

# comment

‘Huge sums may be spent with great flourish but with little benefit to the people who are affected most’

**NO HOLDS BARRED** Margaret McCartney

## Does mental health “first aid” help?

**A** million British volunteers will learn skills in mental health first aid, at a cost of £15m. The government, which is funding the exercise, says that this will improve “personal resilience” and “help people recognise and respond effectively to signs of mental illness in others.”

This will include an online learning module “based on what has been shown to work, so that we can all be better at supporting people experiencing poor mental health.” Public Health England will also work with Mental Health First Aid England to build “on the knowledge and experience of the sector.”

Theresa May has said that she wants to “use the power of government as a force for good to transform the way we deal with mental health problems right across society.” Even Jeremy Hunt has been on a mental health first aid course, where he discovered that “quite a lot of the course is about looking after your own mental wellbeing” and learnt how to “spot signs in others around you who might be experiencing difficulty.”

Is this a good thing? One case study from 2016 cites an incident where a welfare benefits officer had mental health first aid training. When one man expressed suicidal thoughts after his money was cut, the benefits officer thought that she didn’t need to call the police—apparently the usual response—but could now encourage him to call the crisis team instead.

It’s profoundly sad that such basic training for being a benefits officer should be supplied as an optional add-on. The research cited finds that people who undertake this training feel more confident



about supporting people with “mental health difficulties” and feel more empathetic. But data are distinctly lacking on what people with mental illness think about it.

Does mental health “first aid” help the people receiving it? Do people with mental illness find it supportive—or intrusive? Is it helpful to talk to a comparative stranger? Do some people prefer privacy and more subtle support?

What about side effects? If we encourage people to seek professional help, could this lead to overdiagnosis and the medicalisation of human distress? And might such medicalisation inappropriately and harmfully trump sensible and kind human care? Hunt says that we can avoid this by teaching “resilience and self help” as a first step. I think that we’re in an evidence-free zone. The risk is that huge sums may be spent with great flourish but with little benefit to the people who are affected most.

Let us remind ourselves: access to children’s mental health services is a lottery, where waits of years are commonplace; constant difficulties arise in obtaining inpatient beds for children and adolescents; more than 5400 people had to travel away from family and friends for inpatient care in 2014-15; and a third of referrals to child and adolescent mental health services are turned down and often bounced to the charity sector.

If this was cancer there would be an outcry. But it’s mental health, so we get a sticking plaster instead.

Margaret McCartney, general practitioner, Glasgow  
margaret@margaretmccartney.com

Follow Margaret on Twitter, @mgmtmccartney

Cite this as: *BMJ* 2017;359:j5407

# Is being a doctor really “just another job”?

Oaths and declarations signify a deeper vocation

Over at the blog site of the *Journal of Medical Ethics* Iain Brassington, senior lecturer in bioethics and medical law at the University of Manchester, has launched an acerbic critique of the Declaration of Geneva, the modern day Hippocratic oath, whose latest revision was adopted by the World Medical Association on 14 October 2017.

Brassington methodically dissects the declaration. I focus here on one aspect of his analysis. The declaration states, “I will foster the honour and noble traditions of the medical profession.” This clause existed in near identical form in the original 1948 version of the Geneva declaration. Brassington comments dismissively: “Huh? It’s just a job, mate. Get over it.”

Is being a doctor just a job? Is that clause “phenomenally pompous,” as Brassington asserts?

The 1948 adoption came only a year after the doctors’ trial at the Nuremberg tribunal, in which 20 Nazi doctors were charged with “murders, tortures, and other atrocities committed in the name of medical science.” These atrocities included freezing people to death and infecting people with typhus, cholera, smallpox, and other diseases. Against this backdrop, the clause serves as a warning against the dishonourable and ignoble use of medicine.

The Hippocratic oath contains similar language to the declaration: “In a pure and holy way I will guard my life and my *techne* [τέχνη, which translates as craft or art],” and, “If I render this oath fulfilled, and if I do not blur and confound it may be granted to me to enjoy the benefits both of life and of *techne*, being held in good repute among all human beings for time eternal. If, however,



**Still today, 70 years after the Nuremberg trials, doctors in countries such as North Korea, China, and Syria are complicit in torture**

I transgress and perjure myself, the opposite of these.”

## Moral vigilance

Although the language is outdated, these are calls to integrity, moral vigilance, and high moral standards. Only then will the doctor be held “in good repute” by his fellows.

The Declaration of Geneva’s injunction to “foster the honour and noble traditions of the medical profession” is also a call for virtuous conduct. It is a fine sentiment to instil in doctors and medical students.

# Supporting care assistants when clients fall ill at home

In England, personal care and support for dependent older people is largely unpaid, provided by family. For people who have no one to do this—and who pass stringent eligibility criteria for statutory social services or can afford to pay regardless—it’s generally provided by care assistants. These carers often earn the national living wage or not much more, and reports show that many have zero hours contracts or are not properly reimbursed for time spent travelling between numerous clients’ homes each day.

Personal care of older people is hard, highly responsible work. But the recruitment and retention of care assistants is collapsing in many parts of the country, along with the provider market. Without these workers, who could earn more in less demanding



**Without these workers, who could earn more in less demanding jobs, our health and care system would implode**

jobs, our health and care system would implode.

