We no longer have a moral contract to practise medicine but instead have an angst ridden, nit picking one that assumes the worst and tries to find it.

Contracts are about to be rewritten, for GPs in England and for consultants. Junior doctors are getting a new one. Yawning gaps exist in out-of-hours GP and junior hospital rotas. Emergency department waits are increasing, as are complaints to the General Medical Council, and morale is disintegrating. Is this the NHS’s decline and fall?

Doctors used to have much autonomy, leading to innovation, excellent care, and high job satisfaction—but also to exhaustion and to a few doctors taking advantage of minimal oversight. We now have bureaucracy, intrusive checking of often irrelevant “performance” data, and an entire (expensive) industry professing to regulate us. We no longer have a moral contract to practise medicine but instead have an angst ridden, nit picking one that assumes the worst and tries to find it.

I won’t resentfully add up the extra hours I worked this weekend or before my official start time, as long as I’m doing a useful job that’s valuable to patients and I retain some control over my working life. If my work feels crammed with conflict, if I’m routinely pleading for referrals to be accepted, or when organisations change without consultation or consideration, then clock watching and declaiming that “it’s not my job” will become natural.

In an emergency if a doctor can’t work a shift, then someone who doesn’t feel valued or part of a coherent service will feel no moral responsibility to help. Treat workers as mere disposable cogs in a corporate wheel, and they won’t imagine or invest their future as part of it. So, no one will innovate, create, or challenge. No one will feel ownership of a shared destiny.

All of this will have to come from external management consultancies with variously laughable grasps of medicine. We’re in a mess, pretending that we can do more with less, prioritising winning votes rather than fairness and without cognisance of opportunity costs—all inflamed by the recurrent misuse of statistics.

Patients are being told to expect more and to complain loudly when it’s not delivered. But in what warped universe can elective surgery at the weekend be more important to deliver than emergency overnight care?

If truth is the first casualty of war, the NHS is fighting for its moral life. Meeting the needs of everyone, free at the point of need: do this first, and then we can talk. We need an evidence based NHS, released from the stranglehold of party politics that causes so much waste and angst. But we also need to backtrack, to take advantage of professionalism and to allow staff to use it.

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MORE ARTICLES ABOUT OLDER PEOPLE IN HOSPITAL ONLINE (SEE DAVID OLIVER, p 358)

- Editorial: Preventing admission of older people to hospital (BMJ 2013; 346: f3186)
- News: Sixty seconds on . . . bed blockers (BMJ 2016;352:i935)
- Feature: What do you think should be the political priorities for the NHS? (BMJ 2015;350:h1808)
The UK National Audit Office (NAO) has just published the report Discharging Older Patients from Hospital. It focuses on the growing number of older people who are technically fit enough to leave acute hospitals in England but remain stranded. Why? Because the community services they need to support them out of hospital lack the funding, capacity, or quick response times to match their need. Such cases are officially reported as “delayed transfers of care” (DTOC). These delays are rapidly worsening and have reached record levels. The NAO found that bed days due to DTOC rose by 31% from 2013 to 2015 alone. We now have 1.15 million bed days a year officially reported as caused by DTOC in English hospitals—85% concerning patients over 65. Meanwhile, emergency admissions in over 65s have risen by 18% since 2010-11, and the percentage of people over 65 is projected to rise rapidly. Despite this demography, social care has seen sustained funding cuts since 2010. The NAO found that waits in hospital for home care have doubled since then, and waits for care homes increased by 63%. Neither the government’s Better Care Fund nor the new Social Care Precept, by which local councils can raise an extra 2% on council tax, can reverse the funding gap.

Delays in community health services are also rising. Average waits from referral for home based intermediate care “reablement” and rehabilitation have risen steeply, to six and eight days, respectively. Commissioners can take weeks to make decisions about funding NHS continuing care, often

**PERSONAL VIEW** Phil Whitaker

GPs are much more than gatekeepers

The only professionals who care for the whole person

Joining the term “gatekeeper” to describe the GP’s role in the NHS was a disaster. It creates an image of the real health service being elsewhere—in that shining citadel yonder, perhaps—with the humble GP huddled in a hut, simply lifting the barrier for those who need to be let in.

