

comment

GPs who own chains of surgeries may boost their own take home drawings—by paying others less than themselves, to do the most important work

NO HOLDS BARRED Margaret McCartney

Pay should reflect value of direct care

You would be forgiven for thinking that all doctors get paid roughly the same, pro rata, for the same work. But some recent revelations have contested this belief.

One such revelation was the leaking of a letter by a public health consultant showing wide disparities in earnings among GPs: some earn well below the average of £100 000 for a full time GP in Scotland, but others earn more than £300 000. Sure, some people are part time, others are full time, others do a lot of on-call, and others do not. But this range is troubling.

What bothers me most about such pay disparities is the existence of a wide, inbuilt gap in doctors' pay, where obscene amounts of money are paid to some GPs and consultants at the top end. These figures are simply too much to justify to taxpayers or to anyone else. What's more, it's possible to earn this much as a doctor only by doing less of the very thing that's most important, and for which we receive the most training—direct patient care.

GPs who own chains of surgeries, and who employ doctors to do the core work at lower cost, may boost their own take home drawings. But they do so by paying others less than themselves, to do the most important work. Consultants at the top end of the scale may sit on so many committees that they see far fewer patients than



their colleagues. These colleagues may then end up doing more work to cover these clinics, while the consultants on committees boost their own CVs with less stressful and less legally risky work.

Direct patient care should be cherished and rewarded. People who do on-call or night shifts should be paid well for doing so, especially given the association with increased mortality. Doctors

who take on extra responsibilities should have their pay banded for doing so—but, if they also do less clinical work as a consequence, their overall pay should be reviewed accordingly.

We should be transparent about pay, including for people in corporate positions in the NHS. GPs already have a contractual obligation to publish average earnings, which can disguise huge disparities, and these declarations are for earnings before employer pension contributions, which makes it hard to determine what GPs actually take home. We need greater transparency around what these earnings mean in terms of take home pay.

None of this would sort out all of the problems with the gap in pay between the highest earning doctors and the rest. But it would at least help us to see where the issues are.

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

Twitter: @mgtmccartney

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Antidepressants: what do we get for £266m a year?

This “epidemic” of depression lets the neoliberal political and economic order off the hook for social suffering

The Royal College of Psychiatrists and the media routinely state there is an “epidemic” of mental disorder—one in four people in the UK, with three in four patients said not to get the treatment they need. These disease mongering assertions have been recycled for so long that they have become unexamined societal truisms.

Yet psychiatry has not confronted the philosophical problem of defining just what we mean by “mental disorder.” Barring categories arising directly from physical disease (for example, dementia), there is no conceptual agreement about when a person “really” has a mental disorder, only the constructed agreement inherent in the methodologies that psychiatry has adopted. If there are sufficient phenomena, at sufficient threshold, a mental disorder is declared to exist. This is a kind of alchemy. If to have a mental disorder

is to have some measure of incapacity, how could one in four UK citizens be thus afflicted and society still keep going? The psychiatric field is making claims it cannot justify. I am not talking about a minority with severe or recurrent psychiatric problems, often needing inpatient care.

When the medicalisation of everyday life and the commodification of “mind” is taken up by wider culture, the language of psychological deficit is inserted into the public imagination. People come to see themselves not as stressed, but as “ill,” with negative emotion recast as a mental health problem. As more resources are called for and provided, more are perceived to be needed, an apparently circular process, a dog chasing its tail. It was clear when I was an occupational psychiatrist that the psychiatrisation of the problems of living frequently perpetuated them.

The more that the mental health field promotes its technologies, such



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Society needs to talk less, not more, about mental health

as antidepressants, as necessary interventions in potentially any area of life, the more there is a downgrading in collective assumptions about the resilience of the average citizen. Ivan Illich called this “cultural iatrogenesis.” To coin an aphorism, the average citizen is as vulnerable or as resilient as the society he is living in expects him to be.

A manifesto for multimorbidity

In 2012 a Scottish study of more than three million people showed that living with three or more long term medical conditions was the norm for people over 65.

In 2016 a study that used data from more than 200 000 people in England aged over 75 showed that 7% had severe frailty and 21% moderate frailty.

This year, researchers predicted the proportion of people in the UK with four or more long term conditions would nearly double between 2015 and 2035, from 9.8% to 17%. Two thirds of these would also have dementia, depression, or cognitive impairment.



We need to transform the business of healthcare, and fast

The need for a greater focus on prevention of ill health is something I have argued for recently. However, for those people who will continue to get sick and continue to require healthcare we need to transform the business of healthcare, and fast. But how? Here are my suggestions.

First, healthcare professionals’ training needs to focus far more on coordinated, planned care of individuals. It should be based on patients’ goals and priorities and on balancing the risks and benefits of treatments, rather than simply on managing single diseases or organ systems. Though there are pockets of good practice, such approaches

are still far from the norm, and practitioners are often not well trained in them. This training must include an appropriate amount of exposure to primary and community care, geriatrics, mental health, dementia, and care at the end of life.

Second, research priorities, and funding need to reflect this reality. Research has tended to focus on single conditions of young or mid life and on high tech, cutting edge interventions, rather than on pragmatic models of service delivery for people with complex needs. We often exclude people with multimorbidity, frailty, or dementia, meaning in turn that the evidence base isn’t fit for purpose.