Care assistants who develop a rapport with the people they help are often the first to notice health deteriorating. Perhaps they find the client on the floor, having fallen; or less mobile, more confused, or drowsier than usual; or with new incontinence. In any event, they generally have 15 to 30 minutes at the property before they must move to the next address.

In such circumstances it’s understandable that carers have to make quick decisions about calling for help, such as an ambulance. They may feel more confident if all parties sign up to a clear care plan about a home based response. Most care agencies have protocols for carers to call head office or an out-of-hours number, or

111, or a designated family member or professional. But they aren’t clinicians. And a fall or delirium or sudden immobility could result from a serious or life threatening illness, as well as less serious clinical problems. So, a clinical assessment of some kind is often imperative to ensure that treatable illnesses aren’t missed.

Sometimes hospital admission is entirely indicated. In turn, when an ambulance arrives, the crew are under response time pressures of their own, which can often lead to hospital as the line of least resistance.

So far as I’m aware, we don’t keep figures on numbers of patients admitted to hospital because of care assistants’ decisions—but, in my experience, it’s a frequent occurrence. These older patients are



GETTY IMAGES

It is also timeless in its relevance. Still today, 70 years after the Nuremberg trials, doctors in countries such as North Korea, China, Uzbekistan, Syria, and others are complicit in torture, whether by direct participation or by failing to record signs and symptoms of torture in medical records and death certificates.

Only recently *The BMJ* published an article on the role of clinicians in the solitary confinement of prisoners in the US, with reference to the case of Arthur Johnson. Johnson had been in solitary confinement for 36 years. The

healthcare providers seemed to have made no attempt to raise concerns about his appalling treatment.

### Intricate balance

Unlike Brassington, I do not believe that being a doctor is “just a job.” Few jobs have senior lecturers whose subject is the ethics of the job, let alone an oath. Few jobs require their practitioners to examine the body of a fellow human being, or expose those practitioners to death and suffering to quite the same degree: the unforgiving decline of a demented patient, the child dying from cancer. Few jobs require that intricate balance between the cool head and the kind heart; detachment and compassion.

Nor do I believe that the clause is pompous. It should, in fact, be an antidote to arrogance, because no doctors aware of their medical lineage—and of the collective toil of previous generations that has allowed today’s doctors to enjoy the public’s trust and respect—could be arrogant.

Even with morale at a low ebb, I doubt that many doctors would agree that theirs was “just a job.” It never has been and never will be.

Daniel Sokol, medical ethicist and barrister, London [daniel.sokol@talk21.com](mailto:daniel.sokol@talk21.com)  
Cite this as: *BMJ* 2017;359:j5257

often vulnerable and have cognitive impairment, so a sudden trip through a busy emergency department or acute medical unit can be unsettling. In many cases, we in acute care find ourselves asking whether they could have been supported differently.

England has several schemes in which ambulance crews can avoid conveyance by using onsite assessment and referral to community rapid response teams, especially for patients who have fallen. Some excellent rapid response intermediate care teams can also support people in crisis. But—even with a response time of two or four hours from the point of referral—this often isn’t quick enough for a care assistant who needs to leave the property and move on.

Still, we see some encouraging examples of service models that allow care assistants to refer directly to

NHS rapid response teams who can send out practitioners, such as the Newcastle and Gateshead Clinical Commissioning Group’s urgent care team. The NHS in north Devon took over the contract for home care services and also offers this rapid at-home response. Norfolk Community Health and Care Trust has a “home ward” multidisciplinary team able to link with social care providers.

Such models are encouraging and are surely right for people keen to remain at home and avoid admission. Sadly, the evidence for savings isn’t robust, and it’s hard to see their use becoming the norm, given current workforce and funding pressures.

David Oliver, consultant in geriatrics and acute general medicine, Berkshire [davidoliver372@googlemail.com](mailto:davidoliver372@googlemail.com)  
Follow David on Twitter: @manunianmedic  
Cite this as: *BMJ* 2018;360:j5110

## BMJ OPINION Tara Lamont

### How the sharing of stories can help staff’s wellbeing

It seems like it really is good to talk. A new study by Jill Maben carefully evaluated the experience of nurses, doctors, and others taking part in Schwartz rounds. These were introduced to the UK 10 years ago from the US, offering a safe, facilitated space for staff (clinical and non-clinical) to share stories about caring for patients, especially when this has been difficult. More than 150 NHS organisations now offer these rounds. The research, funded by the National Institute for Health Research, found that regular attendance improved the mental wellbeing of staff.

Perhaps this is not surprising. Viewers of recent high quality television documentaries, such as *Hospital* and *Junior Doctor*, often express amazement at the emotional (and physical) burdens placed on frontline staff in a typical day. Yet there has not always been enough attention given to how this affects people and what support they need. Schwartz rounds are distinct in being open to all staff in an organisation and focused on supporting them, rather than problem solving.

That said, some precursors do exist. These range from Balint groups—set up in the 1950s by a psychotherapist to support GPs by discussing case stories which were distressing—to action learning sets.



SPL

### Schwartz rounds are open to all staff and focus on support, not problem solving

There are also parallels with mortality and morbidity meetings. Indeed, there is a small, but fascinating, literature on these reflective spaces for doctors. This includes Charles Bosk’s seminal work on surgical error in the 1970s, using deep ethnography to uncover the ways in which these meetings helped to socialise trainees into the culture of surgery. It also showed the importance of the senior clinician’s role in modelling open discussion of things that go wrong.

