comment

> Why would junior doctors—post-MTAS, in debt, on rotten shifts, and with the Antipodes calling—possibly feel demoralised?

NO HOLDS BARRED Margaret McCartney

Pity the NHS—Jeremy Hunt has chosen the nuclear option

Why are junior doctors low in morale? Asking this while imposing the junior doctors' contract is akin to wondering who started the fire as Jeremy Hunt holds a box of matches, an empty can of petrol, and a sign saying, "I did it." Sorry, not a fire: it's "the nuclear option." Why would junior doctors—post-MTAS, in debt, on rotten shifts, and with the Antipodes calling—possibly feel demoralised?

The moral contract between healthcare professionals and patients is the one that matters more. The reason why we have the stress of leaving late, starting early, and fixing problems that "technically" aren't ours is because we work for patients, not the secretary of state. And so, even though it's "not my job," I'll do it—because I know that if I don't, it will get done more slowly or not at all, causing avoidable delay or suffering.

Every professional does this, every day. We do it because we want to do good work, and because we love our work. This vocation is part of our human identity, and it means that when work goes wrong we're upset, and when it goes well we're joyful. For all of the strain and stress and petty bureaucracy, the NHS is a phenomenal achievement conjured up every day by the people who choose to go and make it.

This, however, may stop. Treat people as you would like to be treated: people at work need respect, kindness, and enough resources. Imposing a new contract will lead to none of these. In many parts of the United Kingdom, junior doctors and consultants have adjusted their working patterns to suit local needs within the current contract: Wales and Scotland have no plans to change.

Junior doctors already work in a 24/7 system. When Hunt spoke in parliament of juniors taking on "bonus" shifts, he seems not to have realised that nights and weekends are not optional. Doctors will leave, many will not return, and we will have fewer staff in an even less safe NHS.

The NHS is being set up to fail. It's easy to see how the proliferating private GP companies will profit while the NHS, starved of essential resources, is told that it's not hitting targets and is punished as a result. It will haemorrhage even more staff who hate their lack of ability to provide good care with the resources (not) available.

The NHS will then have its bones picked by whatever private companies are watching and biding their time. This is a disaster for everyone that cares about our NHS.

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ANALYSIS

Open letter to *The BMJ* on qualitative research

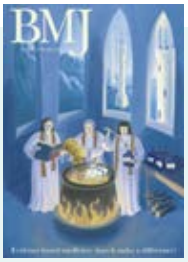
Senior academics from 12 countries invite *The BMJ*'s editors to reconsider their policy of rejecting qualitative research on the grounds of low priority

We are concerned that *The BMJ* seems to have developed a policy of rejecting qualitative research on the grounds that such studies are "low priority," "unlikely to be highly cited," "lacking practical value," or "not of interest to our readers" (box). Here, we argue that *The BMJ* should develop and publish a formal policy on qualitative and mixed method research and that this should include appropriate and explicit criteria for judging the relevance of submissions. We acknowledge that (as with all methods) some qualitative research is poor quality, badly written, inaccessible, or irrelevant to the journal's readership. We also acknowledge that many of *The BMJ*'s readers (not to mention its reviewers and editors) may not have been formally trained to read, conduct, or evaluate qualitative studies. We see these caveats as opportunities not threats.

Qualitative studies included in "Twenty top papers to mark *The BMJ*'s two digital decades"

- Evidence based guidelines or collectively constructed "mindlines?" Ethnographic study of knowledge management in primary care, John Gabbay and Andrée le May.[2]
- What worries parents when their preschool children are acutely ill, and why: a qualitative study, Joe Kai.[3]
- Collusion in doctor-patient communication about imminent death: an ethnographic study, Anne-Mei The, Tony Hak, Gerard Koëter, Gerrit van der Wal.[4]

Find this at: http://dx.doi.org/10.1136/bmj.h3660



The BMJ's mission is method agnostic

The BMJ says its mission is to lead the debate on health and to engage, inform, and stimulate all doctors, researchers, and other health professionals in ways that enable them to make better decisions and improve outcomes for patients.