Thinner skinned

To culturally endorse a much thinner skinned version of a person than previous generations recognised does not seem a good idea if we look ahead to the huge challenges facing the world. Society needs to talk less, not more, about mental health.

Can anyone seriously argue society is healthier as a result of our epidemic of antidepressant prescribing—64.7 m prescriptions in 2016, up from around nine million in the 1990s? Antidepressants cost the NHS £266m in 2016, and these are only direct costs. No diagnostic category is more indiscriminately applied than “depression.”

David Healy describes the idea that abnormal levels of serotonin were connected to depression as the “marketing of a myth.” No consistent defining biological abnormality has yet been found in the brains of people with a diagnosis of depression. Thus the very term “antidepressant” denotes a false specificity.

Antidepressants have non-specific sedative effects, but so far that is all that can be said. Meta-analyses of research data suggest they struggle to demonstrate clinical superiority over placebo. Regarding a recent review in the *Lancet*, it is telling that psychiatric academe considers that ratings only one third above placebo, with

assessment limited to eight weeks, settle the case for mass prescribing.

Life is getting harder

My patients’ presentations often bear out the reality that life in the UK is getting harder: the fortunes of the haves and have-nots are diverging, the fabric of the welfare state thins. Many people receiving a diagnosis of “depression” might be more authentically seen as carrying generic social suffering. The doctor can do little about the patient’s social predicament, but feels she must do something and so prescribes an antidepressant. This “epidemic” of depression lets the neoliberal political and economic order off the hook.

Depression has become the idiom of distress in contemporary culture, eclipsing more nuanced descriptors—sorrow, unhappiness, despair, bitterness, misery. In the process we have lost something that cannot be compensated for by antidepressants. Some rebalancing would be realistic: it could start with the psychiatric field being less self-aggrandising about the claims it advertises to wider society. “Depression” is the case in point.

Derek Summerfield is honorary clinical senior lecturer, Institute of Psychiatry, Psychology and Neuroscience, King’s College, London
derek.summerfield@googlemail.com

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Third, we need to embrace and promote skilled medical generalism of the kind found in general practice, geriatrics, and acute internal medicine.

Fourth, we need to focus on tackling inappropriate polypharmacy and the benefits of rational “deprescribing.” Let’s think about what we want to achieve by prescribing for marginal gains, often driven by incentives that focus on single diseases or overspecialisation, and with insufficient consideration of patients’ goals or the downsides of drug-drug or drug-disease interactions.

Finally, we should redesign delivery to fit the reality of patients’ needs now, and over the next 20 years, not an earlier era when life expectancy was shorter and people often died from single conditions.

This surely includes breaking down arbitrary, artificial, and provider-centred barriers between what has traditionally counted as primary, secondary, community, and mental health services. The historical distinction between health and social care is especially ripe for reform, as is our failure to provide adequate support for the millions of unpaid carers who support so many people.

If we are serious about making any of this happen at scale, as opposed to pockets of excellence, we can’t do it without extra, targeted resources, enough staff, and the time and stability to escape immediate service pressures.

David Oliver is a consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com

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BMJ OPINION

Rhona MacDonald and David Southall

Humanitarianism in the wake of the aid agencies scandal



As revelations of sexual exploitation in the aid sector continue to ricochet around the world, millions of people continue to suffer—unheard, unseen, and largely forgotten. The antithesis of humanitarianism, the idea of exploitation by so-called “aid workers” in disaster settings is particularly jarring.

The downfall of Oxfam has been swift, decisive, and predictable. There have been several times over the past decade when the behaviour of large charities, and some workers, has been questioned. It was often the whistleblowers who bore the brunt of criticism, while the charities continued with reprehensible practices, relatively unscathed and unchecked.

In the wake of the Oxfam fallout, the international development secretary, Penny Mordaunt, has put forward measures to improve safeguarding practices within charities, which will undoubtedly lead to more regulation. The medical profession is all too familiar with how the egregious behaviour of a few has led to an overhaul of practice and regulation for the whole profession. And while, of course, tighter regulation has its place, it’s not the only solution to the abuse of vulnerable people by those in power.

It would be a tragedy if those who seek to drop the aid budget use the scandal to effectively exploit the most vulnerable all over again. Aid saves and improves lives, and need is continuously growing. Forced displacement numbers are at their highest for decades. The delivery of aid needs to be done better by promoting empowerment, and provided by the most appropriate organisations on the ground, whatever their size, who are prepared to speak up against abuse rather than covering it up.

After a period of painful self-examination, the aid sector needs to rediscover the principles of humanitarianism. Agencies need to re-commit to promoting human welfare by protecting the vulnerable and making the prevention of abuse their core ethos—not merely a regulation that needs to be adhered to or a check box that needs to be ticked.