And, once you start thinking about GPs like that, you begin to wonder whether someone else couldn’t do the job just as well. Nurses, maybe; paramedics; physician assistants; or even computer algorithms or internet search engines.

The language of medicine

How should we think about GPs? For one thing, we are medical interpreters, steeped in the biomedical model, yet equally fluent in the ways patients communicate about, and understand, their health. People come with stories involving symptoms and experiences, psychology and emotion, social context and relationships, their hopes and fears. We sift and sort and synthesise this undifferentiated material, making sense of it for our patients and for the healthcare system. Sometimes this results in a diagnosis, sometimes not, but the result is a plan—ideally one in which we’ve empowered the patient to participate in what should be done.

This interpreter role is crucial to both the quality of care and its cost effectiveness. With accurate diagnosis (and non-diagnosis), NHS resources are better targeted and waste is constrained.

To be an effective medical interpreter requires sound knowledge of the whole breadth of medicine, excellent consultation skills, and understanding of the psychosocial aspects of illness, as well as the experience, confidence, and pragmatism to handle and explain uncertainty and risk. A longstanding, trust based relationship between doctor and patient can augment these attributes further. Ladies and gentlemen, I give you: the NHS GP.

It gets better. As well as being interpreters, GPs are medical generalists, managing vast swathes of illness cost effectively. Those patients who do need a referral are a highly selected population, strongly likely to benefit from specialist input. Without this selection, secondary care would become swamped and less efficient. The opinions, tests, and procedures in secondary care depend on a high prior probability of organic disease in the patient population—something that GPs ensure.

Without this, unnecessary investigations and interventions increase, as does overall cost. Patient experience correspondingly declines, and we see greater fragmentation, less holism, and more iatrogenic

**ACUTE PERSPECTIVE** David Oliver

More older patients are stuck in hospitals

The hospital clinicians face a daily “hurry up and wait” ritual.

Hospital clinicians face a daily “hurry up and wait” ritual

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Delays in community health services are also rising. Average waits from referral for home based intermediate care “reablement” and rehabilitation have risen steeply, to six and eight days, respectively. Commissioners can take weeks to make decisions about funding NHS continuing care, often
harm. With so many modern medical interventions, guarding against overtreatment is another important facet of our generalist’s role.

Not all aspects of primary care need a GP’s direct input, and some require very different professionals. Our practice nurses undertake straightforward chronic disease management, family planning, and minor illness triage, alongside more traditional nursing duties. We work with an array of allied health professionals, all with distinct roles.

But none is equipped to case manage the whole person. The GP is akin to a football player-manager: we’re out on the pitch, making our unique contribution, but we also set strategy and tactics to ensure that the team achieves each patient’s goals.

Interpreter, medical generalist, player-manager . . . on top of these, the GP is an expert friend. Illness and its treatment can be a frightening and bewildering experience, and we all deserve a knowledgeable guide for our journey—someone to make sense of it, explain it, and support us through it. If you ask patients, you’ll find that this is what many value most in their GP.

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with patients marooned in hospital while we argue over money.6

Practitioners on the wards have long known that official DTOC figures were overly optimistic. The NAO agrees, estimating the real number of bed days related to delays to be 2.7 times higher. It also estimated that such delays cost about £880m (€1140m; $1270m) a year. Its best case hypothetical estimate for supporting all of those bed days outside hospital was only £180m.

But keeping emptied wards closed is hard when hospitals are already full; hence, modelled savings are hard to realise.7 And now acute hospitals are told to find a highly improbable £22bn NHS “efficiency savings” by 2020.8 Only 5% of all acute admissions in over 65s are longer than 21 days, but they now account for over 40% of all bed days.6

Hospital clinicians face a daily “hurry up and wait” ritual of chasing and challenging staff in community services or families exercising choice for self funded care, and of apologising to patients and carers for delays we don’t control and that we struggle to influence.

