comment

> Food should be our pleasurable fuel, not our quest and destination. We're all going to die, regardless of how much quinoa we eat

NO HOLDS BARRED Margaret McCartney PPA COLUMNIST OF THE YEAR

Coming clean about eating clean

The new way of eating is "eating clean"—healthy, whole, unprocessed foods. If only that were all: note the stacks of açaí berries, coconut oil, cashew butter, and the expanding wheat-free shelf in the more expensive supermarkets. More choice is a good thing for people with coeliac disease—but these products aren't aimed at them.

Bestselling cookbooks tell the public that they'll look and feel better by avoiding wheat, dairy, and refined sugar. City centre juice bars offer similar promises to increase wellbeing (a favourite phrase).

Last month I went to a new gym class. At the end the instructor dismissed the sweaty masses with high fives and directions to drink juice and rehydrate fulsomely. "If you feel thirsty you're already dehydrated," was the fear-mongering message, and I would've protested had I been less breathless. Many attendees took possession of pre-ordered portions of coconut water and miserable looking vegetable purées. Follow-up emails from the gym have included much anti-science: not just a clean but also an alkaline diet, numerous supplements, and doing handstands to detoxify.

The command to eat cleanly implies that everyone else is filthy, being careless with their bodies and lives. It comes with promises of energy boosts, glowing skin, spirituality, purity, and possibly immortality. But this nonsense is all based on a loose interpretation of facts and a desire to make the pursuit of wellbeing an obsessive, full time occupation.

Some of the behaviours being encouraged by the gym and "clean" cookbooks are worrying. The minuscule meals, routine self denial, intensive exercise, and calorie counting seem to be an obsessive quest for a beautiful body and spiritual nirvana. "Cheat meals"—a deviation from clean eating—are frowned on, with terrible threats of constipation and feeling sluggish or bloated. The word "orthorexia," an obsession with eating only healthily, is used to describe this phenomenon, and some of this behaviour is surely on the eating disorder spectrum.

"Nutritionist" is an unregistered title, so anyone can claim to be one. They are legion and loved by the media, claiming new superfoods and diets in the way Columbus found new horizons. "Dietitians" have a protected title, as they are taught evidence based facts and like to talk about the uncertainties in diet studies. They also tend not to get such media coverage.

Food should be our pleasurable fuel, not our quest and destination. We're all going to die, regardless of how much quinoa we eat. If we've "had enough of experts," as one UK politician recently claimed, this sort of thing can only proliferate. We need clean facts, and dietitians need to be much more visible in our post-facts world.

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PERSONAL VIEW Sosena Kebede

Ask patients "What matters to you?"

It helps reframe interactions in a more patient centred way than "What's the matter?"

Maureen Bisognano, one of the keynote speakers at this year's International Forum on Quality and Safety in Healthcare in Gothenburg, Sweden, told delegates that we should ask our patients, "What matters to you?" rather than, "What is the matter?"

The question "What matters to you?" tries to get to the essence of patient centred care, which the US Institute of Medicine has listed as one of the priorities for quality improvement.

As physicians, our success in treating illness depends mostly on our ability to diagnose what the matter is with the patient. Pattern recognition, attention to verbal and visual cues from the patient, deductive reasoning, and good clinical judgment are time revered skills that physicians spend years perfecting.

Patient centred approach

The emphasis on diagnostic skill sets alone, however, has led to approaches in which care is designed around disease and the doctor dictating treatment to the patient. We now recognise that a patient centred approach—where care is structured around patients' needs, values, and preferences and where they and their loved ones are given opportunities to co-design their treatment plan—leads to better outcomes.

The "sick role," even for a brief time, is a disempowering and depersonalising state in which patients have to abide by healthcare professionals' rules—think for a moment about hospital gowns, intravenous line poles, bed pans, call buttons, bed alarms, blood draws, medical team rounds . . . yet each patient is a son or daughter, sibling, parent, grandparent, spouse, employee, employer, and so on, and each has his or her own identity and unique place in life.

The question "What matters to you?" allows patients to disclose their interests, values, and preferences, and it gives the clinical team a chance to appreciate patients as full humans and not just as recipients of care. This is essential to encourage caregivers' empathy towards patients.

Research has shown that patients value the quality of interaction with their caregivers, and their perception of this correlates with their overall satisfaction. Asking patients what's important to them is an invitation to a collaborative communication space that recognises the importance of good rapport for successful care delivery. In turn, good communication has been shown to increase patient adherence to treatment recommendations.