Rhona MacDonald is honorary executive director and chair of trustees

David Southall is honorary medical director and trustee, MCAI (Maternal and Child Health Advocacy International)

Tighter regulation is not the only solution to the abuse of vulnerable people

Accountable care organisations: lessons from the US

NHS policy makers need to be realistic about the potential benefits of new care models, say

Hugh Alderwick and colleagues

Everybody in the NHS policy world in England seems to be talking about accountable care organisations (ACOs)—a concept borrowed from the US. Some, including NHS England and the health secretary, see ACOs (and the related accountable care systems) as a route to better NHS care.¹⁻³ Others view them with suspicion—for example, as a means to cutting services⁴ or a route to NHS privatisation.⁵ The Department of Health is proposing to amend the NHS standard contract to make it easier for ACOs to develop,⁶ with implications for GPs and others. But there is much confusion about what ACOs are and how they could affect NHS care.

Here we summarise evidence on ACOs in the US—including what they look like, their effect on the quality and cost of healthcare, and how they are redesigning care. Recognising major differences in context, we offer lessons from the US experience for NHS policy makers as they consider the future of similar ventures.^{7,8}

What are ACOs in the US?

ACOs were established under the Affordable Care Act in 2010 as groups of healthcare providers held accountable for care quality and

costs. Rather than being paid on a fee-for-service basis, ACOs receive a capitated budget from their payer—the government or a commercial insurer—to provide a range of services for a defined patient population and meet quality targets. Any financial savings are shared between the payer and the ACO. The idea is that providers within ACOs have greater incentives to collaborate to improve quality and reduce costs. There are now nearly 1000 ACOs in the US, serving more than 32 million people.⁹ While ACOs are relatively new, they build on a long history of prepaid group practices in the US,¹⁰ such as Kaiser Permanente.

The success of ACOs depends on expectations, but performance has been mixed and overall improvements modest. ACOs in the Medicare system (government insurance for older people and people with disabilities) have achieved small reductions in spending compared with non-ACOs but only recently started to deliver savings to the government.^{13,14} Savings have often been made in care for complex patients and use of institutional care.¹⁵ Medicare ACOs have been associated with improvements in patient experience and some other quality measures, though performance against some



quality indicators has not improved.¹⁶ Performance on both quality and cost measures has improved over time.

A recent systematic review of 42 studies found that, across all payer types, the most consistent associations between ACO implementation and care outcomes were in reduced inpatient use, reduced emergency department visits, and improved measures of preventive care and chronic disease management.²⁰ The most recent evidence finds no difference in quality or spending by ACO type (for example, large integrated systems versus smaller physician led ACOs).²¹ Greater variation can be found within types than between them, pointing towards differences in leadership, culture, and related factors as alternative explanations for ACO performance.

Are ACOs relevant in England?

In England, the language of accountable care is being used to describe a mix of approaches to

KEY MESSAGES

- ACOs have developed rapidly in the US as a way to hold providers accountable for improving care and containing costs
- Evidence on ACO performance is mixed and overall improvements have been modest
- Lessons relevant to the NHS in England include the importance of collaboration, the challenge of generating accountability, and the need to strengthen clinical and patient engagement
- Differences in context mean that accountable care will look very different in the US and England

Main changes introduced by ACOs to redesign care

- Implementing same day scheduling for clinical appointments
- Developing more team based models of primary care
- Using embedded care coordinators to manage care for complex patients
- Making use of electronic data systems to identify potentially high risk patients
- Providing timely, relevant performance data to physicians
- Targeting reductions in use of potentially low value services
- Applying lean management methods to redesigning care.



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There are now nearly **1000** ACOs in the US, serving more than **32** million people

Integrated care and ACOs in the NHS

England has a long history of initiatives to closely integrate health and social care services. In the past decade this has included partnerships for older people projects (POPPs), integrated care pilots, integrated care pioneers, and the Better Care Fund, as well as several legislative changes to encourage service integration. More recently, ACOs and ACSs (accountable care systems) have been used to describe efforts to integrate health services in England. The terms ACO and ACS are often used interchangeably, but there are some distinctions:

ACSs are defined by NHS England as groups of NHS organisations—commissioners and providers—working together to provide care and manage funding for their local population, including by working with local government.²⁷ They are more advanced versions of STPs—the 44 partnerships

improve NHS care (see box above)—including the 50 vanguards seeking to integrate health and social care services,³⁴ as well as the broader sustainability and transformation partnerships (STPs) responsible for planning and coordinating services across regions.²⁸ As with US ACOs, these approaches aim to encourage providers to coordinate services around patients' needs, focus on disease prevention, and manage resources efficiently. Some commissioners are also exploring ACO contracting models, to hold providers accountable for quality of care and costs.

However, there are major differences in context between accountable care initiatives in the US and England (see table overleaf). For example, the US spends almost twice as much of its GDP on healthcare as England,³⁶ while continued austerity in the NHS has left services in need of funding to maintain standards.³⁸ Financial incentives also operate differently in a market based system like the US, where ACOs stand to win or lose financially based on their performance. More broadly, the structure, values, and cultures of the two health systems vary widely. For these reasons, NHS policymakers should be selective in what they learn from the US, focusing primarily on how ACOs are redesigning services for patients and the factors that

Individual NHS organisations also often use the language of ACOs to refer to local initiatives to redesign care

between the NHS and local government created in 2015 to plan and coordinate services and achieve financial savings²⁸

ACO in England are defined as evolved versions of ACSs, where a single organisation holds a contract to provide all health and social care services to a local population. A draft ACO contract has been produced by NHS England,²⁹ along with proposed changes to NHS regulations.⁶ For NHS England, an ACO “simplifies governance and decision making, brings together funding streams and allows a single provider organisation to make most decisions about how to allocate resources and design care for its local population.”³⁰

To add more confusion, NHS England recently renamed ACSs as integrated

care systems,³¹ but their definition seems unchanged. Accountable care partnerships are sometimes talked about by NHS managers too, but the distinction between these and ACSs is unclear. Individual NHS organisations also often use the language of ACOs to refer to local initiatives to redesign care.