It’s demoralising for us. For patients, it’s often bewildering and soul destroying.9

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See FEATURE, p 350

THEBMJ.COM BLOGS
Reena Aggarwal

Strike politicised junior doctors

I have a confession. A year ago, I would have been ambivalent, indeed indifferent, about the BMA. I’ve been a paying member for nine years, but I have rarely engaged with it. The BMA holds a split identity between being a professional association and a trade union. For me, the former role has always prevailed and I had never considered the potential power of being in a union. How times change. Recently I even attended the BMA junior doctor conference for the first time, alongside 300 junior doctors from across the country.

The conference exuded optimism, kinship, and a sense of purpose. As a doctor who has been an active grass roots campaigner against the junior contract, I had been struck by how 54 000 junior doctors—the workhorses of the NHS, the ones who rarely complain about their working conditions—became so engaged in a political discourse that it led to the first junior doctor strikes in 40 years and an unprecedented emergency walk out.

This past year, I have become even more proud to be a doctor as we have stood united against an unsafe and unworkable junior contract

This past year, I have become even more proud to be a doctor and part of the BMA as we have stood united against an unsafe and unworkable junior contract. We have experienced tough times in the profession, but I am reminded of the words of CS Lewis: “Experience that most brutal of teachers, but you learn; my god you learn.” Over the past few months, I think junior doctors will tell you they have learnt much about the interface between politics and health, their ability to unify, and, ultimately, the importance of fighting for a junior contract that provides safe and effective care.

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Read more at bmj.com/blogs
See NEWS, p 342

See FEATURE, p 350

PARISEAU PIERRE-PAUL
Guideline driven care: time to get personal

Margaret McCartney and colleagues argue that new models of evidence synthesis and shared decision making are needed to move from guideline driven care to individualised care.

Over more than two decades, evidence based medicine has rightfully become part of the fabric of modern clinical practice and has contributed to many advances in healthcare. But many clinicians and patients are dissatisfied with the way evidence based medicine has been applied to individuals, especially in primary care. There is concern that guidelines intended to reduce variation and improve the quality of care have instead resulted in medicine becoming authoritarian and bureaucratic.

Shared decision making
Guidelines grew out of a need to communicate best current evidence to clinicians, but their limitations are often not explicitly stated (box 1).

There is the danger of guideline recommendations being applied to people who do not place the same values on those recommendations as their clinician, or indeed those intended by the guideline creators. Evidence reviews by organisations such as National Voices have found that shared decision making engages people in their care and leads to decisions which patients find most appropriate to them. Surveys have shown that most patients wish either to share decision making with their clinicians or to take the decisions themselves. Guidelines should enable, not subvert, this process.

We therefore call for a transformation in the presentation and implementation of guidelines. Rather than relying on single disease focused guidelines that emphasise “best practice” for the population, we call for resources that will help doctors and patients to choose the evidence based interventions that fit with their values.

From tramlines to options
“Guidelines, not tramlines,” said David Haslam, chair of the National Institute for Health and Care Excellence (NICE), at its 2015 conference. To have impact, this principle must be echoed by other organisations, both professional and lay, and accompanied by actions. Guidelines are still required as collations of the best available evidence. But almost two thirds (62%) of research referenced in primary care guidelines is of uncertain relevance to primary care patients.

Because of these limitations, guideline recommendations should indicate the quality of evidence on which they are based and include information about treatment effect size or probability of benefit, the characteristics of the patient group evidence is based on, and where uncertainty makes extrapolation difficult. Moreover, guideline producers need to resist the temptation to tell clinicians and patients what to do. Making recommendations for the population, often based on expert opinion, reinforces the power imbalance between professional expertise and the patient’s values and preferences.