Some clinical and policy questions are best answered by the results of randomised controlled trials or other quantitative approaches, but other decisions and outcomes are more usefully informed by qualitative studies. Qualitative studies help us understand why promising clinical interventions do not always work in the real world, how patients experience care, and how practitioners think. They also explore and explain the complex relations between the healthcare system and the outside world, such as the sociopolitical context in which healthcare is regulated, funded, and provided, and the ways in which clinicians and regulators interact with industry.

Some of *The BMJ*'s top papers have been qualitative

The BMJ recently celebrated 20 years of online presence by asking experts to name the most influential paper published in that period.[1] The 20 nominated papers included three qualitative studies (box).

The three qualitative papers explored how primary care clinicians develop and use collective "mindlines" instead of written guidelines[2]; what worries parents when their preschool children are acutely ill[3]; and the nature of collusion in the doctor-patient relationship when death is imminent.[4] They have been cited by 572, 197, and 114 subsequent papers respectively (Google Scholar data).

Good qualitative research with a clear and important clinical message can be highly cited, is popular with readers, and enriches *The BMJ*'s overall contribution to the knowledge base.

> Qualitative studies help us understand why promising clinical interventions do not always work in the real world, how patients experience care, and how practitioners think

MQHRG @mqhrg • Sept 30

Thank you for sending us your paper. We read it with interest but I am sorry to say that qualitative studies are an extremely low priority for *The BMJ*. Our research shows that they are not as widely accessed, downloaded, or cited as other research.

We receive over 8000 submissions a year and accept less than 4%. We do therefore have to make hard decisions on just how interesting an article will be to our general clinical readers, how much it adds, and how much practical value it will be.

Excerpt from rejection letter tweeted by McGill Qualitative Health Research Group (@MQHRG)

Different study designs provide complementary perspectives

Few research topics in clinical decision making and patient care can be sufficiently understood through quantitative research alone.

The surgical safety checklist is a revealing case in point. A controlled before and after study published in the *New England Journal of Medicine* showed that in 3733 patients having non-cardiac surgery, the introduction of a surgical safety checklist was associated with a highly significant reduction in perioperative mortality (from 1.5% to 0.8%) and complication rate (from 11% to 7%).[8]

But attempts to replicate these impressive improvements have sometimes failed dramatically.[9 10] Eighteen qualitative studies, summarised in a recent qualitative systematic review, help explain why.[11] The operating theatre is a complex social space with established hierarchies and routines. Depending on a host of contextual factors, safety checks may substantially disrupt team routines and be resented rather than welcomed.

From the policy maker's perspective, qualitative studies of the professional, organisational, and political context of nationally driven checklist based patient safety initiatives can help explain both successes and failures.[12 13]

The BMJ has a long tradition of educating its readers about less familiar research methods

Statistics is a closed book to many jobbing clinicians. "Bite sized" methodological commentaries,

often linked to exemplar papers published in the research section of *The BMJ*, have enabled its readers to grasp important concepts such as why continuous variables should not be dichotomised[14] or why some apparent improvements are explained by regression to the mean.[15] Through the journal's Statistics Notes and Economics Notes series, the quantitative research literacy of its clinician readership has significantly improved.

The BMJ has not yet introduced a comparable ongoing educational approach for qualitative research. Through such a series, the journal's readership would gain in qualitative research literacy.

A proposal

We believe it is time for a prospective study to assess whether *The BMJ* can come to value and be proud of qualitative research as part of its mission to lead the debate on health, inform clinical decision making, and improve outcomes for patients. We challenge *The BMJ* to allocate one slot a month for one year to a "landmark" qualitative paper along with an accompanying methodological commentary from an international expert. We offer to assist *The BMJ* to appoint an appropriate team of reviewers, guest editors, and commentators. We can also advise on training to build capacity and confidence of editorial staff."

Conclusion

The BMJ is by no means an outlier in its current policy on qualitative research. Many leading US journals (including *JAMA* and the *New England Journal of Medicine*) also consider such research low priority. We believe all such journals would benefit from revisiting their policies.