Importantly, these three letter acronyms are supposed to help implement the care models described in the NHS *Five Year Forward View*.³² The two main models are “multispecialty community providers” and “primary and acute care systems”—both based on joining up services around patients' needs and improving coordination between providers. The forward view explicitly compared these care models to US ACOs.³³

may influence their performance. Other features of US ACOs—such as their ownership or shared savings arrangements with insurers—are of less relevance to England.

With this in mind, we think the following five lessons from the US experience are relevant to accountable care initiatives in England today.

1. Have realistic expectations

Developing new care models is complex, and providers need time—often several years—to develop the relationships and processes required to improve care. Even then, average improvements among ACOs have been modest, and improvements in quality have not always been matched with reductions in healthcare use or costs. Better care for patients with chronic conditions, for example, has not always led to savings or fewer hospital admissions.¹⁶ This is consistent with broader evidence on integrated care from several countries⁴¹ and should provide caution to NHS leaders projecting major reductions in hospital use and costs through STPs.²⁸

2. Collaboration is essential

ACO depend on partnerships between organisations, which often have little experience of working together.¹² The same is true for STPs and vanguards in the NHS.²⁸ Providing better care for people with chronic conditions, for

example, depends on collaboration between primary care, mental health, hospitals, and social services. Finding ways to develop trust, manage conflict, share data, and make collective decisions is essential for partnerships to work in practice.

In the US, a “hidden” role has emerged in ACOs for non-provider partners supplying technical skills and funding—for example, private companies providing data analytics (with comparable performance between ACOs with and without these partners).⁴² In England, some have raised the spectre of private companies becoming responsible for commissioning and providing all NHS care under ACOs.⁴³ Others point out, rightly, that private companies lack capabilities to do so.⁴⁴ The US experience, however, hints that a more relevant target for debate in England may be these behind-the-scenes roles for private companies, and the related risks concerning their accountability and costs. While private sector involvement in the NHS is not new, NHS England recently invited bids from suppliers to provide various support services to STPs and ACSs—including in IT, administration, and commissioning.⁴⁵

3. Focus on leadership and management

Broader evidence suggests that organisational type is not associated with ACO outcomes.²¹ Internal

Comparing accountable care initiatives in the US and England		
	US	England
Health system context	Market based system with mixed public and private insurance, including high out-of-pocket costs for many individuals	Comprehensive, publicly funded system, free at the point of use
	9% of the population uninsured ³⁵ 17.2% of GDP spent on health ³⁶ ; national spending projected to grow at more than 5% a year to 2025 ³⁷	All residents have access to NHS care 9.7% of UK GDP spent on health ³⁶ ; NHS spending projected to grow at less than 1% a year to 2021 ³⁸
Objectives	Improve quality and coordination of healthcare services	Improve quality and coordination of health and social care services
	Improve disease prevention and overall population health	Improve disease prevention and overall population health
	Reduce growth in healthcare costs	Make the best use of NHS resources (including by managing reductions in NHS budgets)
Organisational structure and governance	ACOs vary widely in their structure—from single integrated organisations to collaborations of multiple provider organisations	STPs and ACSs are primarily informal collaborations between multiple NHS organisations and local government
	Organisations within ACOs are governed by a mix of formal (such as contracts) and informal (such as shared norms) approaches	ACOs are being developed as single organisations that manage all care Some NHS providers in vanguard sites are using or exploring formal models of collaboration—including lead providers (who subcontract to others), joint ventures, and mergers ³⁹
Commissioning and contracting	ACOs are based on contracts between payers (the government or insurers) and providers that hold providers accountable for costs and quality of care	STPs and ACSs rely on informal collaboration between commissioners and providers and the use of existing NHS contracts
	Some “softer” versions of ACOs rely less on financial incentives and contracts (such as Medicaid ACOs in Colorado)	A national ACO contract is being developed ²⁹ for NHS commissioners to hold providers accountable for costs and quality of care Some NHS commissioners in vanguard sites are using or exploring new contracting models to hold providers accountable for costs and quality of care ³⁹
Care models	Team based models of primary care	Multispecialty community providers focus on team based models of primary care and coordination of services in the community
	New roles such as care coordinators and health coaches to help manage patients’ care (often focused on complex patients)	Primary and acute care systems (PACS) bring together all health and care services for a local population and integrate hospital and community based care
	Service integration between care settings, such as primary and specialists	
Population focus	Most ACOs focus on patients enrolled in a particular health plan, though some Medicaid ACOs (such as in Oregon) and all payer ACOs (such as in Vermont) focus on geographically defined patient populations	STPs, ACSs, and other new care models typically focus on geographically defined populations (such as Greater Manchester)
	Capitated budgets bring together funding for the population of attributed patients to be managed by ACOs	Capitated budgets are proposed to bring together funding for a population’s care to be managed by ACOs—though whether this will be GP registered or local authority populations is unclear ⁴⁰
Scope of services	Healthcare services as defined in the contract but vary depending on the payer (for example, Medicare versus commercial ACOs)	STPs and ACSs cover all NHS services and are intended to involve collaboration with adult social care and other local government services
	Some ACOs have funding for flexible services that can be used to purchase social supports (such as transportation or housing assistance)	ACOs, if established, could cover all health and social care services NHS vanguards vary in their scope of services (for example, some exclude core primary care and involvement of social care is mixed)

factors more to do with leadership, culture, and management—such as capabilities to redesign services or the ability to overcome professional inertia—offer alternative explanations for ACO performance.^{13 23}