Tools and aids
Resolving such uncertainties with a definitive decision for all is sometimes appropriate, but the more informed the public become, the less tenable is the paternalistic approach—especially for serious illness, frailty, long term conditions, and primary prevention. We need resources that encourage conversations between the clinician and patient that include, “What are the options?” “What matters to you?” and “What are your hopes and priorities for the future?”

Currently, it is difficult to personalise recommendations from guidelines, even for those skilled in evidence based medicine.

The creation of usable tools to share decisions with patients is patchy and uncoordinated, despite robust international quality standards. These standards include visual representations of benefits and risks of the main treatment options and presentation of data in absolute not relative terms, in natural frequencies, and as numbers needed to treat and harm (NNT, NNH).
Box 2 | Suggested actions to improve evidence informed, individualised decisions

- The patient as a whole should matter more than their individual conditions
- Limitations of the evidence should be explicitly stated. Can guidelines safely be applied to people with frailty or who are very old? Are women and people from ethnic minorities adequately represented in the underlying trials?
- Key evidence from guideline writers should be summarised using visual representations of benefits and risks, or numbers needed to treat and harm
- Guidelines should be written assuming that patients will wish to make choices and give information in a way that highlights what choices fit better with different preferences (eg, fewer blood tests, less medication)
- Patient decision aids should be published in tandem with guidelines, but better research is required into how to provide information about choices
- Chronic disease management “courses” sharing current practice should be developed by patients and professionals and then evaluated
- Clinicians and patients should be encouraged to make decisions according to both the evidence and patient preference
- The negative effect of guidelines on the quality of care for individuals requires evaluation. Guidelines should be created for and evaluated in real world conditions

In the UK some NHS shared decision aids were produced, but they were not commissioned in tandem with NICE guidelines and are not widely used. NICE produced two pilot patient decision aids for preventing stroke in atrial fibrillation and lipid modification to reduce cardiovascular risk, but there is no published strategy to progress this work.

Elsewhere, the Alberta cardiovascular risk reduction guideline for primary care is two pages long, offers lifestyle and drug options without judging which is best for an individual, and has links to attractive risk calculators that show visually and with NNTs that, for example, the reduction in risk from adopting a Mediterranean diet may be as great for some patients as taking a high intensity statin. The Option Grid project, Dartmouth College, US, produces straightforward, readily understood, simple decision aids for primary care. Usable decision aids are one of the most important end products for evidence based medicine. They should include formats suitable for people with learning disabilities, poor literacy, and be available in multiple languages. We urgently need to move away from resource consuming duplication of effort by guideline producers in different countries, towards a global coordinated system of shared knowledge production focused on individual decision making.

Clinicians need help to share decisions

The paternalistic model of “doctor knows best” is, we believe, fading, but it is less clear how to embed the primacy of the patient as key decision maker consistently into routine clinical practice. This requires a shift in role and consultation style for many healthcare professionals. Some patients will be keen to make all possible decisions about their care; others may prefer recommendations from healthcare professionals. Both extremes have to be accommodated.

The complexity of how decisions are made needs to be better recognised and, indeed, encouraged as good practice. Healthcare professionals who have grown used to “one size fits all” outcome targets (such as being penalised for failing to reach flu vaccination targets) may feel uncomfortable when patients make decisions different from their advice or national guidance, and feel responsible if subsequently “things go wrong.” Yet autonomy is key.

Pay for performance systems are part of the problem. They do not encourage shared decision making because doctors are penalised if they do not comply with guidance. Such schemes should take into account what choices are acceptable to patients, what trade-offs are acceptable, and what factors such as more time or better information would facilitate more options.

We believe that GPs should not be paid according to how many patients comply with guideline recommendations. Instead, they should be encouraged to make decisions according to the evidence and patient preference (box 2). When decisions differ from guidance these could be noted in the medical records using codes such as patient choice, shared decision, or discussed and decided rather than marked as exceptions.

