which grew substantially over time and is now known as St Mary's Medical Group. After several heart attacks and successful coronary artery bypass surgery in 1991, he retired close to his children in Buckinghamshire. Predeceased by his wife, Yvonne, in 2009, he leaves three children, nine grandchildren, and 12 great grandchildren.

Andrew Partner

Cite this as: *BMJ* 2015;351:h5157

Graham Abbott

General practitioner (b 1964; q Leeds 1989; MRCGP), died from mesothelioma on 18 July 2015.

Graham Abbott was instrumental in setting up a one stop clinic at North House Surgery, to streamline services for patients with chronic diseases. He was also a keen advocate of Ripon Community Hospital. Diagnosed with mesothelioma in 2011, he featured in the *Daily Telegraph* newspaper in an article about mesothelioma and also provided help and support to other mesothelioma patients via Mesothelioma UK. He leaves his wife, Rachel, and two daughters.

Morag McDowell

Cite this as: *BMJ* 2015;351:h5223

Peter Leo Frank

Consultant orthopaedic surgeon and expert witness in medicolegal advice (b 1928; q Manchester 1956; FRCS Ed), died from pneumonia after a severe stroke on 19 November 2014.

Peter Leo Frank spent the war years in concentration and slave labour camps. He trained in orthopaedic and trauma surgery in Manchester and Salford, where he introduced new operative techniques. He bore his final illness with bravery and acerbic wit, just as those who knew him would have expected. He leaves his wife, Pauline, and six children and stepchildren.

Mark B Gabbay

Cite this as: *BMJ* 2015;351:h5689

Thomas Davidson Veitch Lawrie

Walton professor of medical cardiology University of Glasgow (b 1920; q Glasgow 1943; MD, FRCP), died from myeloma and systemic infection on 3 September 2015.

Thomas Davidson Veitch Lawrie ("VL") held the inaugural Walton chair of medical cardiology at the University of Glasgow from 1966 to 1985, where he initiated the development and application of computer technology to electrocardiology. In 1972 he married his secretary, Edith Jamieson, who predeceased him by approximately one month.

Ian Hutton, Ross Lorimer

Cite this as: *BMJ* 2015;351:h5695

Michael Bernard Matthews

Consultant cardiologist Western General Hospital, Edinburgh (b 1920; q Cambridge/St Thomas' Hospital 1944; FRCP Ed, FRCP Lon, MD), died peacefully from old age on 2 June 2015.

Michael Bernard Matthews ("Mike") took up his consultant post in Edinburgh in 1954. He spent most his career at the Western General Hospital. Predeceased by his wife, Mary, in 1988, Mike leaves four children, nine grandchildren, and a great grandson.

Philippa Matthews

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Muhammad Naseemullah

Professor of medicine Rawalpindi Medical College (b 1943; q Nishtar Medical College, Multan, 1967; FRCP Lon, FRCP Ed), died from a myocardial infarction on 12 January 2015.

After initial house and registrar jobs in Pakistan, Muhammad Naseemullah ("Naseem") moved to London, where he acquired his membership of the Royal College of Physicians. He returned to Pakistan in 1974 and held various academic positions. He considered his real contribution to be the improvement of medical education in Pakistan.

Adnan Naseemullah

Cite this as: *BMJ* 2015;351:h5159

Ruth Owen

Former consultant anaesthetist and intensivist (b 1929; q University of Pennsylvania School of Medicine 1955; FFRCS), died from a gastrointestinal haemorrhage on 1 August 2015.

Ruth Tate met Griff (S G Owen) on a trip to London from her native US in 1953. They married and she moved to the UK. She became a consultant anaesthetist at King Edward Memorial Hospital in 1975 and also worked as a senior lecturer at the Royal Postgraduate Medical School. Predeceased by Griff, she leaves four children and five grandchildren.

Margaret Owen

Cite this as: *BMJ* 2015;351:h5154

OCCUPATIONAL MEDICINE

Health and Safety Executive's failures

The Health and Safety Executive's response to Raynal (Personal view, 14 November) neither deals with her key arguments nor contests her statistics on occupational medicine's demise within HSE. HSE's 2015 assessment of its performance compared with Europe is not evidence of occupational health leadership.

HSE's "goal based self regulatory approach" looks like a device to justify staff and resource cuts, especially when no one has been prosecuted for not reporting occupational disease and related deaths in the past five years. Evidence for self regulation as a substitute for effective regulation and enforcement in occupational health and safety is minimal and hides all sorts of shortcomings.

A better approach would be for the HSE and UK government to place occupational health on at least an equal footing to quality and profit. We need workplaces that are effectively regulated by HSE, where "management of the working environment is implemented in close interaction with public regulation."

Andrew Watterson (aew1@stir.ac.uk)

Cite this as: *BMJ* 2015;351:h6437

Challenging times for occupational medicine

We of the Faculty and Society of Occupational Medicine join Raynal (Personal view, 14 November) in calling for increased training in occupational medicine; it should begin in medical school and feature in postgraduate training (particularly for GPs) and continuing professional development. GP interest in occupational medicine is rising, as is recruitment to the specialty.

We welcomed the proposal for a "Fit for Work" service. Work is key to most people's self worth and family life. Although people in "good work" call on healthcare resources less, too many cannot access the help needed to return to work after illness.

Our first obligation will always be to our patients. We are sorry that some doctors feel threatened; in most cases, advice is valued by employees and employers. Although complaints against occupational physicians have increased, few progress to investigation. Occupational medicine is no less noble a cause than it was in the 19th century, and no less important.