Responsiveness to public need

Asking questions to find out what really matters to our patients is a great opportunity to improve quality in service delivery. A US Department of Veterans Affairs study on patient centred care found that patients and family members were able to provide "unique perspectives" of veterans' needs that allowed for a targeted intervention by the healthcare team.

The optimal way to engage patients and their loved ones in their own care is still not fully clear. Moreover, barriers to engagement

It allows patients to disclose their interests, values, and preferences—as full humans, not just recipients of care

ACUTE PERSPECTIVE David Oliver

Lies, damned lies, and the NHS

My school maths teacher got us reading Darrell Huff's seminal *How to Lie with Statistics*. The lessons have endured. In a similar vein was a wonderful recent column in the *Observer* by the statistician David Spiegelhalter on nine ways people misuse numbers to support their arguments. Three of these included recent examples from the NHS.

Use total numbers rather than proportions. Remember government claims that more emergency department patients than ever were being seen within four hours? This despite the percentage dropping to a new low as activity rose, which Jeremy Hunt later conceded.

If all else fails, make the numbers up

Casually imply causation from correlation. Consider categorical government claims that 6000, then 11 000 "excess weekend deaths" in hospital were caused by staffing, with no credible data to back this assertion.

Choose your definitions carefully. Check the claim and counterclaim in 2014's prime minister's questions about the number of NHS nurses, depending on the debaters' choice of time frame.

Spiegelhalter listed six other tricks. I've seen the following five repeatedly employed regarding the NHS.

Don't provide relevant context. Remember government claims that an additional £3.8bn had been given to social care thanks to the Better Care Fund? This ignored far larger budgetary cuts and played down the transfer of all funds from existing NHS budgets.

Prematurely announce the success of a policy initiative using unofficial selected data. The coalition government pushed a "three million lives" telecare and telehealth campaign and funded independent "whole systems demonstrator" trials. Officials announced major benefits before peer reviewed publication and

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include some patients' inability to fully engage (for social or cultural reasons) and providers' reluctance to engage with patients (owing to time constraints or a lack of clarity on effective methods). Methods such as the modified Delphi panel, feedback surveys, and patient advisory committees are some of the ways we can try to engage patients. From personal experience, the value of meeting with our patients with the sole intention of finding out what matters to them cannot be overstated.

I recently asked one of my patients what mattered to her, after attempted pain control did not alleviate her distress. In between tears, she told me about her hobbies and family. A lot of what matters to our patients is outside of our clinical armamentarium, and our success in meeting their needs demands our ability to integrate our care with their lives outside of our four walls.

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urged mass implementation. The eventual trial results were largely null.

Make the numbers look big (but not too big). For example, a *Daily Telegraph* article claimed that "EU health tourists cost the NHS £2m a day." This amount vanishes next to the total NHS annual spend of about £120bn.

Exaggerate the importance of a possible illusory change. The government has given local authorities powers to charge an extra 2% council tax to fund social care. But the total raised won't get close to the funding gap, and property values show that this further disadvantages the most deprived areas.

If all else fails, make the numbers up. This year the Department of Health announced that the English NHS was getting the sixth biggest funding increase in its history. Comparable data are available only since 1975-76, and the King's Fund showed this year's increase to be the 28th largest in real terms. I've yet to see a convincing explanation or defence of this claim.

Doctors have some training in critical appraisal of evidence and statistics. Best be vigilant, then, and use it beyond research and clinical practice.

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THEBMJ.COM BLOGS Clare Marx

Making the best of Brexit for the NHS

Change, challenges, setbacks, and advances are the hallmarks of modern medical careers. Post Brexit, maintaining and enticing staff to work in the UK has to be a top priority. Over 40% of surgeons trained outside the UK. Attracting and training more UK graduates is clearly important, but losing our non-UK colleagues would be cataclysmic. Within surgical teams are thousands of technicians, porters, and cleaners who have moved to the UK to serve our NHS. Toughened migration rules often particularly affect such workers, and we must send a clear message to the government that the NHS also needs to retain these vital staff.

I believe that there are areas where we now have the potential to improve patient safety. Along with all EU countries, the UK has been required to accept the lowest common denominator of standards across Europe. For example, under current medical device legislation some devices can reach the UK having been approved in European countries with lower safety standards. We can now toughen those laws.

Losing our non-UK colleagues would be cataclysmic

Language testing rules need to change too. Since 2014 the General Medical Council (GMC) has asked EU applicants to demonstrate their English language proficiency before getting a licence to practise. The GMC requires doctors from the rest of the world to demonstrate their language proficiency in a clinical context before allowing them to practise. However, the test for EU applicants asks candidates only to demonstrate their broad language skills and cannot insist on how it's done. We would like to see the same rules applied to all applicants from outside the UK.