The BMJ, with its history of supporting qualitative research, is in a unique position to lead the field.

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Qualitative research: *The BMJ* responds

Trish Greenhalgh and colleagues argue persuasively that qualitative research is important.[1] Why, they ask, has *The BMJ*, once a champion of qualitative research, seemingly turned away from it? In the past, qualitative research was a higher priority for *The BMJ*, so we understand why the community of qualitative researchers does not like our change in emphasis. And yet, despite the extensive discussion within and outside *The BMJ* that this letter has provoked, we are not persuaded that we should make the major changes requested.

The BMJ does not have quotas for specific types of research and we do not intend to establish them. We believe it is reasonable to consider study design, research questions, and limitations when deciding which articles to publish. Like many journals, *The BMJ* aims to have a clear scope (albeit a broad one). As editors, we owe it to readers and authors to make that scope explicit, and this includes identifying priorities for the research we want to publish. *The BMJ's* research goals and objectives have changed over the past few years. In general, our aim is to publish studies with more definitive—not exploratory—research questions that are relevant to an international audience and that are most likely to change clinical practice and help doctors make better decisions.

There are many sorts of research that, although worthy and valuable, do not fall within *The BMJ*'s chosen scope. This includes case reports, case series, cost of illness studies, economic evaluations of single clinical trials, surveys of self reported practice, simple open loop audits, and even placebo controlled trials of drugs or devices when alternative therapies are available (rather than those that compare new interventions head to head against current best practices).[2 3] As with qualitative research, there is no blanket ban on these types of studies. We keep the door ajar, but we publish very few of them.

There is no blanket ban on these types of studies.

Medical journals play different roles and address the needs of distinct audiences. We can only publish a small fraction of the thousands of research papers that we receive each year, many of which are important and well done. We recognise the merits of qualitative research as described in Greenhalgh and colleagues' article, which include helping us understand "why promising clinical interventions do not always work in the real world, how patients experience care, and how practitioners think." But we do not prioritise qualitative research because, as mentioned in our information for authors, qualitative studies are usually exploratory by their very nature and do not provide generalisable answers.[2 3] Our policy on qualitative research is posted on our website and is also communicated in rejection letters. Including these details is evidence of our desire to make the process fair and transparent.

Although most qualitative studies will not be in line with *The BMJ's* objectives, we agree they can be valuable, and recognise that some research questions can only be answered by using qualitative methods. Several other publications in the BMJ family, especially *BMJ Open*,[6] have a stronger focus on qualitative research and welcome the submission of qualitative studies.

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THE BEST POLICY Nigel Edwards

Involve clinicians to avert a digital disaster

And other lessons for creating a paperless health system

The UK government's recent spending review announced £1bn for health technology. "Better connected services for patients," it promised, and the information that doctors needed "at their fingertips."

Nobody can argue with the aspiration—but nobody can forget the less than encouraging history of spending on information technology in the NHS.

The lessons of the National Programme for IT, which cost more than £10bn a decade ago, seem to have been learnt. One size does not fit all: the government has now sworn off top-down rollouts, in favour of trying to support and guide initiatives with more local input. But there exist many other potential paths to disaster, as we at the Nuffield Trust found while carrying out research worldwide for our new report.[1]

Too many systems make life worse for clinicians—but achieve little for patients

The good news: our investigations of the most advanced hospitals and healthcare systems found that technology is at a stage now where it really can help to reduce patients' length of stay in hospital, rates of infection, and duplication of testing. It can help clinicians take difficult decisions and to know when to intervene before health problems bring patients to hospitals.

The bad news: introduced in the wrong way it can still simply get in the way. The key lies in four crucial lessons from troubled rollouts of the past, in the NHS and elsewhere.

