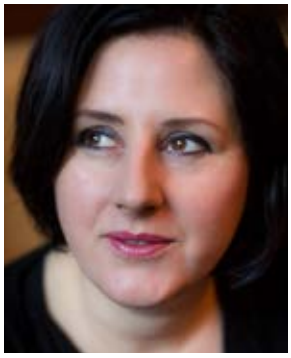
> It is, as yet, an unregulated profession. It's far easier to know when to prescribe than to know when not to

NO HOLDS BARRED Margaret McCartney

Are PAs just "doctors on the cheap"?

Jeremy Hunt tweeted on 18 September, "PAs [physician associates] used to be looked down on as 'drs on the cheap' but now widely welcomed as reducing clinician stress & burnout." Is he right?



In 2015, the NHS sought to bring 200 physician associates from the US into English primary care and hospital specialties, through the National Physician Associate Expansion Programme. The aim was to train new physician associates in the UK to work with, and then replace, the US sourced associates. Around 600 PAs now work in the UK, to rise to 3200 in the next three years. The training is a two year postgraduate course, and Hunt has mandated 1000 new posts in primary care.

The Royal College of Physicians (RCP) has set up a Faculty of Physician Associates. The college describes the posts as "not plugging or filling medical workforce gaps, but rather helping with the redistribution of the medical workload."

The equivalent position in the US is "physician assistant," but in the UK "physician associate" has been used in preference. This, says the RCP, is "to enable the profession to proceed towards statutory regulation and to distance PAs from another category of practitioner (still referred to as physician assistants) who work as technicians rather than clinicians, without a PA's approved education and training."

This difference in terminology is confusing, as are the descriptions of what PAs can and can't do. The RCP says that "PAs have the requisite knowledge and skill to prescribe" but can't do so because they have no statutory regulation.

And this is the rub: despite plans to do so it is, as yet, an unregulated profession. It's far easier to know when to prescribe than to know when not to. PAs can't work unsupervised, and they can't prescribe or request tests involving ionising radiation.

The RCP also says that PAs should be involved in service design, act as clinical placement leads for students, undertake minor operations, and take part in education and quality improvement projects. No wonder many junior doctors in secondary care—paid less for taking more responsibility and doing more unsocial hours—are concerned about this and the threat to their training opportunities. I'm sceptical that having more PAs join the health service will cut levels of burnout among junior doctors in secondary care.

The RCP adds that, in primary care, PAs' inability to prescribe is overcome because "many PAs working in general practice have the ability to quickly interrupt their supervising GP for a signature." I find that alarming. Taking responsibility for prescribing for a patient we've not seen or spoken to, whose notes we may not have reviewed in full, requires a lot of trust and means accepting a huge amount of risk. And being interrupted can easily become a safety issue: who else has forgotten to write down crucial information when our attention is pulled in several directions at once? General practice done right is difficult. Forgive me for my old fashioned view that GPs are best placed to see patients.

In primary care the evidence for PAs reducing workload is uncertain; the longer time taken to see people, who are likely to have minor problems, negates any savings; and research has not considered the cost of GP interruptions and supervision or looked at physician stress or burnout.[6]

So, no: Jeremy Hunt isn't right.

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PERSONAL VIEW Allyson Pollock, Peter Roderick

Beware of US style health bodies

If accountable care organisations are allowed to operate they can be given multi-billion pound health budgets

The secretary of state for health, Jeremy Hunt, intends to change secondary legislation to enable US-style accountable care organisations (ACOs) to operate in England. He has consulted on technical changes to 12 regulations which would define ACOs and let them operate under contract. But there has been no public consultation on whether the law and the NHS should undergo this major change.

ACOs were conceived in the US. They involve government and private insurers awarding contracts to commercial providers to run and provide services. The evidence on quality improvement is contested, and at best mixed, while projected savings to federal budgets translated into a net loss in 2015 and spending may have increased.

NHS England (NHSE) says it intends to consult on a model ACO contract in 2018. But if Hunt's changes are brought in earlier, the legal framework would facilitate ACO contracts to be introduced before consultation. That consultation would then be too late to influence a major—and deeply worrying—reorganisation of health services, including what the government refers to as "dissolution of the boundaries" between health and social care.

If ACOs are allowed to operate they can be given multi-billion pound budgets, including those for GPs and public health, for up to 10, or possibly 15, years.

The rationale for ACOs is the integration of health and social services, and reduction in the complexity and expense of the tendering process. That rationale has been quietly extended to "dissolving" the boundaries between health and social care—a move that could have far reaching implications for the availability of free health services and which has not been publicly debated.

ACOs will be in charge of allocating resources—deciding which services are available free

Primary legislation

There is no proposal to enact primary legislation, which would have to pass all parliamentary stages, to introduce ACOs to the UK. The proposed changes to secondary legislation are presented as minor and technical, but Hunt's consultation told us next to nothing. They were even defined differently in

ACUTE PERSPECTIVE David Oliver

We need statutory duty of candour for NHS executives

Robert Francis QC's report into historical care failings at Mid Staffordshire made more than 200 recommendations. Most were endorsed by the government. These included a statutory duty of candour and transparency for doctors and nurses, to be enforced by their professional regulators—the GMC and the Nursing and Midwifery Council. A few key recommendations were rejected or abandoned, including minimum safe nurse staffing levels and healthcare assistant registration.