Surgeons have had longstanding concerns about the impact of the European Working Time Directive (EWTD) on the time available for training. In 2014 the EWTD Taskforce concluded that we need greater flexibility for training hours while never going back to a culture of excessive working hours. The Association of Surgeons in Training has suggested that the EWTD should be slightly relaxed to a maximum of 56 hours a week.

The research programmes that cross the European health and medical research communities will need supporting and protecting. We need sustained funding and mobility of researchers and clinicians, as well as regulations and policies to ensure that the UK research community can thrive and advance patient care.

Clare Marx is president of the Royal College of Surgeons of England

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Kate Granger

Geriatrician and cancer patient who started the #hellomynameis campaign

Consultant in geriatric medicine (b 1981; q Edinburgh 2005; MRCP), died from desmoplastic small round cell tumour on 23 July 2016.

Promoting compassionate care was vital to Kate Granger, award winning geriatric consultant, who used her experience as a cancer patient to ensure that the NHS kept compassion at its core.

Originally from Huddersfield, West Yorkshire, Kate showed an early interest in older people's care, as shown by her decision to help out at a local care home for older people when she was still at school.

Kate trained at the University of Edinburgh, where she graduated with honours in 2005 before returning to Yorkshire to get married to the love of her life, Chris Pointon, and start working—all in the same year.

Her first job after qualifying was at Dewsbury and District Hospital, part of the Mid Yorkshire Hospitals NHS Trust. Her work interests included medical education, continence, delirium, palliative care in the acute hospital setting, and the interface between geriatric medicine and surgery.

In 2011, at the age of 29, Kate was diagnosed with a desmoplastic small round cell tumour (DSRCT)—a rare aggressive form of sarcoma—and was given just six months to live. Instead of giving up, she decided to get busy doing as much as possible that would be useful.

#hellomynameis

During a hospital stay in 2013, Kate noticed that many of the staff looking after her did not introduce themselves before delivering her care. An example was a junior doctor, who, having failed to introduce himself, looked away and told her "your cancer has spread" before leaving quickly—something that she felt left her psychologically scarred.

This led her to launch the "Hello, my name is…" campaign, primarily using social media initially, to encourage and remind healthcare staff about the importance of introductions in healthcare.

Simple, but effective, the campaign has now got the backing of more than 400 000 doctors, nurses, therapists, and porters across 90 NHS organisations and has been adopted in around 100 countries.

Her husband, Chris, says: "It's grown and grown and is now global. When we went out on tour last year in the UK to promote this, we got to about half a million people who work in trusts who have signed up to it."

Kate Granger noticed that many of the staff looking after her did not introduce themselves before delivering her care

Political backing

The campaign also has the backing of the former prime minister, David Cameron, and many celebrities, while more recently, the new prime minister, Theresa May, wrote personally to Kate to thank her for her contributions to the NHS.

In addition to the campaign, Kate wrote and published two books about her situation (http://theothersidestory.co.uk/thebrightside), which have helped to raise more than £250 000 for the Yorkshire Cancer Centre—a target that was reached only a week before her death.

Kate spent most of her working life at the Mid-Yorkshire Hospitals NHS Trust. She also worked at the Leeds Teaching Hospitals NHS Trust, where she was treated as a patient. Julian Hartley, the trust's chief executive, says: "Kate has been an inspiration to so many people during her all too short life and has achieved so much. She was an outstanding doctor here in Leeds, a committed fundraiser for our Yorkshire Cancer Centre Appeal, and a true champion for patients everywhere.

One of Kate's friends—Jane Cummings, chief nursing officer for England—says: "Her honesty, courage, grace, and determination to share her experiences of living with a terminal illness and dying have enabled many to learn and speak openly about death and, in particular, about the need to improve communication and compassionate care."

Awards and honours

In 2014 NHS England created the Kate Granger Awards for Compassionate Care—annual awards in honour of Kate to "recognise an individual, team, or organisation that has made a positive difference to patient care."

Kate received an MBE in the 2015 New Year Honours for services to the NHS and improving care in recognition of her campaign and was thrilled to have the medal awarded by Prince Charles.

Earlier this year, Kate was awarded the Jane Tomlinson Award for Courage and was named overall Yorkshire Woman of Achievement at a celebratory lunch event held at the Royal Armouries in Leeds.

She also received a Special Achievement Award at the BMJ Awards 2016.