When I worked at the National Patient Safety Agency, one of our most downloaded reports was “Medical Error.” This featured first hand accounts by medical leaders of mistakes, from giving 10 times too much heparin to a child to missed diagnoses. Many of these errors happened early in their careers, but haunt them still. These testimonies are important—and show why, in safety circles, staff are known as the “second victims” when mistakes happen.

It makes sense that, in order to care for patients well, staff need to be looked after. Schwartz rounds enable this to be done in a structured way, but careful planning and facilitation are needed to make them work well. In this country, organisations wanting to introduce Schwartz rounds can find support at [www.pointofcarefoundation.org.uk](http://www.pointofcarefoundation.org.uk). It seems that sharing stories about difficult encounters can help staff feel better—and build resilience to carry on caring.

Tara Lamont, deputy director of the NIHR Dissemination Centre. The views expressed here are her own



## ANALYSIS

# Putting patients in control of their data held on electronic health records

Research shows use of linked, computerised records offers great potential in healthcare, but patients must be informed about how their data are to be used and why, argue

**John New and colleagues**

**M**any areas of healthcare use electronic health records to document and store clinical data,<sup>1</sup> and there is much interest in using this information for clinical research. However, such use requires patient consent if the data are identifiable.

Several approaches can be used to get consent for identifiable data being shared for purposes other than personal care. Organisations have tended to favour an opt-out model, believing that an opt-in approach based on active consent would be unfeasible or lead to a low participation rate. In both models, if not enough patients opt in or too many patients opt out, it could be argued that the data are no longer useful or generalisable.

NHS England's care.data programme, designed to provide access to health and social care information from different settings, was abandoned, partly because it failed to provide clear information about how data would be used and win the confidence of patients and health professionals.<sup>2,3</sup> Patients must be informed of the intended uses and benefits of sharing data for research to raise confidence in data sharing and to avoid opt outs. Here, we describe our experience of an opt-in approach for sharing electronic health record data and discuss it in the context of national and global approaches to consent for sharing health data in research.

### Using electronic health records

Electronic health records can provide comprehensive data on medical history, prescriptions, and service use for large populations. They have an advantage over research databases as there is no interviewer or patient recall bias (eg, adherence to medication can be estimated by the number of prescription refills). Linking electronic

primary care data to secondary care records allows researchers to assess disease progression and use of resources. By recording clinically important outcomes in a wide range of participants,<sup>4-6</sup> observational research studies of routine clinical care allow comparative effectiveness research to be integrated into clinical care.<sup>7</sup>

In England, primary care has used computerised record keeping since 2000 and general practices use one of several, nationally available electronic systems. However, they are not generally used for research and there is no standardisation between systems. Across the UK, national datasets such as the Clinical Practice

### KEY MESSAGES

- Data from electronic health records cannot be used for research without patient consent
- Opt-in methods for consent have been avoided because of fears about low participation
- Experience in Salford suggests patients will opt in to data sharing if properly informed



GETTY IMAGES

## SIR: a model of integration

The founders of Salford Integrated Record explain how it has grown to be the foundation of a randomised patient trial across Manchester

Research Datalink use primary care records for clinical research, but these are not linked to other electronic records and are not suitable for use to monitor a clinical study because they are not updated in real time.

Other countries, including the US, use electronic health records for clinical and other purposes, such as processing insurance claims.<sup>8</sup> However, these records are not representative of the general population, as some only contain information on individuals who have health insurance. These records may also be limited to data from hospitals, rather than information from both primary and secondary care. The US has recently taken steps towards greater standardisation.<sup>9</sup> Adoption of new standards, such as the Fast Healthcare Interoperability Resources (FHIR), is likely to improve the ability to use linked datasets in clinical trials, although it may be some time before these technologies are widely available.

In Europe, Sweden and the Netherlands lead the way. Sweden has a national health record that can be accessed by healthcare providers across the country as well as by patients and their nominated family or carers.<sup>10</sup> Information from different providers is harmonised by use of standard interdisciplinary terminology (Systematized Nomenclature of Medicine Clinical Terms, SNOMED

Ten years ago, Salford in Greater Manchester, relied on many disease specific registers to identify and manage patients, resulting in much duplication of effort for those with comorbidity.

In 2007, the Salford Integrated Record (SIR) was launched with real time links between primary and secondary care, capturing data on everyone accessing health services in the city.

Key to the success of the project was informing patients about how their data would be used—that is, predominantly to allow local clinicians access for better healthcare. All patients were sent an information letter and asked if they wanted to opt out. Fewer than 500 of 230 000 patients chose to opt out (<0.2%).

SIR was developed before the movement to allow patients access to their records, and only allows access to healthcare professionals. If launched today, an active opt-in approach may have been considered, offering patients different levels of data sharing—such as solely for clinical care or for both clinical care and research.

In 2008, the NorthWest EHealth (NWEH) group was established (<https://nweh.co.uk>) to use SIR data for research. The group brought together computer scientists, clinicians, epidemiologists, researchers, statisticians, and project managers to develop methods and a governance framework to extract patient healthcare data for use in real world research studies. The Salford lung studies (SLS) are one example of the integrated record being used for research.