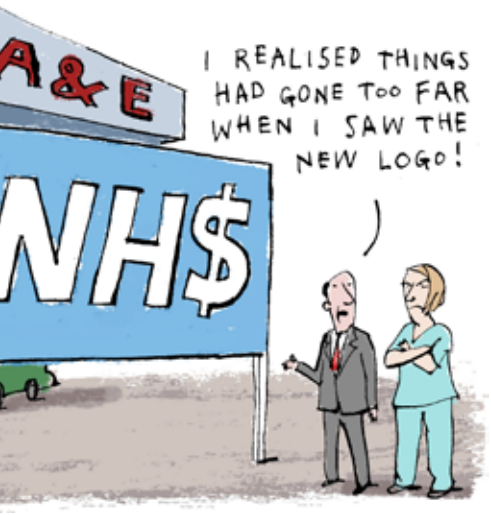
Another recommendation seemingly deemed too difficult was statutory professional regulation for health service managers. This is a shame. Surely, a duty of candour and transparency should apply even more to people in such key senior roles: their actions or omissions affect far more patients. Suppressing or ignoring bad news was a major feature of the original Mid Staffordshire story. We now have a statutory duty of candour on provider organisations and fit and proper persons tests for trust directors, but this isn't the same as holding individual executives to account through a newly created professional regulatory body for managers.

We have a culture among senior NHS managers that instils a fear of speaking up about problems

The serious concerns about NHS funding, workforce, demand, and consequent risks to performance and safety are well documented—and in plain sight. At a recent NHS Providers conference a panel of journalists discussing the NHS's reputation in the media advised staff to speak out as frankly as they would to a friend or colleague. The media might like that, but it could be career suicide.

The Chartered Institute of Public Finance and Accountability reported concerns that senior NHS finance officers were being bullied into compromising their professional ethics. The King's Fund's reports on the experience of NHS chief executives and finance directors highlight a culture of huge, top-down pressure and of people being judged failures against undeliverable expectations. "Oppressive scrutiny" and "bullying" regulators were cited.

It's generally much easier for senior doctors to speak out and put



different regulations.

Crucially, ACOs will be non-NHS bodies "designated" by NHSE, even though there is no statutory provision conferring such a function on NHSE. Behind the ACO it appears that there will be a network of companies—large providers, subcontractors, insurers, and property companies—but the consultation is silent on ACO membership and their contractual relations.

According to NHSE, ACOs will be in charge of allocating resources—effectively deciding which services are provided and to whom; which services are available free, through insurance, or out-of-pocket payments; and which services are to be means tested. They can take over patients on GPs' lists, and they can subcontract all "their" services.

Public consultation

ACOs are being introduced at a time when the 207 clinical commissioning groups are increasingly merging and aligning with the 44 non-statutory Sustainability and Transformation Partnership "footprints" across England. STPs are now forming as virtual organisations, possibly to replace CCGs, thus making it easier to drive through £26bn savings and associated cuts and closures, reducing the need for local public consultation.

Introducing ACOs is so fundamental that the proper way to do so would be for the proposals and their justification to be set out openly and clearly, as in a White Paper, and to invite wide public and professional responses. It is of grave concern that this has not been done to date.

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our names to comments. We have clinical "day jobs" to go back to, and the GMC discourages anonymity. But senior managers' tenure is often precarious. For middle managers in operational roles, who see more than most where the problems and risks to care lie, speaking out in public could be a bruising experience.

Thank goodness we've started to see a shift. For example, Andrew Foster, chief executive of Wigan and Wrightington hospitals, spoke recently about "understaffing across the NHS." Dame Julie Moore, of Birmingham University Hospitals, also pulled no punches on BBC2's *Newsnight* about the growing crisis in acute care provision.

But those speaking out tend to be fireproof—chief executives long in the job, in well regarded organisations. In *The BMJ*, David Lock described an endemic culture in which NHS managers are prevented from speaking truth to power. He said managers were forced to collude with promises of unfunded, undeliverable, understaffed plans for service change and performance or savings that no one believes are deliverable.

I'd welcome statutory professional regulation for non-clinical senior NHS managers with legal obligations around candour and transparency. It should be a key part of their role to describe problems we all know are there but aren't being made public.

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BMJ OPINION Roghieh Dehghan

A migrant GP on upfront NHS charges

As a European GP of Middle Eastern background working in post-referendum Britain, the political is very personal to me. This includes the recent policy from the Department of Health (DH) on upfront charges to "overseas visitors" using the NHS.

The DH's approach carries some hidden costs that many health professionals intuitively know but dismiss as negligible. This includes the demoralisation or loss of its staff, and the deterioration of the doctor-patient relationship as two incompatible cultures clash: that of medicine based on trust and respect, and that of medicine as a proxy for the Home Office—informed by suspicion and scrutiny.

According to a survey undertaken by the BMA, I am not the only EU doctor struggling to maintain the level of commitment to the NHS that I once had. This disappointment is reinforced by policies that are hostile to migrants, and which further alienate a considerable proportion of health professionals. These policies render us second class doctors, and many of our patients second class citizens.

No one subject to the demands of working in the NHS wants to be scrutinised as a patient

No amount of "You can stay" or "You are safe"—not even a letter from Theresa May—is enough to protect me and my patients from racial profiling and the everyday microaggressions that these policies encourage. Outside of my GP surgery, I am just another migrant. I don't look any different from many other migrants, nor do I sound different.

Infecting the NHS with immigration policies clashes with the standards of care the GMC holds us to. Three out of the four domains of the GMC's Good Medical Practice discuss the patient-doctor relationship, stressing trust as the most important quality.

A large proportion of a doctor's work revolves around establishing and maintaining a trusting relationship with patients. This is not a luxury that we can cut down on; it is the glue that holds medicine together. Drawing attention to trust as the building block of medicine is not a soft argument. It is the trust that a vulnerable person places in my intent, actions, and agenda. Without that, there is no history taking or examining.

If a policy is putting this at risk, then it is only sensible to demand solid justification and evidence as to why it's being rolled out at all.