Personal ambitions

Knowing of her terminal illness made Kate all the more determined to squeeze in as much as possible, and she created a bucket list of personal ambitions. These included skydiving; getting a tattoo; qualifying as a consultant gerontologist; meeting the Queen; going on the Orient Express; renewing her wedding vows; afternoon tea at the Savoy; dinner at Claridge's; and trips to Paris, Edinburgh, and the east coast of the US. All were achieved. She was also a keen flautist and played in the Wakefield Orchestral Wind Band.

Her husband Chris says: "Compassionate is the best word to describe her. She said you should always see the patient as though he or she were one of your relatives because then you would take extra care with them and go above and beyond what a person would normally expect."

Kate took notice of the little things at work, he adds, such as making sure she never stood over somebody at the side of the hospital bed, kneeling down or getting a chair instead so that she was at the same eye level as the patient, to make the hospital experience less daunting.

"She was given only six months to live five years ago, and look at what she did in those five years," he says. "You've got to play the cards you're dealt in life, and Kate has done some amazing things and achieved great things in healthcare."

Kate died at St Gemma's Hospice, Leeds. She leaves her husband, Chris; her parents; and her brother and his family.

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Oscar Wendell Jordan

Consultant general physician and diabetologist Queen Elizabeth University Hospital, Bridgetown, Barbados (b 1939; q Edinburgh 1965; DCH Glas, FRCPE), d 4 June 2016.

Oscar Wendell Jordan was born in Barbados, into a family for whom hard work, self improvement, and education were essential aims. He entered Edinburgh University in 1959 and soon made his mark, academically and in sport. He returned to Barbados in 1971 to put something back into the community that had paid for his education. At Bridgetown's Queen Elizabeth Hospital he worked tirelessly to promote the highest quality of healthcare in diabetes, a major problem in Barbados and throughout the West Indies. He initiated the Barbados Diabetes Foundation in 2001 and achieved his long held dream of providing holistic care for individuals with diabetes and their families in Barbados with the opening of the Barbados diabetes centre in 2014. He leaves his wife, Marsha; three children; and four grandchildren.

C Christopher Smith, Mike Ford

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Anthony Carl Kaeser

Retired consultant psychiatrist (b 1932; q London 1957; FRCP, FRCPsych), died from complications of amyloid heart disease on 18 May 2016.

Anthony Carl Kaeser ("Tony") was appointed consultant in general adult psychiatry to Runwell Hospital, Wickford, in 1969. He became the driving force behind the opening of a new psychiatric unit at Basildon Hospital in 1977 and led the first training approval visit by the Royal College of Psychiatrists to Hong Kong. Having been liaison psychiatrist to the regional burns and plastic surgery unit in Billericay for 11 years, he was latterly a full time psychogeriatrician. During his retirement he was one of two Lord Chancellor's visitors for England. His interests were philately, contract bridge, and a wide range of music. He leaves his wife, Wendy; two daughters; and six grandchildren. In line with his humanistic principles, Tony donated his body tissues for the benefit of others and his brain for research into amyloid disease.

M R Lowe

Cite this as: *BMJ* 2016;354:i3828

Mark Malak

Consultant obstetrician and gynaecologist East Sussex Healthcare (b 1956; q 1980; MSc, PhD, FRCOG), d 13 November 2015.

Mark Malak settled in Eastbourne in 1995 as a consultant obstetrician and gynaecologist and established the first integrated and multidisciplinary urogynaecology team there in 1996. His team won numerous prestigious awards. Mark developed extensive clinical and surgical expertise in the management of urinary incontinence and pelvic reconstructive surgery, achieving an outstanding level of care. He was also the lead colposcopist for Eastbourne. A subjective retrospective audit of his continence surgery showed a success rate of 97% (complete cure rate of 94%). Elected on to the publication committee of the International Urogynaecology Association in 2008, he set up regular educational updates for local GPs. He leaves his wife, two children, and three grandchildren.

Miriam Malak, Nicky Roberts

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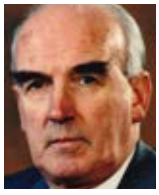
George Alexander McDonald



Consultant haematologist Glasgow Royal Infirmary (b 1924; q Aberdeen 1954; MD, FRCP Glas, FRCPath), died from respiratory failure on 3 April 2016.

After house posts at Aberdeen Royal Infirmary George Alexander McDonald became a senior research fellow, studying blood disorders. This was followed by a lecturership in medicine. In 1962 George moved to Glasgow Royal Infirmary as senior registrar in haematology, and later became consultant in charge. He greatly developed the department for it to become the regional leukaemia reference centre and later the Scottish regional bone marrow transplant unit for adults. George was a founder member and president of the British Society of Haematology and published widely in his specialty. He acted as visiting professor to several overseas centres and was for many years president of Leukaemia Research Fund for Scotland. George leaves his wife, Margaret; three children; 10 grandchildren; and one great grandchild.