What does this mean for the NHS? While fixing fragmented payment systems could help remove barriers to collaboration, it is unlikely to be sufficient to improve care. Nor is creating new organisational structures. Other approaches, such as systematic use of quality improvement methods, dedicated management support for redesigning care, and leadership training in multistakeholder collaboration, are likely to be just as—if not more—important.

4. Accountability must be clear

Accountability is muddled in the US because ACOs typically hold multiple contracts with multiple payers, each with different quality measures and incentives. This is one explanation for their modest performance.¹³

Accountability for patient defined outcomes is also weak.⁴⁶ In England, the approach to generating accountability for performance will differ but is still important. One approach could involve redesigning the fragmented performance measurement frameworks for the NHS, social care, and public health to provide a single outcomes framework for local health systems.⁴⁷ But this raises the question, who are STPs, ACSs, and emerging ACOs accountable to, and how? None of these structures has any statutory basis, creating an unsustainable tension between formal rules and the reality of today’s NHS.

5. Get clinicians and patients involved

Finally, the success of ACOs depends on the involvement of clinicians and patients. Physician leadership of ACOs in the US appears strong.⁴⁸ Little is known about how ACOs engage patients in shared decision making and improving care, but there is evidence that patients receiving care from more patient

Hugh Alderwick, Harkness fellow, University of California, San Francisco
Hugh.Alderwick@ucsf.edu

Stephen M Shortell, professor of health policy and management, University of California, Berkeley

Adam D M Briggs, Harkness fellow

Elliott S Fisher, professor, Geisel School of Medicine, Lebanon, New Hampshire

centred practices report better outcomes.⁴⁹ In England, STPs have struggled to involve clinicians, patients, and local authorities²⁸—just like the integrated care pioneers that preceded them.⁵⁰ The strength of this engagement is likely to be a major determinant of success for new care models in future.

It's complicated

Translating policy ideas between contexts is fiendishly complex. Accountable care is likely to look very different in England—relying less on financial incentives and more on collaboration within the public sector to improve health. The direction of reform in England represents a shift away from competition towards collaboration to improve care and manage resources.⁵¹ Clinical leadership will be needed to turn policy changes into care improvements. As these approaches continue to develop in the US and England, sharing evidence can benefit both countries.

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ASTHMA GUIDELINES

NICE guidelines need resourcing

As co-chairs of the NICE guideline committee on asthma, we support the aim of a guideline with contributions from both NICE and the British Thoracic Society, covering all aspects of management and care (Editorial, 20 January). NICE stands ready to take the next steps in developing a single, joint approach.

We appreciate spirometry and fractional exhaled nitric oxide testing is challenging in primary care and in children. But objective testing was shown to be cost effective in NICE's primary care pilot study and in robust economic models developed by our committee, so we think it can be achieved with the right support and resources.

We acknowledge that establishing it as routine practice will take time. NICE's advice is to use current approaches to diagnosis from the British Thoracic Society's guidance until the capacity is in place.

Andrew N Menzies-Gow, consultant respiratory physician, London
John Alexander, consultant paediatrician, Stoke-on-Trent
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Developing guidelines is expensive

Keely and Baxter are right that the UK needs a single, regularly updated, comprehensive and evidence based guideline (Editorial, 20 January). But I am not convinced that their "logical way forward" is the best solution.

I was director of clinical and public health at NICE from 1999 to 2012. I spent much of my time managing the "fallout" when NICE recommendations differed from other guidance. One solution was to encourage the Department of Health not to refer topics that were already well covered. Another was to collaborate on guidance.



LETTER OF THE WEEK

Brexit will affect supply of radioisotopes

Brexit threatens our access not only to drugs (Seven Days in Medicine, 3 February), but also to radioisotopes, which are mostly imported from Belgium, France, and the Netherlands and are used to diagnose and treat diseases in about one million people in the UK each year. Currently, appointments are occasionally cancelled owing to delays at border control. This is despite the UK being a member of the European Atomic Energy Community (Euratom).

Euratom facilitates the movement of nuclear goods, provides regulation and safeguards for the transportation and use of radioactive materials, and governs UK international nuclear cooperation agreements with European and third party countries. Euratom is separate from the European Union, but the Euratom treaty requires freedom of employment for nuclear specialists and falls under the European Court of Justice's jurisdiction. Membership would be untenable after Brexit. Withdrawing from Euratom will inevitably affect arrangements for the guaranteed supply of radioisotopes to UK hospitals.