Roghieh Dehghan, part time GP in north London and an NIHR in-practice fellow at the Institute for Global Health at University College London

ANALYSIS

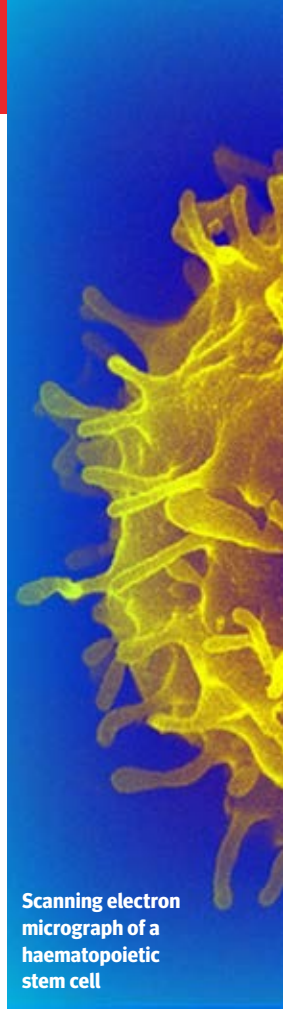
Too high a price to pay? Treating children with sickle cell disease

Haematopoietic stem cell transplantation from non-sibling donors is curative, but the risks may be too great, say **David Rees and colleagues**, particularly as alternative, effective treatments are available

Sickle cell disease is one of the most common severe inherited conditions in the world. Around 300 000 babies are born with the disease each year, mostly in Africa, although there are roughly 100 000 affected people in the US and 50 000 in Europe.[1]

The prognosis for children born with the condition today varies enormously, particularly with geography: only about 20% of babies born in Africa survive to adulthood,[2] whereas more than 93% of children survive to adulthood in Europe[3] and the US,[4] thanks to basic medical care, screening programmes, vaccinations, prophylactic antibiotics, blood transfusions, stroke prevention, and hydroxyurea.[1] Median survival is 60 years in some high income countries, such as the UK .[5]

Children severely affected with sickle cell disease (around 5%) fail to respond to treatment with hydroxyurea or regular blood transfusion. These children may have acute complications, including frequent attacks of severe pain and acute chest syndrome, or have evidence of progressive organ damage such as cerebrovascular disease. They are admitted to hospital frequently, which can negatively affect siblings and parents. Even in children with few overt complications, quality of life may be substantially impaired by fatigue, nocturnal enuresis, jaundice, and delayed puberty. Multiple comorbidities develop over time, with further reductions in quality of life.[1] These observations have justified the use of high risk treatments such as haematopoietic stem cell transplantation (HSCT).

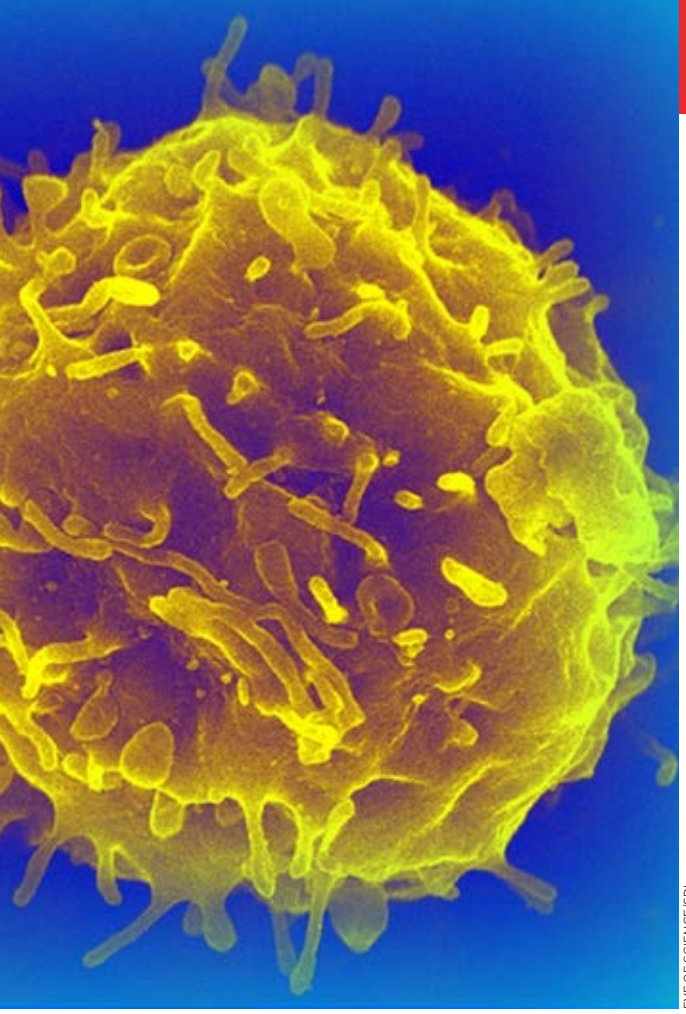


Scanning electron micrograph of a haematopoietic stem cell

KEY MESSAGES

- Curative treatment for sickle cell disease is potentially available to all patients using haematopoietic stem cell transplantation from alternative donors, but the risks are very high
- We don't know when these high risk transplants should be offered to children or how parents should be counselled to give appropriate consent
- In high income countries, non-transplant treatments are being developed that are likely to improve prognosis
- We need to develop safer transplants and to explore the ethics of offering high risk procedures to children with sickle cell disease and other chronic conditions

MAURO FERMARIELLO/SPL

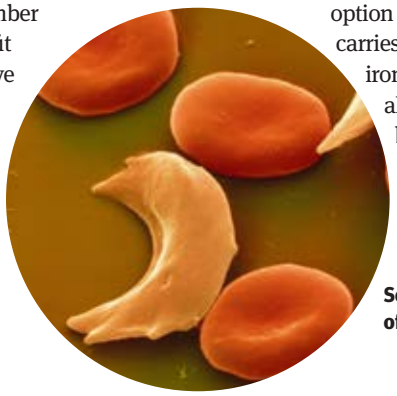


EYE OF SCIENCE/SPL

HSCT is the only curative option for sickle cell disease and has been routinely used for this indication in well resourced countries for more than 40 years.[6] Transplantation from HLA matched siblings has the best results, with mortality of 5% and event free survival of more than 90%.[7 8] These excellent outcomes have justified systematically offering HSCT to severely affected patients, especially those requiring chronic transfusion, who have a sibling donor with identical HLA.[8 9] It is also increasingly being offered to patients with less severe disease.[10] But we lack long term analyses of the relative benefits of HSCT over medical therapy.