Change how people work

Firstly, current ways of working need to be rethought, including greater standardisation and better organisation of work. Simply digitising a highly variable or suboptimal process is a missed opportunity. The problem to crack is changing how people work, not how the machines work. NHS staff consistently said that they thought lack of training was the greatest barrier to adoption of new technology.[2]

Secondly, strong clinical involvement is needed. Too many systems have been designed to help the finance department or managers, to reflect what IT specialists think clinicians need, or to satisfy political aspirations. They often make life worse for clinicians, through clunky interfaces, poorly designed workflows, multiple logins, and unhelpful alerts—but achieve little for patients. US researchers found that doctors spent 40% of their time with computers and just 12% with patients after new regulations and technology were introduced.[3]

Thirdly, the need to learn and change never ends. The rapid change in medicine, as well as in systems' capabilities, demands continuous adaption and improvement. That

PERSONAL VIEW Heather M Gilmartin

Use hand cleaning to prompt mindfulness in clinic

A regular reminder for reflection could reduce distraction

In the frenzied environment of clinical practice, we often don't notice what we're doing until a problem arises. Shuttling between patients and tasks may feel overwhelming. When we're hurried it's easy to lose focus on the task at hand and to become distracted. When we're not fully engaged in the experience of each step in our day, we may blindly react to events instead of noticing what is occurring and then responding with a focused approach.

The act of cleaning hands, a simple yet important task practised throughout the day, could serve to prompt a time of mindfulness to bring a clinician's awareness back to the present and allow for moments of clarity, insight, and reflection during a work day.

The modern practice of mindfulness has been described as a process of paying attention on purpose, in the present moment, and non-judgmentally.[1] The practice is meant to help move a person from simply reacting to an event to intentionally suspending judgment of reactions, observing the moment, and responding thoughtfully.[1]

Informal mindfulness practice requires little instruction beyond recommending a focus on breath, the body, and what is happening in the present moment, and it can be practised during ordinary activities.[2]

Hand hygiene is a habitual procedure before and after patient contact. The automatic nature of the intervention can allow it to be missed or incorrectly performed, as attention is not focused on the process and the reason for it. The cleansing of one's hands should be reframed as an act

When we're hurried it's easy to lose focus on the task at hand and to become distracted

of self care that provides a moment of mindfulness to increase presence and awareness, as well as an act of infection prevention for each other.

If a connection can be made between the hands and the mind, we may transform this fundamental tool of infection prevention from an act of passive compliance to one of self care.[1] To realise the practice, the process should be broken down into steps so that each moment is fully experienced.

In a state of mindfulness, thoughts and feelings are observed, acknowledged, and accepted as is. This dispassionate state of self observation is thought to introduce a space between perception and

ROSE LLOYD

takes continuous, and sometimes painful, cycles of revising how a system works before the investment starts to pay off. Unfortunately, many NHS organisations have lacked the realtime data needed to know whether changes are succeeding.

Integration and interoperability

Finally, integration and interoperability are important. Clinicians want customisation, but that cannot mean small hospitals with 100 or more different systems talking past one another. Each organisation should aim for single systems but make sure that they can support the range of applications clinicians need for specialist use.

The danger otherwise is that digital information remains in specialist silos, isolated from everyday clinicians. Almost all clinicians use intuitive, reliable apps outside work and increasingly expect this at work too. They will need to be involved in thinking about how best to deploy these new tools and how to redesign care processes to get the best out of them.

Doing this when doctors are overwhelmed with work and under attack will not be easy, but the government and service leaders must realise that it is the only way to avoid another round of disappointment and waste in NHS technology.

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response, allowing for a switch from automatic pilot to a state of cognitive awareness.[3]

This skill of switching, which involves the flexibility of attention so that people can shift their focus from one subject to another, is imbedded in the practice of healthcare.[4]

We move from moments of diagnosis and treatment to responding to queries and to interacting with patients and colleagues. The act of focusing attention on breath during a time of scattered thinking allows us to acknowledge the present state, and it's a skill that can be developed by busy clinicians through practice.

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A MOMENT OF MINDFULNESS

Focus your attention on your thoughts and emotions. Stay present and accept whatever arises, just as it is, without reacting.