SIR helped to quantify the burden of asthma and

chronic obstructive pulmonary disease (COPD), identified exacerbations, and evaluated differences in disease outcomes and healthcare resource use. Building on this, SLS evaluated the effectiveness and safety of an unlicensed inhaled medication for the two conditions in everyday clinical practice in Salford and South Manchester.

These studies are the first prospective, randomised controlled trials of an unlicensed drug using

Fewer than  
**500** of  
**230 000**  
patients chose  
to opt out

electronic health records to capture data on clinical endpoints. The linked database system captured data in near to real-time from trial participants accessing local hospitals and general practices in these areas.

Although SIR's opt-out approach is adequate for sharing data for clinical care, a randomised trial requires explicit informed consent. The Medicines and Healthcare Products Regulatory Agency required real time patient safety monitoring and information governance for the trial, and the local ethics committee specified that the use of patient data needed written consent. So NWEH set up data sharing agreements with every general practice and hospital, the Office for National Statistics, and the NHS Secondary Uses Service.

Participating patients signed a consent form which permitted their GPs to share their data in entirety and link to other databases. Explicit information was provided to patients about how their data were to be used and for what purpose. This was achieved by extensive training of primary care nurses, pharmacists, and GPs, the study's main recruiters. Patients were given an ethics committee approved patient information sheet, which described the terms of data use. We also established a public education campaign and a website to further clarify the requirements of the study and detail how data would be collected and used.

By consenting to join the trial, participants confirmed they were comfortable for NWEH to hold their electronic records and for researchers to receive an anonymised subset of these data for analysis. All data shared with the sponsor were predefined, specific to the study, and approved by the appropriate ethical bodies.



SPL

As the COPD study collected all safety data and most efficacy endpoints through the electronic record, patients who had opted out of SIR were not eligible to participate. However, we invited those who met the clinical criteria for the study and explained that they must opt in to SIR to be eligible—58 chose to do so. In total 7039 patients have been recruited.

international). Data from the database are copied into national registries that may release data to researchers, subject to ethics committee approval. Consent for data sharing is on an opt-out basis, and patients can request information from their provider on how their details are used.<sup>11</sup>

In the Netherlands, most medical records are updated electronically and several systems are in place for the electronic exchange of data between primary and secondary care providers.<sup>12</sup> Amsterdam's two university medical centres (the VU University Medical Centre and the Academic Medical Centre) have adopted a shared electronic patient record system and patients are being asked for consent to merge their data and create a single shared record.<sup>13</sup>

Inconsistencies between sources of data can make sharing difficult. In the UK, primary and secondary care providers use different coding schemes and terminology for classifying diseases and these must be cross mapped, although coding for long term conditions has become more robust since the introduction of the Quality and Outcomes Framework in 2004.<sup>14</sup> In addition, certain data important for clinical research, such as disease severity, are not well coded in electronic health records.

### Acceptability

Experience from SIR (see box, page 25) suggests that the opt-out approach is acceptable across Salford. The transparent opt-in approach used in the lung studies informs patients about the purpose for which their data are to be used and who will have access. Trial participants did not object to their information being held by a trusted third party for research and supported anonymised extracts being sent to the sponsor. This suggests that UK patients might be willing to provide informed consent to data sharing and give consent for specific use of their data if the government restricts access to health related organisations.<sup>20</sup>

The Salford experience also provides evidence that local data for local use is acceptable

to patients and health providers. This approach is consistent with the recently revised Caldicott principles<sup>21</sup> and may be more acceptable to patients than NHS Digital holding all data centrally. Patients' views were considered when designing SLS, and many expressed their pleasure at being able to take part in clinical research.

In Greater Manchester, the newly devolved Health and Social Care Partnership is developing and rolling out DataWell, a platform that will enable health data to be shared between healthcare providers. This could enable the SIR/SLS technologies to be extended to the entire Greater Manchester population of 2.9 million.

The main barriers to the opt-in approach were the time and staff required to explain the terms of data usage to patients. Although it took time to help patients understand, in general they were reassured by the explanations. The most common patient questions asked by patients were who would be able to see their data and if they would be used for their clinical care; in this case, the data were only used for the study.

**The main barriers to the opt-in approach were the time and staff required to explain usage to patients**

### Rationalising an opt-in approach

An opt-in approach to data sharing aims to provide an ethical resource to support clinical research that ultimately benefits patients, clinicians, and payers. Patient consent for data sharing allows the linkage of datasets, which is more difficult to achieve with anonymised data. Under an opt-in approach patients should be informed before their data are accessed.

The system should also allow for varying levels of data sharing with different stakeholders (eg, for clinical care, for research, for clinical commissioning, or with pharmaceutical or healthcare providers), ideally with patients being informed of who has been provided with their data, for what purpose, and what the outcomes of the research were, to

alleviate concerns over misuse of personal data. Patients should be able to amend their opt-in choices at any time, allowing them control of how their data are used.

In light of the NHS strategy to allow patients access to their medical records online, the NHS has been in discussions about developing a simple, secure portal.<sup>22,23</sup> Parallel incorporation of an opt-in choice for different levels of data sharing, and enabling users to update their permission settings (akin to updating cookie preferences for website access), would add extra value for patients, clinicians, and payers. Development of individual "health accounts" could allow patients to access their data and approve or amend their use by certain organisations at any time. Such developments must be underpinned throughout by effective and transparent communication with patients to build trust.