We think that the considerable risks of using alternative donors are not justified in most cases

HSCT is limited by the availability of suitable donors, with HLA identical siblings available in only 10-20% of cases.[8] To expand the number of children who might benefit from HSCT, investigators have developed new protocols using alternative donors, where the donor is either an unrelated HLA identical sibling or haploidentical (parent or sibling with one matched HLA haplotype). These procedures are available only in high resource settings and are offered to children with the most severe disease. The few existing publications[11-14] show that these alternative donor transplants are associated with significantly higher risks of death and rejection. We consider here the acceptable risk of curing sickle cell disease in children.



Scanning electron micrograph of blood in sickle cell anaemia

Risks of alternative donors

A trial of unrelated bone marrow transplantation for children with sickle cell disease by Shenoy and colleagues found that seven of 29 (24%) children died and 11 (38%) had extensive graft versus host disease at one year.[11] The largest cohort study of HSCT for using haploidentical bone marrow donors, by Dhedin et al, was not a formal clinical trial and used different approaches at different times.[14] Of 22 children, aged 3-18 years, three died (14%) and two had graft failure (9%); event-free survival was 82%. Overall in these two trials, 51 children received transplants from alternative donors, and 10 died.

These studies show higher rates of transplant related death and graft rejection than with HLA identical transplants (7% in a study of HLA identical HSCT that included several protocols from 1986 to 2013).[7] The excellent benefit-risk ratio of HLA identical siblings is much reduced when alternative donors are the source of haematopoietic stem cells.

Randomised controlled trial data show that some of the indications for transplantation used in Shenoy's study (>2 episodes of acute pain a year (n=12), abnormal transcranial Doppler velocities, (n=2), and >1 episode of acute chest syndrome (n=4)) can be effectively managed in most cases with hydroxyurea[15 16] or regular blood transfusions,[17] although neither option is curative. Chronic transfusion carries substantial risks, particularly iron overload and red cell alloimmunisation, but these can be managed using iron chelation and erythrocytapheresis, and extensive blood group typing, respectively.

Balancing risk and benefit

Parents value curative treatments highly and are prepared to take high risks on behalf of their children to achieve a cure. In interviews, 12% of parents of children with sickle cell disease were willing to accept a short term transplant related mortality of more than 50%.[18] But research on the opinions of families and children on the risks of potentially curative treatments in sickle cell disease is sparse, particularly in light of improving medical outcomes and the possibility of transplantation as an adult. Similarly, few ethical analyses have tried to balance the benefits of cure against the risks of death, and studies on how to present these difficult choices to children and parents are lacking. These aspects should be developed in parallel with medical and transplantation advances.

We think that the considerable risks of using alternative donors are not justified in most cases. Alternative donor HSCT may be appropriate in about 5% of children, including those with progressive cerebrovascular disease or other organ failure despite optimal non-transplant treatment, including transfusion, hydroxyurea, or both.

In high income countries, the life expectancy of children with sickle cell disease is roughly comparable with that for other chronic illnesses such as insulin dependent diabetes mellitus and cystic fibrosis. The timing of lung transplantation in patients with cystic fibrosis is a similar dilemma—a lifesaving but high risk procedure that has around 30% mortality at five years. Guidelines recommend that lung transplantation is considered in cystic fibrosis with significant impairment of lung function (FEV_1 <30%) corresponding to a median survival of five to six years.[19] No such guidelines exist for sickle cell disease, partly because survival is hard to predict and partly because very few children with sickle cell disease in high income countries die in childhood (<7%).[3]

Timing of alternative donor transplantation

The optimal time to offer HSCT using alternative donors is unclear. Studies of HSCT in patients with

haemoglobinopathies consistently show that transplants in adulthood are associated with higher toxicity and poorer outcomes, largely because older patients have more complications, as severity of sickle cell disease increases with age.[7] Reduced adherence to treatment during adolescence and the transition to adult care may also contribute to worsening disease.[20]

Older patients are less tolerant of transplantation, but early transplants may be responsible for the death of children who would not have experienced severe complications and could have lived more than 60 years. Moreover, adult transplantation enables patients to give consent themselves, not their parents.

The decision to perform a high risk procedure in children is complicated by the improving prognosis with medical management and emergence of treatments—in 10 years there may be many more effective non-transplant options. A better understanding of the pathophysiology of the disease has led to the development of drugs acting on inflammatory, coagulation, and endothelial damage pathways.[21] An unprecedented number of clinical trials are under way, with promising results, such as the recent evidence for the effectiveness of P-selectin inhibition,[22] which may substantially reduce the number of patients with refractory pain. Gene therapy and editing also offer real promise, with active clinical trials.[23] We need more time to assess the effectiveness and middle and long term benefits of these new treatments.

Clinical trials

Research on the long term effects of HSCT for sickle cell disease is lacking, particularly using alternative donors.[24] We need multicentre randomised controlled trials comparing alternative HSCT with optimal medical care. Such studies are very difficult to perform, owing to the scarcity of patients who are very severely affected, the absence of a clear definition of "severely affected", and the need for long term follow-up. An adequately powered, randomised controlled trial may take more than five years to complete, by which time both transplant and non-transplant arms may be using redundant treatments.