Set an intention—to listen with intent, choose your words mindfully, or act with compassion in your next encounter.

Smile to acknowledge this act of kindness to yourself and to your patient.

Alcohol based hand rub

Pause, take a breath, and notice the sound and feel of hand rub being delivered to your palm.

Be present in the moment and experience the sensation of rubbing the foam/gel into your wrists, hands, and fingers until the product evaporates and leaves you clean.

Soap and water

Pause, take a breath, notice that you are turning on the faucet, and regard the feeling of water flowing from your wrists to your fingers.

Be present in the moment and experience the sensation of rubbing soap into your wrists, hands, and fingers, and then washing it all down the drain.

ACUTE PERSPECTIVE

David Oliver

Solidarity across generations

Two popular books followed the latest financial crash and austerity drive: *The Pinch* and *Jilted Generation* urged those under 35 or so to protest against the self interest of baby boomers. Born from 1946 to 1964, boomers had allegedly saddled younger generations with public debt, student tuition fees, job insecurity, and an unreachable housing ladder—while boomers grew asset and pension rich.

Amid the unrest over contract changes for junior doctors in England, I've witnessed hints of intergenerational conflict in medicine. Cynics might even say that it's a deliberate ruse to divide and rule our profession. In letters to newspapers, the surgeon Claire Hopkins replied to her father, the retired surgeon Russell Hopkins, that the current job is unrecognisable from the one he did. Several older doctors fed reactionary comments to columnists such as Dominic Lawson, questioning the current generation's professionalism and work ethic. Des Spence hinted in *The BMJ* at a misplaced sense of entitlement among juniors.

We had far less formal support, supervision, or protected training time. But we had free degrees and hospital accommodation

The "you don't know you're born" flak has been thrown back, with younger doctors confidently telling older ones who actually did the job in the 1980s or '90s what it was like (much easier than nowadays, apparently).

This isn't constructive. Roles and conditions evolve over a long career for us all. Looking back at my 27 years, we've simply traded one set of pros and cons for another. Hours, rotas, staffing, and on-call pay were worse. But the volume and complexity of patients, the range of interventions, and public expectations were lower.

Soon, with the proposed new consultant contract, we'll risk new discord between older and younger consultants as those who've taken on leadership roles over many years lose a chunk of income in scrapped clinical excellence awards, while younger consultants will hit the top of the scale a few years in.

No good will come of this competitive, "who had it worse" behaviour. Each medical generation faces its own challenges. We need intergenerational solidarity right now, not an unseemly scrap.

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Mary Catterall

Former consultant radiation oncologist and sculptor (b 1922; q 1952; FRCR, FACR, DSc), d 4 October 2015.

Mary Williamson met Duncan Catterall while doing a locum post in 1953; they married in 1957 and moved to Leeds in 1959. Mary became a senior registrar in cardiothoracic surgery at the Leeds General Infirmary. In 1969 she was appointed consultant in charge of the fast neutron clinic at the Hammersmith Hospital. She travelled extensively internationally to promote the use of neutron therapy, and several other trials were initiated in other countries. After her husband's death in 1993 Mary spent most of her time sculpting, until an inoperable detached retina made this impossible. In 2005 she was awarded the Cross of Saint Augustine by the Archbishop of Canterbury.

Caroline Mussared

Cite this as: *BMJ* 2016;352:i290

Laurence Langdon

Retired consultant anaesthetist (b 1925; q St Bartholomew's Hospital, London, 1953; FFARCS), died from heart failure on 23 November 2015.

Laurence Langdon ("Laurie") served in the Royal Naval Volunteer Reserve on minesweepers before reading medicine at Bart's. Appointed consultant in the Southampton and South West Hampshire Health District, he developed a particular interest in the treatment of back pain. Resident in Lymington, he became a keen member of the yacht club. Predeceased by his wife, Anne, he leaves two children and two grandchildren.

T M Young

Cite this as: *BMJ* 2016;352:i286

John Anthony Chappel

General practitioner Aylesbury (b 1930; q Westminster Hospital, London, 1955), died from thoracic aortic dissection on 13 November 2015.