Richard Heron, Robin Cordell (president@fom.ac.uk)

Cite this as: *BMJ* 2015;351:h6440

PIERRE-PAUL PARISEAU

LETTER OF THE WEEK

HSE's view on demise of occupational medicine

We disagree with Raynal (Personal view, 14 November)—the UK health and safety system has led to the UK being one of the safest places to work in Europe.

Raynal summarises the situation in terms of the likely numbers of work related ill health problems. However, estimates of new cases of self reported work related illness fell between February 2001 and December 2011, as well as working days lost to work related illness, with the UK among the best in class in the EU. In parallel, reports by specialist respiratory and dermatological physicians show downward trends, with evidence of reduction in disease attributed to exposures that have been the focus of HSE led preventive approaches.

We agree that there is no room for complacency. Absolute levels of musculoskeletal ill health and occupational stress remain high, and classic health risks remain problematic in certain workplaces and sectors. The Health and Safety Executive (HSE) fully appreciates the future challenges in workplace health. However, HSE's view, aligned to the modern world of work, is that interdisciplinary approaches are needed to solve these problems. Only by working across traditional discipline boundaries will we be able to develop simple practical solutions to prevent unplanned downtime through ill health. Obviously, HSE needs those with responsibility in this area to help it in its mission to improve the health of the working population.

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CARERS ON THE WARDS

May put too much pressure on carers

Welcoming carers on to the wards in an NHS under pressure seems compelling (Acute perspective, 14 November). The benefits to patients are obvious, but some carers will be less than enthusiastic.

By the time some patients are admitted to hospital, carers and families are already exhausted. The prospect for elderly carers of continuing the same role, with the added challenges of transport to hospital, resuming their caring role in a busy challenging environment, and managing their home circumstances might be daunting.

Of course, carers don't have to accept this role, but there may be pressure from patients or staff and feelings of guilt if they don't. Restricted hospital visiting times give carers a break without making them feel guilty. Perhaps flexibility of visiting hours and expectations of carers is the answer, allowing them to do more if they wish without too many formal arrangements.

Rod Jennings (rodthedoc@gmail.com)

Cite this as: *BMJ* 2015;351:h6435

Author's reply

As a GP, Jennings must deal with many distressed and worn out carers (previous letter). Neither I nor the John's Campaign advocates the use of carers as a substitute nursing workforce in an understaffed NHS.

The initiative to allow carers on to the wards comes from many carers wishing to be more involved in supporting or advocating for their loved ones in a potentially bewildering environment. In addition, geriatricians (or nurses or therapists) spend a large part of the day communicating with patients' families—to plan discharge, reassure and update them, or get better background information. Having families around means that they can point out important things, that we can reassure or inform them in real time, and that we can work more closely together to plan care. I would never want already stressed and tired carers to feel they were being used as unpaid healthcare assistants.

David Oliver (davidoliver372@googlemail.com)

Cite this as: *BMJ* 2015;351:h6436

Brian Keighley

General practitioner and former chair of BMA Scottish Council

Brian Douglas Keighley (b 1948; q Glasgow 1972; MBE, FRCGP, FRCP Ed, DFM), died from coronary artery thrombosis on 9 November 2015.

A favourite fixture in Brian Keighley's calendar was his annual gig as doctor for the Drymen Agricultural Show, in Stirlingshire, central Scotland. After the last prizes were awarded, Keighley hosted a barbecue at his home in the Glasgow commuter village of Balfron, where he worked as a general practitioner from 1974 to 2013. At this year's barbecue, guests watched as Keighley again flew the BMA flag from his house, symbolising a career that straddled rural general practice and medical politics, and which culminated in a five year stint as chair of the BMA's Scottish Council.

Before standing down in 2014, Keighley told the BMA annual representative meeting that although Scotland's devolved NHS had been spared reorganisation, unlike in England, continuing pressures facing the service were like a "five year car crash." His comments sparked a debate among politicians gearing up for the forthcoming referendum on Scottish independence.

Brian Keighley's nickname "The Laird" was due to his liking of deerstalkers, Range Rovers, and annual fishing trips to a secret location, as well as to his sense of duty and courtesy

Brian Keighley with his wife and sons

Sense of duty

Keighley's "couthie" personality invited inevitable comparisons. Colin Hunter, former chair of the RCGP in Scotland and now chair of the college's board of trustees, describes the man he first met in 1996 as an "unfailingly polite, almost parental" character, redolent of Dr Finlay, the fictitious TV doctor in the 1960s.

Another nickname among colleagues who served alongside him at the college, the BMA, and the GMC (Keighley was an elected member from 1994 to 2007) was "The Laird." This was due in part to a liking for deerstalkers, Range Rovers, and annual fishing trips to a secret location on North Uist. More importantly, according to former BMA Council chair Hamish Meldrum, Keighley had a laird-like "sense of duty and old fashioned courtesy." The pair first met when Meldrum joined the BMA general medical services committee in 1991. Meldrum adds: "Medical politics can be difficult and challenging at times. Brian instinctively knew what was right. He had an incisive mind and could cut through the nonsense and get to the real meat of the problem." A liking for "pomp and ceremony" led to his personally inviting the Princess Royal to open Balfron's new surgery premises in 2006. She accepted.

Hunter adds: "Brian was a very experienced and astute chair of the BMA's Scottish General Practitioners Committee when I first met him. I learnt from him how to negotiate and influence 'off piste,' outside the formality of meetings."

It was these qualities that made Keighley an ideal candidate to chair the Royal College of GPs' independent audit committee for six years. He performed a similar role at the BMA (alongside being on many other committees), served on the board of the BMJ Publishing Group from 2002 to 2013, and was deputy chair from 2006. He was made an MBE in the 2015 New Year's Honours for services to primary care.

Keighley's first marriage was dissolved. In addition to his second wife, Lesley, and his mother (aged 88), he leaves two sons.

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