At a time when the health system is facing enormous pressures, unnecessary cancellations due to lack of materials needed for treatments is deeply concerning. The government is proposing a new nuclear safeguards bill, but this does not specify how the UK will guarantee a supply of nuclear material for medical use. We urgently need clarity about future arrangements and the huge implications that Brexit has for the NHS and its patients.

Claire M Rooney, clinical oncology registrar, Belfast
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Keely and Baxter seem to suggest that NICE should become the "health economic" engine for the continuation of the guideline from the British Thoracic Society and the Scottish Intercollegiate Guideline Network. Why not have a collaborative UK guideline, all equal partners? Developing and updating guidelines is expensive and protracted. Better to spend on supporting implementation than duplicating production.

Peter Littlejohns, professor of public health, London
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Authors' reply

We question Menzies-Gow and Alexander's statement that "objective testing is shown to be

cost effective" (Editorial, 20 January). The health economic modelling was carried out before the implementation study, the findings of which seem to substantiate our concerns.

At the end of study period, 59% of patients with suspected asthma remained of uncertain diagnostic status, and spirometry was normal in 73% of those diagnosed as having asthma. The diagnostic value of fractional exhaled nitric oxide (FeNO) testing was not reported.

NICE's economic analysis made the unrealistic assumption that all FeNO testing and spirometry would be performed in primary care, allowing no costs for increased referrals.

We agree with Littlejohns that money is better spent supporting implementation than duplicating guidelines. But implementation costs for the controversial NICE diagnostic algorithm would be high. Why did the Department of Health refer the topic of asthma to NICE when it was already well covered?

Duncan Keeley, executive committee policy lead, Solihull
Noel Baxter, chair, Solihull
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RESPONSE TO WINTER CRISIS

Creating more problems than it solves

Cancelling routine NHS operations doesn't solve any long term problems (NHS Winter Pressure, 13 January); it merely creates a backlog of people waiting for surgery.

What are surgical staff meant to do instead? Considerable resources are wasted. Freeing up beds is the main reason for cancelling surgery, but surgical beds are not the best place for acute medical patients. This massively increases workload for teams based on other wards and introduces inefficiencies.

Daniel R Gibney, locum doctor, London
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Heading for total system breakdown

Our drive to treat or prevent illness and to improve survival leads inexorably to the need for ever more care (NHS Winter Pressure, 13 January)—we are pushing a snowball uphill.

Improved efficiencies and anticipatory care provision won't prevent the ultimate system breakdown, brought about by delaying the end of life. Perhaps meltdown has already occurred. It depends how we define it—how long is the queue of waiting ambulances or the corridor strewn with trolleys?

Nicholas McDowall, retired GP, Gloucester
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OBITUARIES

Dennis James Stoker

Consultant radiologist (b 1928; q Guy's Hospital, London, 1951; FRCP, FRCS, FRCR), died from the combined effects of dementia, which had developed several years earlier, and old age on 24 September 2017



Dennis James Stoker was considered the doyen of British musculoskeletal radiology in the 1980s and 90s and was acknowledged as a true connoisseur of the interpretation of bone radiographs. Many radiologists benefited from his teaching, including from outside the UK. He published numerous papers and was an author and co-editor of several books. A loyal servant of the Royal College of Radiologists, he was its vice president from 1989 to 1991. He was a founding member of the International Skeletal Society and a member of other professional societies. Dennis was predeceased by his first wife, Anne Forster, in 1997. He leaves his second wife, Sheila; four children from his first marriage; eight grandchildren; and six great grandchildren.

Mark Davies

Cite this as: *BMJ* 2018;360:k850

Gordon Canti

Consultant pathologist St Bartholomew's and Charing Cross hospitals (b 1917; q 1942; MRCS, FRCPath, MIAC), died from old age on 21 January 2018



Gordon Canti, son of a pioneering Barts pathologist, started his own long career in pathology at Barts after wartime navy service. His main interest was cytology, as a rapid and reliable diagnostic technique. Building the service at Barts and training a generation of cytologists, he also had an instrumental role in the 1970s when what is now the British Association for Cytopathology was founded to develop all cytology's applications under the College of Pathologists, rather than focusing mainly on the gynaecological ones. He published prolifically, and in 1988 his own *Colour Atlas of Sputum Cytology* was published. Predeceased by Christine, his wife of 66 years, in 2014, he leaves four children, six grandchildren, and nine great grandchildren.

John Canti

Cite this as: *BMJ* 2018;360:k776

Peter Kirwan Sylvester

District medical officer Southern Derbyshire Health Authority (b 1924; q Westminster Hospital 1948; DPH, FFPH), died from dementia and illness associated with old age on 30 November 2017



Peter Kirwan Sylvester did national service in the Royal Army Medical Corps, serving at home and abroad (New Territories, Hong Kong), before gaining further hospital experience on returning to the UK. After three years in general practice he entered the public health service and undertook appointments in Oxford, Reading, and Cambridgeshire before becoming area medical officer and subsequently district medical officer (1974-85) for Derbyshire. After retiring from full time work he served part time as a consultant in public health medicine for Central Nottinghamshire Health Authority. In his final retirement, he served for a short time with the Armed Forces Charity and on the local regional war pensions committee for six years. He leaves his wife, Emily; two children; and four grandchildren.