A way forward

We do not expect that more patient decision aids, clearer guidelines, and opportunities to practice real world patient centred consultations will make decisions perfect, but for some people they will make them better.

Good care involves a partnership between patients and health professionals where people matter more than their separate health conditions.

Good care involves a partnership between patients and health professionals where people matter more than their separate health conditions.

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Ihsan Raouf Al-Bahrami
Cardiologist (b 1930; q Baghdad 1953; MRCP Glas, FRCP Edin), d 20 March 2016.
Ihsan Raouf Al-Bahrami was born in Baghdad, Iraq. After practising medicine as a trainee in hospitals in his home town, he travelled to the UK for his postgraduate training. He introduced cardiac catheterisation in Iraq in 1963, with a team under his supervision. His main interest throughout his career was in rheumatic heart diseases. He was appointed professor of medicine at Baghdad University’s medical school in 1978. In 2011 he published his biography while in Jordan, in which he remembered his medical service in the main teaching hospital in Baghdad and his interest in travelling around the world. He died in Amman, Jordan.

John Crampton
Cite this as: BMJ 2016;353:i2538

Antony Pascal Barter
General practitioner (b 1924; q Charing Cross Hospital Medical School 1951), d 31 March 2016. The second world war delayed the medical studies of Antony Barter (“Tony”) as he enlisted into the Royal Navy, serving as an officer on the King George V battleship. After being demobbed, he started as a student at Charing Cross. He met a local GP in Bridport, in Dorset, while on holiday, and he consequently chose general practice as his career in this area. Antony practised for 35 years and helped develop general practice considerably in this time. He led the creation of the first integrated health centre, bringing together doctors, nurses, and social services in one location.

Led the creation of the first integrated health centre
He also looked after patients in the two community hospitals. Outside medicine, Tony was the first chair of the local Round Table and a keen sea fisherman. He was married for more than 50 years and leaves his son and daughter.

Simon Barter
Cite this as: BMJ 2016;353:i2535

Valentine Urie McHardy
Former general practitioner Edinburgh (b1943; q St Andrews 1967; BA) died from myeloma on 12 August 2015. Valentine Urie McHardy (née Dewar) was born and studied in St Andrews. As a student she played lacrosse at international level. As a clinical student in Dundee she obtained an attachment to John Crofton’s department in Edinburgh, where she later became house physician and research assistant and married one of the consultants. In 1974 she joined J B McDougall and W G Macintosh in their group practice in Edinburgh and retired in 2003. Her lifelong interest in music focused on opera, and she was awarded an honour’s degree in opera studies from Manchester University through Rose Bruford College in 2008. Medicine and music brought her many friends, who remember her for her infectious enthusiasm. She leaves her husband of 46 years, three children, and three grandchildren.

Ross McHardy
Cite this as: BMJ 2016;353:i2540

Catherine Provan Pike
Retired consultant cytopathologist Guildford (b 1920; q Glasgow 1943), died from bronchopneumonia after a road traffic accident on 16 January 2016. Catherine Provan Pike was the daughter of Edward Cathcart, professor of physiology at Glasgow University. She was president of the students’ union, and after qualifying she served in the Women’s Auxiliary Air Force (WAAF) at RAF Fighter Command Uxbridge. In 1951 she married Andrew Pike, a provincial commissioner in Tanganyika, where the family lived for some years. Catherine was a pioneer of early screening programmes and the use of fine needle aspiration to diagnose cancer. She was awarded the medal of the Swedish Medical Academy for her contributions in the area. She was a patron of the arts, choralist, councillor, and opera buff, but, above all, a wonderful hostess. Predeceased by one of her sons, she leaves three sons and 10 grandchildren.

William Pike, Elizabeth Mackenzie
Cite this as: BMJ 2016;353:i2547
Maurice Wood
Primary care pioneer and advocate influenced family medicine worldwide

Emeritus professor of family practice, Virginia Commonwealth University (b 1922; q Newcastle University, Newcastle upon Tyne, 1945; MRCP), d 11 March 2016.