The static, one-off approach used in SLS is not a perfect model. Ideally, patients would be able to review their consent and opt-out at any time. Additionally, the single level of consent in SLS made all sections of patients' electronic records accessible. A more refined system that allows patients to select who can access their records, and the level of access for each person, would be an improvement.

Although the costs of implementing an opt-in versus opt-out approach are considerable, the benefits may recoup this outlay. For example, medical tests are often repeated because healthcare providers do not have access to previous results. Linked electronic records could prevent the additional time and costs of repeating these tests. Greater linkage of records could also facilitate future clinical studies, reducing the initial costs.

---

John P New, clinical professor of diabetes and endocrinology, Salford Royal NHS Foundation Trust, Salford, UK  
john.new@manchester.ac.uk

---

David Leather, global medical affairs and study lead, GlaxoSmithKline UK, Uxbridge, UK

---

Nawar Diar Bakerly, respiratory physician

---

John McCrae, chief technology officer

---

J Martin Gibson, clinical professor of diabetes and endocrinology, Salford Royal NHS Foundation Trust

Cite this as: *BMJ* 2017;359:j5554



## MENTAL HEALTH ACT DEBATE

## Views from the frontline

The Mental Health Act and Mental Capacity Act have caused a lot of difficulties. These pieces of legislation are often at odds with each other. Unlike in many comparable jurisdictions, the English mental health legislation is unwieldy and unnecessarily complex. There are definitely grounds to streamline or fuse its processes, as suggested by Szmukler (Maudsley Debate, 18 November).

Another view from the frontline is that, although detention saves lives, it may also do damage. Clinicians are now forced to resort to detention to secure services or a bed. That black patients are three times more likely to be compulsorily admitted may say more about society than the law. We require funding to tackle this inequality.

Mental illnesses are different from physical illnesses and need extra safeguards. We support streamlining the law, but we think that compulsory treatment saves lives, which is a cardinal responsibility of psychiatry in England and Wales.

Ebunoluwa A Patrick, specialty doctor, Liverpool

Itoero Udo, consultant psychiatrist (locum), Widnes

Cite this as: [BMJ 2017;359:j5767](https://doi.org/10.1136/bmj.2017.359.j5767)

## E-CONSULTATIONS

## Online access has benefits for GPs and patients

We shouldn't write off electronic consultation tools because a single system achieved very low rates of use (Seven Days in Medicine, 11 November).

What really matters for online consultations is improving the speed of patient access and the ability of GPs to respond quickly. With the online consultation tool askmyGP, patients usually get a response on the same day. Standard appointment booking systems often make patients wait

## LETTER OF THE WEEK

## Urinary infections are hard to treat

A quinolone beats a non-steroidal anti-inflammatory drug at treating dipstick positive urinary tract infections (UTIs) (Research, 11 November). But we have more serious problems. Pathogen culture is insensitive, and dipsticks are worse. Dismissing UTI on dipstick or culture data confuses "no evidence of disease" with "evidence of no disease." Fresh, microscopic pyuria counts are the best option and are unused.

The normal and infected bladders evince a complex, polymicrobial soup, including fastidious or unculturable organisms. Culturable isolates are not necessarily the culprits, and multiresistance is no justification for broad spectrum prescribing. Mixed cultures are unsurprising and not necessarily contaminants. Abundant urinary epithelial cells seem to be expressions of the UTI and not grounds for specimen rejection.

Treating acute cystitis is no less problematic. Microbiological and symptomatic failure has been reported in 28%-37% of patients after 4-14 days of treatment.

Urine infection represents numerous realignments of a complex microbiome. It may involve the formation of surface and intracellular biofilms, which deter antibiotics and are hard to eradicate. No evidence shows that three or 14 days of antibiotics correct the situation.

This is extremely worrying. Evidence implies that some people fail guidelines, are betrayed by insensitive tests, and have untreated infection. I see such people, and they experience years of suffering.

An honest reappraisal of our assumptions and guidelines could prevent such misery at its onset.

James Malone-Lee, emeritus professor of medicine, London

Cite this as: [BMJ 2017;359:j5766](https://doi.org/10.1136/bmj.2017.359.j5766)



days or weeks and typically reject 10-15% of requests because no appointment slots are available.

Online systems like askmyGP won't work for every patient. But they can work for a large proportion. Because the system makes access faster and GPs more efficient, the benefits accrue to the patients who don't use it as well as to those who do.

The goals of faster access and more efficient GPs can be met if developers learn from experience and adapt their systems accordingly.

Stephen Black, data scientist, Biggleswade

Cite this as: [BMJ 2017;359:j5769](https://doi.org/10.1136/bmj.2017.359.j5769)

## FATIGUE AND RISK

## Loneliness and tiredness result of working time rule

Greig and Snow conclude that the European Working Time Regulations (EWTR) for doctors should not be loosened (Analysis, 18 November). They did not discuss work intensity or the difference between working alone and in a team.

The EWTR has reduced the number of doctors working out of hours. Where there used to be a team of three junior doctors working on call, there is now often just one working shifts. This allows little or no

opportunity for uninterrupted 15 minute breaks every few hours to overcome performance reductions due to fatigue. Has the effect of loneliness on tiredness ever been investigated? Long haul flights never have a single pilot.