Peter Kirwan Sylvester

Cite this as: *BMJ* 2018;360:k845

Katherine Paule Cotter

Consultant haematologist Cork University Hospital, Ireland (b 1943; q 1966; MD, FRCPath, FRCPath), died from pneumonia on 9 October 2017



Katherine Paule Cotter was appointed consultant haematologist at Coventry to a combined clinical and laboratory haematology department, where she treated patients with acute and chronic leukaemia with cytotoxic drugs. In 1979 she moved back to Ireland, where she was appointed consultant haematologist at Cork University Hospital and senior lecturer at University College, Cork. In addition to developing a department of clinical and laboratory haematology, she engaged in bone marrow transplantation of autologous stem cells. She was a member of the British Society for Haematology and the International Society of Hematology. Her husband, Patrick James McGrath, predeceased her in 2011.

Oonagh Gilligan, Keith Shinton

Cite this as: *BMJ* 2018;360:k773

Mary Catherine Ann Jorro

General practitioner (b 1931; q Bristol 1955; DRCOG), died from pancreatic cancer on 30 July 2017



Mary Catherine Ann Jorro was born in Bristol to a Spanish father and a Bristolian mother. After qualifying and house jobs, she joined Jimmy Macrae at Ham Green Hospital, treating, among others, victims of the polio epidemics of the period, where they were among the first to use "iron lung" respirators. After general practice training and various locums in London and Bristol, as well as a stint with the Canadian Air Force in France, she joined a group practice in Horfield, where she worked until she married in 1970. She then joined a similar practice in Ystrad Mynach and became a popular and respected member of the Welsh Valley community. She leaves her husband, Laurence; a daughter (the author of this obituary, who is also a doctor); and two grandsons.

Bernadette Hard

Cite this as: *BMJ* 2018;360:k779

Kenneth Scott

General practitioner (b 1925; q Guy's Hospital Medical School, 1953; OBE, DRCOG, FRCGP), died from complications of neurovascular disease on 14 January 2018



Kenneth Scott did two years' national service in the Royal Air Force before studying medicine. Postgraduate hospital posts prompted him to seek a career in general practice. He was one of the few remaining GPs who continued to perform home deliveries and believed that visiting patients in their home was an essential part of general practice. Kenneth was responsible for developing a small, two man practice in Beckenham into a large, leading group practice. He also was a part time clinical assistant in the accident and emergency department of his local hospital. He was an enthusiastic first wave fundholder during the 1990s. Many charities were recipients of his generosity. In 1994 he was appointed OBE. He leaves Anita, his wife of 67 years.

James Carne

Cite this as: *BMJ* 2018;360:k848

Peter Pritchard

General practitioner with “legendary” improvisation skills

Peter Michael Maddock Pritchard (b 1918; q Cambridge/St Thomas' Hospital, London, 1942), died from gastrointestinal bleeding one month after a serious fall on 6 January 2018

Peter Pritchard, who died just a few months short of his centenary, had an extraordinary ability to improvise pragmatic solutions to practical problems, whether physical or organisational. This made him well prepared for 37 years in NHS general practice.

When his father, an airship pilot, died in 1921, Peter was only 3 years old, his sister 6, and his brother 5.

Ten years later Peter started at Woodbridge School in Suffolk, and here we have the first evidence of his improvisational genius. The school had a small theatre and put on numerous plays, and Peter took charge of the stage lighting. He made dimmers from six inch ceramic drainpipes filled with salt water with a lead sheet electrode at the bottom and a second electrode suspended from a pulley with a counterweight. The main isolator was a knife switch with exposed contacts, and the whole setup was very dangerous. Apparently there were some electric shocks but no electrocutions. It was clear by this time that Peter had special talents.

He qualified in medicine in 1942, and, astonishingly from today's perspective, after only three months' experience as a house officer, he was called up and joined the Royal Army Medical Corps. In 1943, he was posted to India and from there, in 1944, to Burma as part of General Wingate's special force, the Chindits. In March of that year, Peter landed in a glider in northern Burma with “Operation Thursday,” the second largest airborne invasion of the war. His unit operated behind the Japanese lines for four months with support from the Kachin hill people. Casualties from malaria and dysentery far outnumbered battle casualties, and there was never

enough to eat because they were totally dependent on air drops, which were understandably erratic.

On discharge from the army in 1946, he spent four years in paediatrics at Great Ormond Street and University College hospitals. At Great Ormond Street he constructed a primitive machine for cineradiography to help with the investigation of congenital heart disease. The machine was improvised from two army surplus US aerial survey cameras driven at more than their designed speed by switches used in telephone dialling. In 1951 Peter entered general practice in Dorchester on Thames.

Social conscience

Peter had been born into an affluent family but his father's early death, combined with the effects of the Wall Street crash, meant that his mother had to bring up her young family in more straitened circumstances. This seems to have motivated his commitment to poor communities and, particularly, to the postwar squatter camp of homeless families using the damp, cold huts of a disused airfield in the neighbourhood of his new practice. He played a major part in the planning and development of the new village of Berinsfield, which gradually replaced the camp. The work of several decades culminated in the practice moving to the new Berinsfield Health Centre in 1970.