ALAMY

We must identify prognostic factors that will reliably identify children likely to follow a severe clinical course

Clinicians who perform transplants, paediatricians, haematologists, patient groups, and ethicists should debate the indications for entry to these high risk trials. We must identify prognostic factors that will reliably identify children likely to follow a severe clinical course. Currently such children are only identified after substantial organ damage has occurred, such as cerebrovascular disease causing overt stroke. New genomic and proteomic approaches to identify reliable prognostic markers for these severe complications will enable high risk HSCTs to be offered to those who most need them, and this should improve the risk to benefit ratio.

Notably, the Shenoy study reported mortality of 24%,[11] whereas even one procedure related death in a clinical trial of non-transplant treatments is likely to result in the suspension or permanent stopping of the study. Although it could be argued that the same standards should apply to all novel treatments, including transplantation, sequential trials of transplantation may lead to the evolution of more effective and safer treatments, as happened in the treatment of thalassaemia major.[25] We must develop appropriate entry and stopping criteria to avoid inappropriate management of children with sickle cell disease.

Low income countries

HSCT is not widely available in low income countries, where most patients with sickle cell disease live, owing to high costs and the lack of necessary infrastructure. The high risks of alternative donor HSCT are arguably more justifiable in African countries because of the poor prognosis of sickle cell disease. However, far greater benefit is likely to result from investing in increasing access to cheaper effective treatments, including prophylaxis against infection, safe blood transfusion, and hydroxyurea.[2]

Conclusions

In theory every patient with sickle cell disease could now be offered curative treatment for their disease with HSCT. But for the majority of people, who don't have an HLA identical sibling, the risk of death is 10-24%. We cannot currently identify which children will develop severe disease without transplantation, making it difficult to weigh the risks and benefits.

We encourage the development of randomised controlled trials and more research into offering these difficult decisions to parents and children. Recent research in decision theory for implementing high risk treatment shows that physicians should defer to the considered preferences of the participants rather than rely on their own judgment of the benefit-risk ratio, although this is more complicated when the participants are children.[26]

The medical community must work with patients and parents on how to increase the availability of transplants, while tackling ethical questions with the same priority as the technical ones.

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Valentine Brousse, consultant paediatrician, Hôpital Universitaire Necker-Enfants Malades, Paris
Subarna Chakravorty, consultant paediatric haematologist, King's College Hospital, London
Antonio Pagliuca, professor, King's College Hospital
John Porter, professor, University College London Hospitals
Paul Telfer, consultant haematologist, Royal London Hospital
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DRUG CONTROL

Misuse of pregabalin and gabapentin underestimated

Our data support the government's decision to reclassify pregabalin and gabapentin as class C controlled substances (Seven Days in Medicine, 30 September).

At Imperial College we conduct toxicology analysis for coroners throughout London and the South East, handling roughly 2500 cases a year. In January 2016 analysis for pregabalin and gabapentin was introduced for all coroners' cases that require a general drugs screen, owing to growing concern over their misuse and the rising number of deaths with these drugs recorded on the death certificate. Gabapentin, pregabalin, or both, are regularly detected, primarily in combination with other drugs and often unexpectedly.

Many laboratories screen selectively for gabapentin and pregabalin in postmortem cases owing to limited funds or regulations. This means that the number of gabapentin and pregabalin deaths may be underestimated.

We recommend that toxicological screening for coroners' cases routinely include pregabalin and gabapentin to investigate the extent of their misuse.

Limon K Nahar, toxicologist
Rebecca Andrews, senior toxicologist
Kevin G Murphy, professor
Sue Paterson, consultant toxicologist, London

Cite this as: *BMJ* 2017;359:j5312

FRONTLINE LESSONS

We must change the culture around complaints

Sokol says that lawsuits encourage "better, safer practice" (Ethics Man, 21 October). But litigation and complaint investigations create a culture of fear.

Physicians respond by practising defensively. We found that more than 80% of doctors admitted to "hedging" (overinvestigating or overprescribing) and more than 40% admitted to avoidance (avoiding high risk patients or abandoning procedures early) after experiencing complaints procedures or witnessing a colleague do so. These behaviours are not in the interest of patients and drive up costs.

Should a case reach a courtroom, the doctor may have already undergone formal investigation at his or her institution, a serious untoward incident investigation, and/or been referred to the GMC. All while suspended and isolated from colleagues.

Instead of this punitive approach, we must develop a culture where mistakes are learnt from quickly and systems constructed to reduce the risk of human error. This should be achieved locally without intervention by regulators or courts.

Tom Bourne, consultant gynaecologist, London

Cite this as: *BMJ* 2017;359:j5313

LETTER OF THE WEEK

Treatment for codeine dependence


Anaesthetist is jailed after stealing codeine from hospital

A doctor who repeatedly used his old hospital pass after his employment ended to enter the hospital and steal codeine tablets has been jailed for eight months.

Paul Wilkinson worked for two years in anaesthetics at Aintree University Hospital in Liverpool, but when his contract ended he retained his pass. Over an eight month period he used it

Paul Wilkinson admitted burglary, burglary with intent, and theft

have put in place systems to ensure that [this] will never happen again. Nobody at the hospital has picked up that this pass has been repeatedly used in this period."

Wilkinson's job ended in August 2016, but he was not caught until the following April, when a nurse spotted him and realised that he had no right to be there. He had entered the hospital in ordinary clothes and

Wilkinson, who has a serious h injury and depression, admitte burglary, burglary with intent, theft. He said that he had been codeine since 2012 and, while 100 tablets a month prescribed taking as many as 300.

Jayne Morris, prosecuting co said, "He said he knew he woul ultimately be caught, but was s

The anaesthetist jailed for stealing over 2500 codeine tablets from a hospital shows not only the vulnerability of the healthcare system to diversion of drugs but also the need for addiction treatment for those suffering from codeine dependence (This Week, 28 October). Codeine dependence is a serious problem that can cause physiological and psychological harm.