Pierre Fouin, Michael Williams

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JUNIOR DOCTORS' GOLDEN AGE

Juniors' "reduced" hours are more intense

The problems facing juniors have no straightforward solution (This week, 9 July).

Treatment for many conditions was once rest, as options were limited. Today, many inpatients need active, often complex, intervention: for juniors, reduced hours are intense hours. Rotas have deconstructed teams and created staff relays, often working alone rather than with support from overworked colleagues.

Consider the foundation programme. Juniors allocated to a superspecialty can be perceived as a burden, which motivates no one. Exploration of interests should be in a re-created SHO3 role, which post-FY2 doctors often self create anyway. Foundation should focus on general specialties and acute admissions.

Needing consultants in hospital relates to these points and staffing issues, and it's a symptom of training adequacy. Senior "juniors" should be capable of assessment and common practical tasks. Consultants should be available to aid decision making. The burden of assessments is snowballing, with no evidence of better doctors.

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JUNIOR DOCTORS' EARNINGS

Negotiated junior contract is even worse

I was glad to see Burns's article on juniors' earnings under the proposed contract (This week, 25 June), but little of the detail applies to many of my junior peers. The inclusion of very frequent/infrequent weekend working data does little to advise many: in surgery, one in five or six (rota gaps aside) is the norm.

I've heard no juniors looking forward to the contract, never mind any who think that fair pay or work-life balance will improve.

The BMA should bear some blame for leading juniors into this. The contract was deemed not fit for purpose; for my peers, the negotiated compromise is worse. The royal colleges' encouragement to support this inflames discontent. The commitment to "work together, to make things better" seems patronising when we face a pay cut and manipulated working hours. If we accept this, will the colleges reduce their fees in recognition?

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LETTER OF THE WEEK

Generational divide over junior doctors must stop

The European Working Time Directive has damaged junior doctors' lives in many ways, but perhaps the saddest is that it has created a generational divide within medicine. Hospital spreadsheets implying that junior doctors work a maximum of 48 hours a week have allowed the old and the bold to make ill considered statements such as, "I am not sure that juniors now understand what hard work means" (This week, 9 July).

The assumption seems to be that, because junior doctors work fewer hours, they must be doing less work. This would be surprising given that our population is increasing in size, age, and morbidity—and that we now have urgent interventions for many conditions, delivered in large part by juniors, which were simply untreatable in days gone by.

The attitude that junior doctors no longer work as hard as their predecessors has contributed to the erosion of juniors' working conditions. Free accommodation, free meals, and maid service are replaced with the grudging provision of limited mileage allowance for on-call shifts, where employees are viewed as commodities whose long term loyalty and morale are of no consequence.

This must stop. All doctors commit to providing care for patients, and this is best delivered by doctors who are well cared for themselves. Tacit resistance to improving juniors' working conditions is damaging for our profession and our patients.

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DRUG COMPANY SUSPENSION

No action, no shame: UK response to drug wrongs

The Association of the British Pharmaceutical Industry suspended Astellas for inviting clinicians to a sham "educational event" (Seven days in medicine, 2 July). How is Astellas's record ignored by so many professionals? Why this relative inertia of the UK government?

Astellas has wide influence. In 2011 it unsuccessfully sued *Prescrire*, which had determined that the benefit/harm ratio for a tacrolimus based ointment was unfavourable and criticised regulatory authorities for extending the drug's licence to include "maintenance treatment" to prevent flare-ups of atopic dermatitis. In the US, Astellas paid $7.3m (£5.6m) to resolve False Claims Act allegations relating to the marketing of Mycamine to children.

The APBI's attempts to present itself as responsible are inadequate: it continues to argue that "[industry] plays a valid and important role in the provision of medical education." The public health "responsibility deal" shows that industries put their vested interest first.

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Self regulation is an oxymoron

Braillon et al (previous letter) summarise current partnership working with industry.

The Association of the British Pharmaceutical Industry recently published its voluntary register. The *Telegraph* reported that up to half of NHS staff also working for drug companies have refused permission for their names to be included in a new online database.

The Scottish parliament commissioned a public consultation on the need for a Sunshine Act. Most respondents considered that financial declarations should be mandatory.

NHS England has set up a group to set rules to manage conflicts of interest. It's not clear whether these will be voluntary or mandatory.

Other countries have moved on from voluntary to mandatory requirements because the former have been ineffective.

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