In 1971, with colleagues, he ran the first training course for practice nurses, and in 1972 he helped to start the first patient participation group in the UK. He became a teacher in general practice and a part time lecturer to social work students at Oxford University.

He retired from NHS general practice in 1978 but continued with locum work for another 10 years. Oxford University Press asked him to write a manual of primary healthcare, which was published in 1978. Later he and his son, James, were coauthors of books on teamwork and shared care. In 1995 he was awarded



Pritchard had an extraordinary ability to improvise pragmatic solutions to practical problems

the George Abercrombie medal of the Royal College of General Practitioners for his contribution to the literature of general practice.

In 1938, while still a medical student, Peter had joined an expedition to Svalbard and Norway, which kindled his love of the Nordic countries. In 1981, the World Health Organization invited him to serve in Finland as a rapporteur for a workshop on primary healthcare—from theory to action. He developed strong educational links with general practice in the Nordic countries, and with Oxford colleagues set up the UK-Nordic Medical Educational Trust in 1968.

In 1996, he helped to raise the money to buy the Hurst water meadow close to his home in Dorchester, and he served as the honorary secretary of the charitable trust until 2010, by which time he was 92. In recognition of this work, he was awarded a British Empire Medal in June 2012.

Belatedly, in 2017, he was awarded a RCGP certificate of commendation for his “outstanding contribution to the discipline of general practice and primary care.”

He leaves Daphne, his wife of almost 75 years; three children; and four grandchildren.

Iona Heath, London
iona.heath22@yahoo.co.uk
Cite this as: *BMJ* 2018;360:k676

Let's talk about the weather



As March began with the **Beast from the East blowing across the UK, it was fitting that the latest article in Neville Goodman's Metaphor Watch series, which looks at figures of speech in medical literature, was on meteorological metaphors. Here is an extract:**

"Meteorological metaphors are common in everyday speech: he was lightning fast; you are my sunshine; it's clear skies from now on. That doesn't make them common in medical writing, and nor are they easy to search. Bad weather—storms and whirlwinds—provides the more common medical metaphors. There are thyroid storms and cytokine storms. Someone asks if the genepatient storm clouds are dissipating, and there are worries that there are storm clouds ahead for medical funding.

"The 'perfect storm,' a rare set of meteorological circumstances that leads to catastrophe, was coined in the 1930s. Lake Superior State University put 'perfect storm' top of their 2007 list of overused words to be consigned to the waste bin, but there are plenty in PubMed, most of them after 2007.

"Most blizzards are for the Johanson-Blizzard syndrome, a rare congenital disorder named for Robert M Blizzard. 'Whirlwind' is the trademark of a make of wheelchair, which is unnerving, but is also a histological appearance and a radiological sign. There are whirlwinds of paperwork, consultations, and potential inpatient admissions. Even more chaotic are tornadoes, but most tornadoes in PubMed are actual, meteorological events."

Read the full article at blogs.bmj.com/bmj/

MOST READ ONLINE

Optimising sleep for night shifts

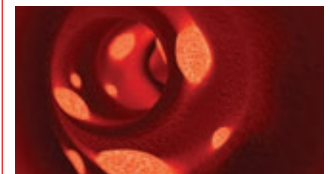
BMJ 2018;360:j5637

Junior doctors take trust to court for denying them breaks every four hours

BMJ 2018;360:k852

Deep vein thrombosis

BMJ 2018;360:k351



Eighteen doctors were struck off for sexual assault or rape in past four years

BMJ 2018;360:k913

Sleep—a panacea?

BMJ 2018;360:k947

bmj.com highlights is curated by Kelly Brendel, assistant web editor, *The BMJ*

WHAT YOU'RE TWEETING ABOUT

On the night shift

Last week's cover story gave an evidence based sleep strategy for working night shifts. Many readers tweeted their experiences of night shifts and their hopes that working practices could evolve to better accommodate them. Here are some of your responses:

How can you counsel patients to get rest when you yourself aren't getting enough
[NastassiaR @nastass2](#)

The time has come to change culture to stop the "epidemic of sleeplessness" in healthcare! No winners in this "sleep deprivation" ritual
[Krishna Bhaskarabhat @Baskarabhat](#)

I find resetting incredibly hard. My body just says no
[Dr Ben White @drbenwhite](#)

Unfortunately the "new contract friendly" rotas have taken shift working from bad to worse, with constant day to night switching and unpredictable off days. And napping in the early part of a night shift is a pipe-dream for most juniors in acute specialties
[Sophie Howles @SophieHowles](#)

Where would you take these naps? There's precious little in terms of on call rooms nowadays
[Kenneth Mangion @kenneth_mangion](#)



I use most of my break to just rehydrate and regain my equilibrium
[Mark Tehan @renal_phem](#)

If we don't start mandating basic expectations of safe shift work it becomes challenging to argue we're not working safely. Perhaps for today it's a conversation, by tomorrow it's a minimum standard
[EMTA @EMTAcommittee](#)

Excellent, but putting it into practice is the challenge
[David Reid @dijreid](#)

The key to power naps is breaks. For too many, breaks either don't happen or equate to doing admin work while eating a sandwich. You are entitled to 2 proper 30 min breaks on a night shift. You need them; your patients deserve it. We have to be better about emphasising that
[Michael Farquhar @DrMikeFarquhar](#)

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