When the EWTR is replaced, we should consider that working slightly longer hours as a member of a team may be less tiring and more rewarding than working alone, not to mention improving continuity of patient care by reducing patient handovers.

John Black, retired surgeon and past president, Royal College of Surgeons, Malvern

Cite this as: [BMJ 2017;359:j5775](https://doi.org/10.1136/bmj.2017.359.j5775)

## Daily number of patient contacts for GPs

An appropriate measure of workload in general practice is the number of daily patient contacts in face to face consultations, telephone consultations, and home visits.

In my 29 years as a GP I found that 35 patient contacts daily is the safe and tolerable limit. Beyond 35, I was beginning to feel below par. Beyond 45, I was at a noticeably higher risk of making an error. Beyond 50, my brain was shutting down, and any patient after that was not getting the best of me.

Each consultation requires an important social element, clear thinking space, a shared decision, and communication of the thought and decision. Repeating this pattern too many times in a day greatly increases the risks of error.

To maintain safety, jobs in general practice should be rated and doctors employed on the basis of hours of work and the daily number of patient contacts.

Gregory Warner, general practitioner, Romsey

Cite this as: [BMJ 2017;359:j5770](https://doi.org/10.1136/bmj.2017.359.j5770)

## OBITUARIES

### Peter James Lee

General practitioner (b 1946; q Cambridge 1972; MPhil), died from colon cancer on 7 November 2017

Peter James Lee developed interests in general practice, paediatrics, and obstetrics during his early medical training. In 1976 he started at the Gratton Surgery near Winchester. He worked tirelessly to provide continuity of care, and to support palliative care at home. With friends, he set up the Naomi House Children's Hospice; later in his career he provided medical support; and then, when ill, he worked as a volunteer driver for the hospice. He held posts in paediatrics, men's health, and A&E at local hospitals, and he undertook an MPhil in medical law and ethics. Peter retired in 2008 to work abroad. He worked for over a year at St Mary's Hospital in Kwazulu-Natal before his illness cut short his plans. He leaves his wife, Jill; four children; and 12 grandchildren.

Edward Lee

Cite this as: *BMJ* 2017;359:j5536



### Kenneth John Collins

Clinical physiologist (b 1929; q Guy's Hospital, London, 1973; DPhil Oxon, FRCP), died after a major intracerebral haemorrhage on 7 October 2017

Kenneth John Collins ("Ken") graduated in physiology at University College London in 1954 and then joined the staff of a Medical Research Council unit in Oxford, investigating human thermoregulation and heat illness. This led to his qualifying at Guy's, an interest in tropical medicine, and involvement over 10 years with the London-Khartoum schistosomiasis project. Ken set up a new MRC unit at St Pancras Hospital in London in the 1970s, at a time when urban hypothermia was seen as a major threat. As a member of various task groups within the World Health Organization, he ensured that the potential health effects of environmental temperature became more widely recognised. Ken had married Adèle Fox in 1954; she predeceased him in 2011. He leaves three children and five grandchildren.

Jo Marshall-Collins

Cite this as: *BMJ* 2017;359:j5489



### Kenneth Leslie George Mills

Consultant orthopaedic surgeon Aberdeen (b 1929; q Westminster Hospital, London, 1954; MA, FRCS Ed, FRCS Eng, FRCS Canada), died from cardiac failure on 4 August 2017

Kenneth Leslie George Mills ("Ken") was appointed consultant orthopaedic surgeon at Aberdeen hospitals in 1976 and stayed in post until 1994. His particular interests were in hip replacement surgery and paediatric orthopaedics. He was a coauthor of several colour atlases on orthopaedic and emergency topics and demonstrated anatomy to medical students until he was 85. As a ship's doctor on the British Antarctic Survey supply vessel, he visited South Georgia and the Antarctic Peninsula bases, returning with a frozen emperor penguin that had died on the icecap, in order to study its hip joints to determine whether, as upright walkers, large penguins develop arthritic changes in the same way as humans. Predeceased by his wife, Moira, Ken leaves two daughters and three grandchildren.

Carol Patrick, Thomas Scotland, Graham Page

Cite this as: *BMJ* 2017;359:j5516



### Raymond William Brotherhood

General practitioner Peckham, regional medical officer DHSS, and deputy secretary Standing Committee of European Doctors (b 1920; q Guy's Hospital Medical School 1952),

died after several strokes on 4 November 2017 Raymond William Brotherhood ("Ray") joined a group general practice in Peckham in 1954. In 1969 he became regional medical officer with the DHSS. After retiring from the department in 1983 he worked for the Standing Committee of European Doctors and helped establish the formal training scheme for GPs, until taking full retirement in 1986. Ray was a volunteer with the St John Ambulance from 1959 to 1986, a member of Christian Medical Fellowship, an elder in the United Reformed Church at Walton, and a member of the British Legion until he became bed bound in 2014. He leaves Sheila, his wife of 44 years; his former wife, Gina; children, stepchildren, grandchildren; and great grandchildren.