For more than 60 years Maurice Wood was a passionate advocate for primary care, best evidence, academic research, and the generalist physician’s role, in the UK, US, and around the world.

Born in County Durham, Wood was a GP in South Shields, Tyne and Wear, from 1950 to 1971. A member of the Royal College of General Practitioners, he took his experience of general practice and practice based research to the US and changed primary care research there and globally. He was interested in the classification of diseases, vocational training, health informatics, and mental health. In 1972, as a co-founder of the North American Primary Care Research Group (NAPCRG), he helped pioneer a multidisciplinary, multimethod, and multinational research organisation for family medicine researchers. Also in 1972, he joined Henk Lemberts to form the World Organisation of Family Doctors (WONCA) International Classification Committee. Together the two men co-created a new epidemiology tool for classifying and analysing data from family medicine clinical encounters—the International Classification of Primary Care (ICPC, 1987; now in its second edition).

Early travel
After qualifying Wood served in the Royal Army Medical Corps until 1949, attaining the rank of major. In 1948, while working as a chief embarkation medical officer in Egypt, he married Erica Joan Noble, a nurse from Cornwall. In 1959 Wood joined four other GPs in a group practice and over time this became a teaching practice.

In 1969 he took a sabbatical to visit the US and Canada and present his research (age and sex register, nurse practitioner concept). While there he was recruited to Virginia Commonwealth University (VCU), and in 1971 he accepted a full time faculty appointment as an associate professor at the university’s medical college. Together with Fitzhugh Mayo and Kinloch Nelson, Wood established the VCU medical college’s department of family practice. He would become the department’s director of research.

During his visits he met Kerr Lachlan White of Johns Hopkins University. Wood later referred to Kerr White as his “close mentor and best friend, the architect of my academic career both in the UK and US.”

North American Primary Care Research Group
In April 1972, at a workshop entitled “Data Recording, Data Retrieval, and Research in Primary Care,” Wood was appointed to a steering committee with Lou Filliatraut and David Metcalfe to consider how to organise an interactive group in the US to stimulate research in community based settings. This was the beginning of NAPCRG. As the group’s president from 1972 to 1983, Wood encouraged multimethod research and links between qualitative and quantitative approaches to primary care research. He also mentored novice researchers and provided feedback for research ideas and projects. He was instrumental in the development and implementation of ambulatory sentinel practice networks. Many believe that NAPCRG would not exist without Wood.

The Maurice Wood Award for lifetime contribution to primary care research is given annually to honour a researcher (from any country, working in any professional area or scientific discipline), who has made outstanding contributions to primary care research. Larry Green of Denver, a recipient of this award and a former president of NAPCRG, said, “The manifestations or ‘artifacts’ of Maurice’s impact in the US include

the famous ‘Virginia Study,’ the first quantification of the content of family practice in the US . . . [Maurice] also became famous for being able to conduct an annual NAPCRG business meeting in less than 120 seconds, then getting on with further discussion of ideas and possibilities.”

Wood was a pioneer in using epidemiological information about communities to inform the efforts of primary care practices in those communities, noted Anton J Kuzel, professor and chair in the department of family medicine and population health at VCU School of Medicine. In 1982 Wood was elected to the US Institute of Medicine/National Academy of Medicine.

“Professor Wood encouraged me to become a doctor,” said family friend Nick Booth, chief informatics officer at Connected Health Cities, Newcastle University. “He saw general practice as a business and ran a very impressive, leading edge, efficient practice himself.”

Maurice Wood was predeceased by his wife, Erica, in 2010, and leaves three children, four grandchildren, and three great grandchildren.