Deaths involving codeine or codeine/paracetamol in England and Wales have almost doubled in the past two decades. Although the number of people in treatment for codeine addiction has risen in the past five years, many depend on alternative support, such as from the internet, to manage codeine misuse.

A recent online survey conducted in the UK and Ireland showed the ease with which codeine can be obtained. It found that 30% of those dependent on codeine faked symptoms to get a codeine prescription and 61% bought codeine from three or more pharmacies in a six month period.

People who take codeine for valid reasons may require higher doses over time, and this can develop into dependence. Once dependent, people are likely to start doctor and pharmacy "shopping" or stealing to avoid withdrawal.

Tighter regulation and closer monitoring of over-the-counter sales may be part of the solution, but we also need to examine the service provision for patients with codeine dependence, as current treatment services may not be adequate or appropriate.

Michelle Foley, Marie Curie research fellow, Waterford
Paolo Deluca, reader in addiction research, London
Andreas Kimergård, postdoctoral research associate, London

Cite this as: *BMJ* 2017;359:j5311

Difficult behaviour can protect patients

Discussing medical malpractice, Sokol says, "Insight can be defined as the ability to understand intellectually and emotionally why a behaviour is wrong" (Ethics Man, 21 October).

Insight cannot be defined in such a dichotomous way—"wrong" is invariably defined by those in positions of authority. As a mentor to doctors in disciplinary or regulatory difficulty I am often told that doctors "showed no insight," the real meaning of which is "didn't agree with us" or "hasn't admitted that they are wrong." But awkward, difficult, or rude behaviour may be shown by those who have a genuine point or grievance; it can protect patients, drive up standards, or both.

A lack of insight may represent the doctor considering his or her behaviour as appropriate in a system that often values non-confrontation over tackling its own shortcomings. Is it wrong to confront problems robustly if quality and patient safety are at stake?

Christoph Lees, consultant, London

Cite this as: *BMJ* 2017;359:j5314

RECRUITMENT

GP returners: then and now

In 2004 I returned to general practice some 30 months after retirement on health grounds. Successful surgery restored my health and I wished to return to practice. The local postgraduate dean facilitated this by organising a six month paid half time placement in a local training practice where I would be mentored. The process worked well: I learnt a great deal and my new colleagues offered me a part time post as a salaried GP. Seven years of practice followed.

In 2014, having been retired for almost three years, I became aware of increasing difficulties in recruiting GPs. I investigated a possible return to part time practice. However, I found that every obstacle described by McCartney lay in front of me (No Holds Barred, 28 October). Return to practice has proved impossible.

It is bizarre that no one recognises the potential benefit of facilitating the return of retired GPs to practice.

Robert Grant, GP (retired), Glenrothes

Cite this as: *BMJ* 2017;359:j5315

OBITUARIES

Michael Dixon

General practitioner (b 1922; q St Mary's Hospital Medical School 1944; FRCS, FRCGP), died from pneumonia and heart disease on 16 August 2017

My father, Michael Dixon, took up general practice in Esher, Surrey. He also developed a part time surgical practice at the Thames Ditton Cottage Hospital, as well as carving the turkey there at Christmas. My parents founded Cranstoun, a social housing project that became a therapeutic community for opiate users. The project steadily expanded over the years and has become one of the premier voluntary organisations for drug addiction in the UK. Dad's other love was tennis, and he played for and was president of the local club for many years. In his latter years he spent much time on GP training, to attract more recruits to the specialty. Predeceased by his wife, Annie, he leaves four children, 11 grandchildren, and three great grandchildren.

John Dixon

Cite this as: *BMJ* 2017;359:j5173

Donald Maxwell Ellis

General practitioner (b 1930; q Queen's University Belfast 1953), died from old age on 25 July 2017

Donald Maxwell Ellis ("Don") was a GP partner in Mansfield from 1959 to 1994. He was instrumental in establishing and running the GP deputising service in Mansfield as he recognised its benefits for avoiding GP burnout. His support for his colleagues in their careers was much appreciated over the years, as was his injection of fun into the job. He then worked as a full time locum GP in most of the practices in and around Mansfield for seven years. In retirement he enjoyed travelling extensively around the UK and Europe with Anne, his wife of 57 years. Golf and swimming kept him fit into his mid-80s, when he sadly became bedbound and relied on the devoted care of Anne, until he died peacefully at home. He leaves Anne, three children, and five grandchildren.

Jane Ellis

Cite this as: *BMJ* 2017;359:j5229

Peter James Fitzpatrick

Radiotherapy oncologist Toronto, Canada (b 1930; q London 1954; FRCR, FRCPC), died from parkinsonism on 17 August 2017

Peter James Fitzpatrick combined his love of both medicine and adventure by serving as a ship's surgeon. He was subsequently recruited to join the new Princess Margaret Cancer Hospital in Toronto in 1963. He was appointed professor of radiology and an associate in the faculty of dentistry. On Saturdays he treated cats and dogs with cancer, which led to a position of adjunct professor at the Ontario veterinary college. In 1989 he became physician in chief at the Nova Scotia Cancer Centre and was appointed professor and chairman of Dalhousie University faculty of medicine. He remained fiercely British but loved and embraced Canadian life. Peter leaves his wife, Vivienne; three children; and seven grandchildren.

Peter Fitzpatrick

Cite this as: *BMJ* 2017;359:j5169

Owen Morris Jonathan

Consultant general surgeon Glan Clwyd, north Wales (b 1917; q Guy's Hospital, London, 1942; FRCS), died from prostate cancer on 24 May 2017

Owen Morris Jonathan was posted to Ceylon (Sri Lanka) and Indonesia with the Royal Army Medical Corps. On his return he trained to be a general surgeon in London, Wales, and the US. After a brief posting in south Wales he returned to north Wales as consultant general surgeon, initially at the Royal Alexandra Hospital in Rhyl, and then the new hospital at Glan Clwyd. He developed a reputation as a kind and skilled surgeon with an extraordinarily broad surgical repertoire. In his retirement he served on medical appeal tribunals and was appointed High Sheriff to Gwynedd in 1988. He continued to play golf until the age of 95. Predeceased by his wife, Lowry, he leaves three children, eight grandchildren, and three great grandchildren.