Shân Lythgoe

Cite this as: *BMJ* 2017;359:j5476



### Michael Gerald FitzGerald

Consultant physician Birmingham (b 1924; q Birmingham 1947; MD, FRCP), died from old age on 6 September 2017

Michael Gerald FitzGerald ("Fitz") was a consultant physician specialising in clinical diabetes and thyroid disease. He led his department at the General Hospital Birmingham from 1964 to his retirement in 1989. While at medical school he won many prizes but also played rugby, cricket, and hockey and went rock climbing. On returning from national service in Aden, Fitz continued his medical career in Birmingham, Cardiff, and Oxford. Fitz was honorary secretary of the medical and scientific section of the British Diabetic Association and was offered a professorship in medicine, but he turned down this role so he could remain a clinician. He retired at 65 and with his wife, Iona, moved to a smallholding in the Peak District National Park near Sheffield. Predeceased by Iona in 2016, Fitz leaves four children and six grandchildren.

Alex Wright, Robert FitzGerald

Cite this as: *BMJ* 2017;359:j5484



### John Perry

General practitioner Cambridge (b 1948; q Welsh National School of Medicine 1970; FRCGP), died from acute myeloid leukaemia on 19 October 2017

John Perry was an exceptional GP who had a non-directive style of consulting and gave patients space to make their decisions with him. He took on trainees for over 30 years, most of whom became teachers in their own right. He was course organiser in the Cambridge GP training scheme and associate regional adviser for East Anglia. In 1992 he became involved in the University of Cambridge clinical school and subsequently became director of studies in general practice. He loved France and all things French, and took great pleasure in his cars. He had an eclectic taste in music, was a keen and gifted photographer, could turn his hand to most things practical, and had a love of technological gadgets. He leaves his wife, Kate; two children; and four grandchildren.

Martin Roland

Cite this as: *BMJ* 2017;359:j5532



# Uwe Reinhardt

German born healthcare economist who was the “conscience” of the US medical system

Uwe Reinhardt (b 1937; doctorate in economics from Yale University, New Haven, Connecticut, USA, 1970), died from sepsis on 13 November 2017

As an adult, Uwe Reinhardt, who was born and raised in Germany, became a proud citizen of the US and the pre-eminent healthcare economist of his generation. As a long time professor at Princeton University, he advised government agencies, advisory boards, the White House, and the US Congress. A dynamic speaker and a gifted writer, he had the ability to explain complex healthcare policy and economic issues in simple English.

Reinhardt never succeeded, however, in figuring out why the richest, most powerful nation on earth failed to follow the example of countries such as the UK, Canada, and his native Germany by providing medical insurance for all its citizens. Often described as the “conscience” of US healthcare, Reinhardt once remarked: “The issue of universal coverage is not a matter of economics. Little more than 1 per cent of GDP assigned to health could cover it all. It is a matter of soul.” He believed high prices, and not excessive quantities of care, were the prime culprit behind exploding healthcare costs in the US.

## Humanity

Reinhardt was born in Germany on 24 September 1937. His father served during the second world war. After the war, the family lived in poverty for 11 years in a tool shed that had been part of a former furniture factory. He said: “For many years, we had no light and had to live with carbide lamps. My father, a former chemist, had been captured by Americans as a prisoner of war in Austria, and, although treated kindly, was never able to return to work. My mother did not work. We were always broke. And, yet, we never had to worry about our education and our healthcare. It was



WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

free . . . When you were sick, society was there for you.” Those childhood memories helped build the foundation of Reinhardt’s forceful advocacy for universal healthcare coverage, which he believed must include mandatory health insurance membership for all.

In 2016 Reinhardt was one of the few health economists to predict that the “health insurance marketplaces” of the Affordable Care Act, known as Obamacare, were in a death spiral and doomed to collapse. “I always joke about it like this,” he quipped. “If you got a bunch of Princeton undergrads to design a healthcare system, maybe they would come up with an arrangement like the marketplaces.”

## Leaving Germany

In 1957 at the age of 19, Reinhardt left Germany rather than do mandatory military service. Years later he explained: “I would not serve under generals who had stood straight for Hitler.” He settled in Montreal, working during the day as a shipping company clerk and at night parking cars. Living frugally for three years, he saved enough money to cover the first two years of studies at the cheapest school he could find—the University of Saskatchewan in Saskatoon, Canada.

After graduating in 1964 with a bachelors degree in commerce, he moved to the US for doctoral studies at Yale University. There he met fellow student and future wife, Tsung-Mei “May” Cheng, who became a health policy research analyst at Princeton.

Reinhardt joined the Princeton faculty in 1968 as an assistant

**Reinhardt had the ability to explain complex healthcare policy in simple English**

professor, but it was only in 1970 that he received his doctoral degree from Yale for his dissertation: *An Economic Analysis of Physicians’ Practices*. He remained at Princeton for the rest of his career, and at the time of his death was the James Madison professor of political economy and professor of economics and public affairs at the university’s Woodrow Wilson School of Public and International Affairs.