John Anthony Chappel deferred entrance to medical school until he had done national service as a radiographer with the Royal Army Medical Corps in Egypt. Having started his career in thoracic medicine in London, he was recruited into general practice while a registrar at Stoke Mandeville Hospital, Aylesbury, and never looked back. He was part of a successful town centre practice for 30 years, and he also ran the GP maternity unit and supported the local learning disability hospital. In retirement he worked for several charities and played squash, tennis, and golf. He leaves his wife, Jean; three children; and nine grandchildren.

David Chappel

Cite this as: *BMJ* 2015;351:h6858

Alan Montague Johnson

Former consultant cardiologist Wessex Region, Southampton (b 1921; q Westminster Medical School, London, 1946; MD, FRCP), d 11 December 2015.

In his final year at medical school, Alan Montague Johnson contracted miliary and cavitating pulmonary tuberculosis. In 1962 he was appointed as the first full time consultant cardiologist to the Wessex Region and subsequently to the staff of King Edward VII Hospital, Midhurst. He was a memorable bedside teacher and presented many papers before learned societies as well as publishing widely and holding editorial and advisory positions. Predeceased by his first wife in 1993 he leaves his wife, Frances; three children from his first marriage; four stepchildren; eight grandchildren; two step grandchildren; and seven great grandchildren.

Peter Johnson

Cite this as: *BMJ* 2015;351:h6853

Donald Campbell McNutt

Surgeon captain Royal Navy and general practitioner Gosport (b 1927; q Edinburgh 1950; MBE, DAvMed, MRCGP), died from valvular heart disease on 19 August 2015.

After completing house jobs Donald Campbell McNutt joined the Royal Navy for his national service and obtained a permanent commission in 1954. In 1976 he left the navy and went into partnership in Gosport, Hampshire. He was the BMA representative for Portsmouth, chairman of Hampshire local medical committee, and a member of the General Medical Services Committee. He continued in practice until 1994, although he kept up his involvement with the BMA for some time after. Donald enjoyed sailing and the company of his old naval colleagues. He leaves his wife and two children from his first marriage.

Rosalind Reid

Cite this as: *BMJ* 2016;352:i283

David Mortimer Hill

Consultant endocrinologist (b 1934; q Oxford University 1960; DM, FRCP), d 4 November 2015.

David Mortimer Hill was appointed as consultant physician and endocrinologist to Worcester Royal Infirmary in 1970. He chaired a fundraising mission that led to the setting up of a specialist diabetes centre in a converted bungalow just opposite the Ronkswood branch of the Worcester Royal Infirmary. David served as the consultant member of the district health authority for nine years and was a longstanding member of the local BMA, serving as chairman for a year during this time. He retired from his consultant post in 1995 and finally from all part time work in 2006. Predeceased by his wife, Elizabeth, in 2010, he leaves three children and nine grandchildren.

David Mortimer Hill, David Jennings

Cite this as: *BMJ* 2016;352:i288

Barrie Vernon-Roberts

Emeritus professor of pathology (b 1935; q Charing Cross Hospital Medical School 1960; MD, PhD, FRCPath, FRCPA, FAOrthA (Hon)), d 1 December 2015.

Barrie Vernon-Roberts grew up and trained in the UK, where he also spent his early career. In 1976 he became George Richard Marks Professor of Pathology at the University of Adelaide, head of the Division of Tissue Pathology at the Institute of Medical and Veterinary Science, and senior visiting pathologist to the Royal Adelaide Hospital. In 1997 he was appointed chief pathologist at the IMVS and its director and chief executive in 1998. He was the senior consultant pathologist in the Adelaide Centre for Spinal Research. He leaves his wife, Jane, and family.

Mark Vernon-Roberts

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Ranjit Roy Chaudhury

Clinical pharmacologist, academician, and champion for the rational use of drugs

Ranjit Roy Chaudhury (b 1930; q Prince of Wales Medical College, Patna, 1954; DPhil, FRCP Ed), died from cardiac arrest on 27 October 2015.