David Jonathan

Cite this as: *BMJ* 2017;359:j5226

David Gwyn Seymour

Professor of medicine for the elderly Aberdeen University (b 1949; q Birmingham 1973; MRCP (UK), MD, FRCP Lond, FRCP Ed), died from a rare metastatic cancer on 17 December 2016

David Gwyn Seymour ("Gwyn") took up the chair of medicine for the elderly in Aberdeen in 1994 and retired in 2009. He focused his research on a hitherto little explored area: risk prediction in elderly surgical patients. His research interests were wide, and in 2008 he was awarded the British Geriatric Society president's gold medal for his contribution to academic geriatrics. In private life, everyone looked forward to whatever he had in store for them that day—usually a great deal of laughter. In the terminal phase of his illness, he let everyone know he enjoyed an incredibly lucky, fulfilling life. He leaves Ruth, his wife of 44 years, and two children.

Ruth Seymour

Cite this as: *BMJ* 2017;359:j5176

Peter Townsend

Consultant anaesthetist Queen Elizabeth Hospital, Birmingham (b 1964; q King's College London, 1989 FRCA, FFICM), died from cancer on 1 April 2017

Peter Townsend became a consultant in cardiac anaesthesia and intensive care in Birmingham in 2001. He was pivotal in the early uptake of transoesophageal echocardiography in the department and developed a personal interest in extracorporeal membrane oxygenation, mechanical support, and transplantation. He had trained as a registrar in Birmingham and as a research fellow in Aberdeen. He spent much of his annual leave during his early consultant career administering anaesthesia for a charity run surgical team that specialises in repairing cleft palates in the developing world. This allowed him to visit Nepal, China, South America, and Asia. Peter had many interests outside medicine: he studied and completed a degree in law in his spare time and was undertaking a PhD. He leaves his wife, Atika, and a daughter.

Mark Wilkes

Cite this as: *BMJ* 2017;359:j5183

James Paget Stanfield

Paediatrician dedicated to eradicating childhood malnutrition in Africa

James Paget Stanfield (b 1926; q Liverpool 1950; MD, MRCP, DCH, FRCP), died from heart failure on 17 August 2017

There is something very end of empire about a British paediatrician lying on the floor in Idi Amin's Uganda, simultaneously listening to gunfire outside and an eminent paediatrician on the BBC World Service.

For James Paget Stanfield, known to friends and colleagues as Paget, who died in August aged 91, the experience presaged the unwelcome end to the first of two long stints in east Africa. Having been in the vicinity of gunfire on several occasions, he eventually followed his wife and children—and most other westerners—out of Uganda shortly after that incident in 1973.

Stanfield was the son of a Wirral accountant who gave up medical training after serving as a stretcher bearer in the first world war. His own work as professor of paediatrics at Kampala's Makerere University and, for two years, senior paediatrician at the linked Medical Research Council's child nutrition unit at Mulago Hospital, had already established him as an authority on child malnutrition and infectious disease among children in the tropics. Having been seconded to Uganda from Great Ormond Street Hospital in 1962, Stanfield spent more than a decade working with children by the time of his departure amid the violent chaos of Amin's reign.

A decade later he returned to east Africa as director of community health with the African Medical and Research Foundation in Nairobi, a post he held for eight years. His work included writing protocols for child health that were influential throughout Africa.

In between those African sojourns Stanfield spent a not entirely happy five year stint as director of the University of Glasgow's social paediatric and obstetric unit, and another five as senior lecturer at the University of Newcastle's international child health unit. During this time he was the author of several textbooks.

However, it was practising and teaching in Africa, and Uganda in particular, that he found his true calling. Stanfield built on the innovative work of British paediatrician Dick Jelliffe, whose time in Uganda overlapped with his first years there. They each recognised the cultural aspects of childhood malnutrition and disease, and this shaped their approaches to prevention and treatment.

Overcoming cultural beliefs

Among the beliefs Stanfield and colleagues battled was a disinclination to feed chicken to girls, out of concern they would come to resemble poultry, with supposedly negative implications for their marriage prospects. In response they included mothers—and sometimes grandmothers—in the treatment of their malnourished children, with the expectation that they would promote the benefits of a varied local diet to others in their villages. One British contemporary recalls that mothers who worked with clinicians to bring their children back to health were sometimes asked to talk to a hall of health professionals and medical students.

The broader perspective to child health rooted in communities was brought to life in two centres, Lutete and Mwanamugimu, that Jelliffe initiated. Here, both budding doctors and the people they served were given instruction in nutrition and other elements of a healthy lifestyle. This ranged from digging a latrine to building basic homes and growing and marketing cash crops.

If such projects were building on Jelliffe's innovation, Stanfield, a committed Christian, also did much to support and encourage a generation of east African paediatricians and nutrition experts—not least by passing on ideas for research and shaping the university's masters programme in paediatric nutrition. Stanfield and his wife, a nurse he had met while at Great Ormond Street,

It was practising and teaching in Africa, and Uganda in particular, that Paget found his true calling

returned to Uganda soon after the millennium for the official naming of a ward at Mulago Hospital after him.

"Our loving father of paediatrics"

It is a telling comment on his modesty and affability, a British contemporary suggests, that, on hearing of Stanfield's death, former Ugandan colleagues sent a message mourning the loss of "our loving father of paediatrics."