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Cite this as: BMJ 2016;353:i2129
PRE-ECLAMPSIA RISK FACTORS

Systematic review could not identify risk factors

Bartsch and colleagues (Research, 23 April) attributed risk thresholds to maternal risk factors for pre-eclampsia to identify women who might benefit from aspirin therapy but did not establish the risk lowering effect when these factors were absent. Because this is a systematic review, it cannot assess the significance of interactions between maternal risk factors. A large population based study or individual participant data meta-analysis is needed to develop a reliable prediction model.

They produced aggregate data on pre-eclampsia as a single entity despite early and late pre-eclampsia having different risk profiles, recurrence rates, and responses to aspirin. This approach could lead to unjustified aspirin use in many women. The population attributable risks for pre-eclampsia are modest, so a risk factor based screening programme would not identify many at-risk pregnancies.

The most effective risk factors identified were all predictors of cardiovascular disease, which may support the hypothesis that pre-eclampsia is cardiovascular in origin.

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Cite this as: BMJ 2016;353:i2885

Authors’ reply

Our paper identified several single risk factors that confer enough risk to justify aspirin prophylaxis in pregnancy. For other risk factors, such as maternal age over 40, we recommend that two or more are needed. We agree that our systematic review could not assess the interaction and potentiation of the risk factors and that more complex studies are needed.

LETTER OF THE WEEK

CQC does not assess what matters to patients

McCarthy’s list of “qualities” that the Care Quality Commission (CQC) takes into account (Personal view, 7 May) does not include access. What good are cleaning schedules, audits, and drugs policies if patients cannot access the doctor in the first place? What good are worry entries in the records if there is no time for patients to bring their concerns to their doctor? How have CQC inspections changed from taking the patient perspective to becoming a visit aimed at verifying the general medical services (GMS) contract?

It seems that care and quality have made way for another quango that performs the functions of a health authority but is funded by the organisations that are being inspected.

Our regulators also omit to assign priority or weighting to the various items. No practice can achieve 100% in all aspects—what we need is a sense of realism. “Sufficient” or “reasonable” should be introduced into pass rates, and judgments of overall performance should have patient satisfaction at their heart. It should be recognised that in the real world there are such things as opportunity costs and acceptable risks.

There are established processes with legal and regulatory consequences when patients come to harm through unacceptable risk taking and poor procedural processes. As McCarthy points out, increasing paper trails does not necessarily improve patient outcomes.

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Cite this as: BMJ 2016;353:i2872

SODIUM OXYBATE FOR NARCOLEPSY

End the postcode lottery and use some common sense

Zeman and Zaiwalla’s call (Editorial, 7 May) to end the irrational and inconsistent rationing of sodium oxybate for treating narcolepsy is welcome.

In a recent High Court case, reported in the Telegraph, the judge described NHS England’s decision to decline funding for a 17 year old girl as “totally irrational” and “disastrous.” As this was the most effective treatment for her deteriorating condition, which NHS England did not dispute, he decreed that the case was exceptional and fell within the policy of funding treatment for such cases. The report made clear the relatively small cost of treatment. The legal costs must have dwarfed those of supplying the drug.

That the postcode lottery still exists is disappointing. The NHS was set up as a national service but is now a series of local companies, increasingly run for profit.

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Cite this as: BMJ 2016;353:i2881

HEALTH ANXIETY

Health anxiety in children and parents

Tyrer and colleagues’ editorial (30 April) raises the profile of health anxiety in frequent attenders at GP surgeries and clinics. Health anxiety may also occur in children and young people who repeatedly present to paediatric services; once recognised it can be treated with psychological therapies.

It should also be considered in parents who frequently present their children, despite normal examinations and investigations. It can be mistaken for fabricated and induced illness, or Munchausen by proxy as it was known, and is less common than parental health anxiety by proxy, which requires a different approach and management. The key difference is that parents present their children because of a persistent fear that doctors are missing something in their child, rather than seeking a response from health services for themselves. Paediatric liaison psychiatry services can help disentangle the psychopathology and prevent parents being unhelpfully tagged as potentially guilty of child abuse.

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