Ranjit Roy Chaudhury was the undisputed renaissance man of Indian healthcare. In a career spanning over 50 years he contributed to many areas of health, including clinical pharmacology, medical education, research, clinical trials, traditional medicine, and public health.

Improving healthcare in India

Born in Patna, Bihar, during the British Raj, Roy Chaudhury witnessed the final years of India's struggle for freedom before independence in 1947. Shortly thereafter, he enrolled at the Prince of Wales Medical College, Patna. First prime minister Jawaharlal Nehru was laying the groundwork for a "new India" with science and technology at its heart, and he urged the youth of the country to join in the task of building the nation. Although he did not wear his nationalism on his sleeve, Chaudhury's actions throughout his life indicate a deep commitment towards improving healthcare in the country.

One important contribution was the setting up of the specialised Doctor of Medicine (DM) programme in clinical pharmacology at the Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, in 1978. Vijay Shanker Mathur, retired professor of pharmacology and therapeutics at the College of Medicine and Medical Sciences, Arabian Gulf University, Bahrain, and a former colleague of Chaudhury at PGIMER, recalls: "He was a pioneer in the specialty of clinical pharmacology in India. Not only did he start the first DM programme in the discipline in the country, he was determined to set very high standards for the programme right from its inception."

Roy Chaudhury drew on his experiences at Oxford—where he was the first Indian doctor to be awarded a Rhodes scholarship for a DPhil programme—and his stint as head of the biology division at the Ciba Research Centre in Mumbai, to ensure that the DM programme at PGIMER was world class. "He was an inspiring teacher," said Reginald P Sequeira, professor and chair of the pharmacology and therapeutics department, Bahrain. He completed his PhD at PGIMER under Chaudhury's supervision.

Although Ranjit Roy Chaudhury did not wear his nationalism on his sleeve, his actions throughout his life indicate a deep commitment towards improving healthcare in India

Promoting the rational use of drugs

In 1991 Chaudhury returned to India after a long stint with the World Health Organization. Soon after, he became involved with public health programmes and policy making. In 1994 he set up the Delhi Society for Promotion of Rational Use of Drugs, through which he and his team helped improve access to medicines at hospitals run by the Delhi government. Sangeeta Sharma, professor and head at the Department of Neuropsychopharmacology, Institute of Human Behaviour and Allied Sciences, New Delhi, said it was Chaudhury who had the "vision and conviction" to develop the programme. "Before it was started, access to drugs at government hospitals in Delhi was only 25-30%, but once it had been implemented, access improved to 90%." The model has now been adopted by more than 20 states across India and in several other countries, including China.

In 2005, former colleagues and students compiled a book on Chaudhury, entitled *The Catalyst: A Tribute to a Professor*. In his foreword to the book, Halfdan Malher, director general emeritus of the World Health Organization, described Chaudhury as "having a unique strength in being able to combine infectious enthusiasm for institution building and building up people without sacrificing scientific standards and scientific integrity."

Over the past few years, Chaudhury became actively involved in developing policies on clinical trials. He was a member of the 1980 committee that drafted the first ethical guidelines on research in human subjects for the Indian Council of Medical Research. More recently, Chaudhury was appointed chairman of the expert committee to formulate policy guidelines and standard operating procedures for approval of new drugs and clinical trials, set up by the government of India. He had expressed concern over the decline in the number of trials being conducted in the country and hoped that the new policy would help change the situation.

For his contributions, Chaudhury received the Padma Shri, India's fourth highest civilian award, in 1998. Despite his accolades he continued to be a humble doctor, academician, and healthcare planner. In a television interview some time ago, he said: "I just did whatever I was asked to do." His peers and students, however, know that whatever Chaudhury did, he demonstrated extraordinary vision and commitment.

Ranjit Roy Chaudhury leaves his wife, Manda, and three sons.