For decades, Reinhardt, a member of the National Academy of Medicine, was in high demand as a health adviser. He wrote for *The BMJ*, *JAMA*, the *New England Journal of Medicine*, *Health Affairs*, and other medical publications. He also regularly wrote commentaries for the *New York Times*, including a powerful piece in 2003, urging his fellow Americans to “hope and pray for a minimum loss of human life” on both sides in war. Reinhardt touched on war again in a 2005 commentary in the *Washington Post*. “When our son,” he wrote, “then a recent Princeton graduate, decided to join the Marine Corps in 2001, I advised him thus: ‘Do what you must, but be advised that, flourishing rhetoric notwithstanding, this nation will never truly honour your service, and it will condemn you to the bottom of the economic scrap heap should you ever get seriously wounded.’ The intervening years have not changed my views; they have reaffirmed them.”

Reinhardt leaves his wife, May; four children; and two grandchildren.

Ned Stafford, Hamburg  
ns@europen.de

Cite this as: *BMJ* 2017;359:j5610

**BMJ OPINION** Lulwa Al-Kilani

# South Sudan's refugees: a forgotten crisis

Since the start of the civil war in 2013, 165 000 South Sudanese people have fled the violence and crossed into Sudan's White Nile state to the Al Kashafa refugee camp hospital. Many have fled sexual violence, torture, murder, and the destruction of their homes.

Living like this is not easy. Al Kashafa is one of the oldest camps in the area, but people there are still dependent on international agencies to provide food, water, healthcare, and education.

Those of us who have worked in similar camps in other emergencies see that the international community is not providing the same level of support in this crisis as it has in other, more visible, refugee camps. You don't have to be in the camp for long to realise that access to clean water is insufficient, which can cause many health problems. Similarly, sanitation is poor. Basic toilets are not emptied, and this can be hazardous. This is a crisis forgotten by the international community.

Across the whole emergency, UN agencies have received only 14% of what they need to support South Sudanese refugees across



the region. The Médecins Sans Frontières hospital in Al Kashafa is a significant undertaking and is a referral point for most of the health centres in the area. It serves both refugee populations and the host community, who make up nearly half of the patients using the hospital.

In time, MSF intends to build a more permanent structure that is capable of dealing with the increased demand. The local community has already provided us with land. Yet the system is currently under great strain. Earlier this year, over 50 000 new refugees came across the border when fighting enveloped the towns of Aburoc, Kodok, and Wau Shilluk in South Sudan. Many arrived with little or nothing, often just a

few meagre belongings. Food and water are inadequate, but people make do with what they have.

Sometimes I am asked, "How do you cope with the challenges of running a hospital in such a tough environment?" To be honest, I get sucked into the tasks at hand and don't think about it too much.

But, from time to time, I need a bit of a boost; I need to see the work we are doing in the hospital. The highlight for me is going to the maternity ward where I meet the mothers and play with the newborns. This makes me smile and I feel re-energised. I hope that these children will get to go home soon.

Lulwa Al-Kilani is a project manager with Médecins Sans Frontières

**MOST READ ONLINE**

**The science behind "man flu"**

● *BMJ* 2017;359:j5560

**Does Peppa Pig encourage inappropriate use of primary care resources?**

● *BMJ* 2017;359:j5397

**Incremental effects of antihypertensive drugs**

● *BMJ* 2017;359:j5542

**"Drunk tanks" are studied over festive period to see if they ease pressure on emergency departments**

● *BMJ* 2017;359:j5929

**Wine glass size in England from 1700 to 2017**

● *BMJ* 2017;359:j5623



## The BMJ Christmas appeal: Médecins Sans Frontières' doctors need your support

**DONATE ONLINE:**  
[www.msf.org.uk/bmj](http://www.msf.org.uk/bmj)

**DONATE BY PHONE:**  
0800 408 3897

**Our guarantee to you** We respect and value every one of our supporters. We won't allow any other organisations to have access to your name and address. Neither will we send you constant appeals. We do want to share the reality of our work with you. When you give us your details, you agree to receiving information about our work and the difference your support makes. If you would prefer not hear about us please email Anne Farragher at [uk.fundraising@london.msf.org](mailto:uk.fundraising@london.msf.org), call 020 7404 6600 or write to: Anne Farragher, Médecins Sans Frontières, Chancery Exchange, 10 Funnival St, London, EC4A 1AB.

Please return postage free to: *Freepost RTGZ-KUHI-XHKU, The BMJ Appeal, Medecins Sans Frontieres (MSF), 2a Halifax Road, Melksham, SN12 6YY*

Title ..... Forename ..... Surname .....

Address .....

Postcode ..... Telephone number .....

- I'd like to donate £54, which could provide antibiotics to treat 40 war wounded people
- I'd like to donate £123, which could pay for a blood transfusion for three people
- I'd like to donate £..... to MSF

I enclose a cheque made payable to Médecins Sans Frontières UK

**OR** I authorise MSF to debit my Visa / Mastercard / Maestro / Amex / CAF card below:

Cardholder name .....

Card number

Signature ..... Date.....

Issue number (if shown on card)     Start date (if shown on card)   /   Expiry date   /



*giftaid it*

I wish Médecins Sans Frontières (MSF) to treat all gifts in the last 4 years, this gift and all future gifts as Gift Aid donations. I am a UK taxpayer and understand that if I pay less Income Tax and/or Capital Gains Tax than the amount of Gift Aid claimed on all my donations in that tax year, it is my responsibility to pay any difference (please tick box).

**NB** Please let us know if your name, address or tax status changes; or if you want to cancel this declaration. We can then update our records, thanks.

Today's date   /   /

Registered charity number 1026588  
MSFR0009 7431