Stanfield's career choices must have seemed unlikely when,having graduated from Liverpool School of Medicine in 1950, he fell under the influence of Harold Sheehan, professor of pathology. Within four years he completed an MD (with research on the pituitary gland) and was a member of the Royal College of Physicians. However, while in Malaya on national service, he cared for Gurkha families and on his return became a house physician at Great Ormond Street. In the early 1980s he undertook consultancies for the World Health Organization and the British Council in Nepal and India. After leaving Kenya for semi-retirement in Scotland, Stanfield continued teaching at Ugandan and British universities.

He leaves a wife, Edna (known as Chris), and six children.

Chris Mahony, London

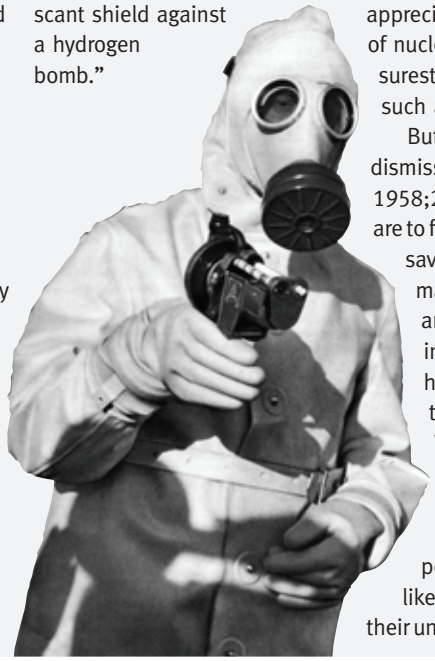
Cite this as: *BMJ* 2017;359:j4771

FROM THE ARCHIVE

Life after nuclear warfare

In a recent column (*BMJ* 2017;358:j3978) Margaret McCartney wrote about the harm nuclear weapons do. "War seems so far away from us," she reflected, "but it isn't. It never has been." In 1958, when G D Kersley wrote an article for the journal (*Br Med J* 1958;2:379) headlined "Nuclear Warfare and the Treatment of Mass Casualties," the possibility of nuclear war was discussed as if it were all too close. Kersley wrote of how "being prepared for the worst" could "reduce the risks of such a disaster." He predicted that proper preparation, supported by medical backing, could "more than halve the casualty rate—it might in the long run even decimate it."

Two readers (*Br Med J* 1958;2:1101), however, found the sanguine way in which Kersley wrote of nuclear fallout slightly maddening. "What, in the name of Hippocrates, leads them to believe that a sufficiency of trained personnel will be left, alive and functioning, to be of any use after an all out nuclear attack?" asked Paul Z Hammet and Joann Z Hammet, before summing up that "a dustbin lid seems scant shield against a hydrogen bomb."



Others also wrote in to express scepticism of Kersley's scenario planning: "If there is an answer to this threat, it cannot lie in plans which bear no relation to reality," wrote M C Berenbaum (*Br Med J* 1958;2:1231). "Widespread appreciation of the realities of nuclear warfare is the surest safeguard against such a war."

But not all readers were so dismissive. E N Owen (*Br Med J* 1958;2:110) thought that "if we are to face annihilation and to save anything from it, every man, woman, and child, and every possible activity in which they engage, will have to be subordinated to [a survival plan]… There are plenty of memorials in the health service already to the work of politicians. A vital matter like this must not be left to their unaided efforts."

MOST READ ONLINE

GMC to push for erasure of paediatrician convicted of manslaughter
BMJ 2017;359:j5223

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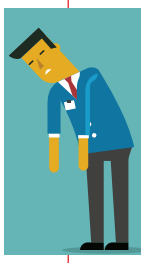
BMJ 2017;359:j4849



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BMJ 2017;359:j5107

David Oliver: Supervision and clinical autonomy for junior doctors—have we gone too far?
BMJ 2017;359:j4659

LATEST PODCAST

To complete or not: the antibiotic course

"Most of the courses we currently recommend to patients aren't really adequately evidence based… and, for many of the patients that we treat, are probably longer than those individual patients need."

In a new podcast, Martin Llewellyn discusses the evidence for completing a prescribed antibiotic course. Llewellyn and several co-authors challenged this idea in an analysis article we published in the summer, which had over 40 rapid responses, both agreeing and vehemently not agreeing. Now that the dust has settled, this podcast revisits the topic.

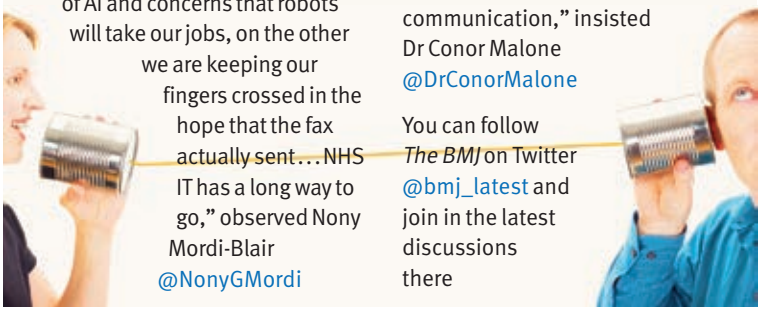
Listen to the podcast at http://bit.ly/antibiotics_podcast

WHAT YOU'RE TWEETING ABOUT

Chat about archaic NHS tech

A BMJ Opinion article highlighting the gap between the communication technology doctors use inside and outside of the hospital was met with a wave of fellow feeling on Twitter.

"On the one hand we have the rise of AI and concerns that robots will take our jobs, on the other we are keeping our fingers crossed in the hope that the fax actually sent… NHS IT has a long way to go," observed Nony Mordi-Blair @NonyGMordi



"I never thought knowing how to send a fax correctly would be an essential skill in modern medicine," said Eoin @bombycinus

"Healthcare staff and patients expect and deserve safer and more efficient methods of communication," insisted Dr Conor Malone @DrConorMalone

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