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SHARING RAW DATA

BMJ research papers should share their analytic code

Freemantle and colleagues reject calls to share raw data on the weekend mortality effect (Analysis, 12 September), citing patient privacy.

This raises an important issue: the need to share analytic code. Pseudonymised patient data pose a re-identification risk. Analytic code generally doesn't. Code sharing is hugely informative: it facilitates rapid sensitivity analyses and allows others to interrogate the impact of each analytic choice on the overall result. If the authors shared their code, anyone with access to hospital episode statistics data could re-run it, modify it, and assess the impact of the original analytic choices on the effect.

The BMJ should require all quantitative papers to publish their analytic codes. This would enhance transparency and reproducibility, creating an archive of codes from which researchers could learn new techniques and shortcuts. Whole routines could be re-used, avoiding duplication of effort. Each publication would contribute more to advancing science and accelerate the discovery of important signals in patient data.

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Author's reply

Goldacre's suggestion is bad science for two reasons.

Replication is key to scientific activity. A senior colleague reviewed our two papers and reported that our analyses were described in sufficient detail for others to replicate. Indeed we know that others have successfully replicated our methods in whole or in part. We expect correspondence with others working in the area and have entered into such communication about this work.

The "code" is an extensive catalogue of SQL and SAS programs that create the datasets and run the analyses. It is partly machine dependent, and would be unlikely to be useful to others, who might be using other environments such as Stata, R, or Genstat. The SAS manual describes thoroughly how to specify survival analyses with time dependencies, and a suitably qualified and experienced statistician would not rely on our code.

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LETTER OF THE WEEK

Tackling the public health needs of refugees

CORBIS

Arnold and colleagues (Editorial, 19 December) highlight the potentially complex health needs of refugees resettling in the UK and argue that clinicians need to be appropriately prepared.

We fully agree and Public Health England (PHE) is working to help deliver this objective. In addition to PHE's Migrant Health Guide, PHE is leading the revision of guidance for the pre-entry health assessment of refugees by consulting disease and migrant health experts, clinical commissioning groups, local authorities, the Home Office, the International Organization for Migration (IOM), and the NHS. This will ensure that health assessments meet the needs of refugees, reflect best practice, and that appropriate pre-arrival information can be shared with local authorities and local health services.

This process is facilitated by a joint information flow working group, where PHE is collaborating with the Home Office, local authorities, NHS England, and IOM to ensure that health related information is shared securely with clinicians and relevant UK authorities, and that it can be used for monitoring and evaluation.

Support for health professionals is also crucial. PHE has an established network of migrant health leads—public health professionals based in PHE centres who work to promote the health of refugees, asylum seekers, and migrants. Migrant health leads link with other stakeholders locally to promote integration of refugees in their community.

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FRENCH TRIAL

It may be time to abandon three-phase trials

Although the risks of phase I trials are small, the consequences can be tragic (This week, 23 January). An alternative to a three-phase trial would inform clinicians and patients of the scientific basis, potential benefits, and risks of a new treatment; offer it to suitable patients; and provide it if they wish to take the risk. At best they are cured, and at worst the loss of life expectancy will probably be less than for young healthy adults in whom teratogenic effects are a concern. Perhaps randomised controlled trials could be followed by such pragmatic trials.

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HARMS FROM ANTIDEPRESSANTS

Alcohol and serious harms of antidepressant treatment

Sharma et al's report (Research, 30 January) confirms that antidepressant treatment is associated with aggression and violence, especially in young people. Others have downplayed a causal link, proposing—on the basis of Swedish epidemiological data—that depression itself may be the cause. However, that study was flawed because it failed to control for the high rates of antidepressant prescription in Sweden.

Another Swedish cohort study cited by Sharma et al indicated increases in violent crime in young adults, but also pointed to increased rates of alcohol related crime and presentation to emergency care. These results align with our finding that antidepressants can both stimulate drinking and cause pathological intoxication, sometimes with catastrophic results. Alcohol use in people taking antidepressants is common but poorly studied; this problem needs to be urgently investigated as a contributor to both serious violence and suicide.

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