> These services are parasites on the NHS, and they can exist only because the NHS does the hard stuff

NO HOLDS BARRED Margaret McCartney

A new era of consumerist GP services

Where does the NHS stop and private healthcare start? Becoming a patient of a "private GP" used to involve registering wholesale. They would require an annual subscription, along with additional fees for consultations, home visits, prescriptions, and referrals. The division was marked not just by better carpets, furniture, and postcodes: the private sector was a separate sector.

We are now on a fuzzy edge that is quickly dissolving into a catastrophic fuddle. Dozens of private GP services now offer consultations for a fee, from £10 and usually under £50. These are an add-on to your NHS care, which you can use to skip a queue and prioritise yourself. Consultations are rapid, online, and fully smartphone enabled. (I'll leave for now the interesting scenario where it's assumed that a camera phone can take a good picture of the tonsils or that you can self palpate the neck to determine the presence of tender lymph nodes.)

Fast access and the avoidance of waiting rooms "with germs" are recurrent selling points for these consultation services. Easy access to antibiotics is frequently alluded to in advertising, and many private services work closely with pharmacies to deliver medicines to your door. I do not blame patients for using these services: I blame the policy making that has placed the NHS on the brink, creating a market for them.

But these services are parasites on the NHS, and they can exist only because the NHS does the hard stuff. They are not willing to fend for patients in good times and bad, and they often insert "fair use" policies that effectively avoid dealing with the distress and needs of people with multiple chronic conditions, histories of abuse, or chronic mental health conditions. These companies are not committed to ensuring a distribution of resources dependent on need, playing instead to the false god of consumerism.

I've seen examples of cases where people have been referred to hospital consultants for conditions for which they wouldn't have been similarly referred by their NHS GP (a situation not helped by a lack of examination or blood taking beforehand). These patients have effectively made other people wait longer. I also have examples of patients whose NHS GP has been asked to take over long term prescribing of drugs of potential misuse, with highly uncertain benefit, which was initiated in the private sector.

This is a new era. In 2009 Harry Burns, the then chief medical officer for Scotland, said of NHS boards that "any arrangements to combine NHS and private care must not compromise the legal, professional, or ethical standards required of NHS clinicians." The BMA, in guidance also published in 2009, mentions "top-up" payments—but not those issues that cross the border between private and NHS care, where the expectations initiated in the private sector are punted back to the NHS.

We urgently need a robust governmental review of the practical issues that are becoming commonplace. If general practice in the NHS is allowed to become a mere depository for enacting decisions made elsewhere, not only will we be tipped over by the weight of the risk but people who scarcely have their basic needs met will be crushed in the stampede.

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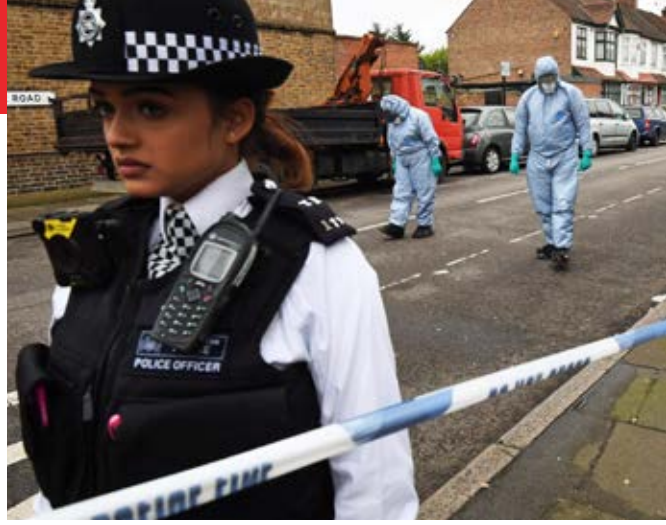
PERSONAL VIEW Jason Reed, Paul Whitehouse

Harsher prohibition will not stop drug violence, but regulation might

We should replace our enforcement led approach with regulation and support in a health based strategy



After a spate of violent crime, the Home Office released its Serious Violence Strategy on 9 April. Amber Rudd, then home secretary, said, perhaps inevitably, that the government's response "must tackle the misuse of drugs" as a priority, with more expected from the police.

But only four years ago the same department released a report which found no correlation between the harshness of a country's law and the extent of non-medical use of drugs. In fact, prohibition causes violence, as the new strategy recognises: "Grievances in illicit drug markets cannot be settled through legal channels, so participants may settle them violently." Spending £40m on prohibition based policies is unlikely, therefore, to solve the problem.

This is the view of Law Enforcement Action Partnership UK (LEAP UK), an organisation made up of retired and serving law enforcement officers including undercover drug officers, chief constables, intelligence agents, and members of the military. LEAP UK works with communities harmed by drug laws, including bereaved families and the organisation Anyone's Child, to promote harm reduction. We also engage with politicians.

Rudd prioritised tackling "county lines," where city gangs recruit children to distribute drugs to provincial towns. Neil Woods, LEAP UK chairperson, tackled this practice for many years as an undercover police officer. He estimates that for the 1000 years of cumulative prison time, with each operation taking around six months to complete, the flow of drugs in any city was interrupted for around two hours, and it often affects the most vulnerable, not those at the head of the supply chain. Woods and many colleagues now call for the control and regulation of drugs to take this £236bn global industry away from organised crime.

The "war on drugs" is expensive: each UK taxpayer spends an estimated £400 a year on drug policy

Deterrent doesn't work

The Misuse of Drugs Act from 1971 makes all drug possession and supply a crime, but the deterrent doesn't work and drugs are more readily available than ever. Scotland now has the EU's highest rate of drug related deaths, with 867 people dying in 2016—more than twice as many as a decade ago. The Advisory Council on the Misuse of Drugs reports that 2677 people died from opioid overdose in 2015 in the UK. More people with drug problems could get help if the threat of criminal action were removed.

The "war on drugs" is expensive: each UK taxpayer spends an estimated £400 a year on drug policy, with the annual cost of class A drug use estimated at £15bn in England and Wales, and around £3.5bn in Scotland.

Police forces take different approaches to drug enforcement

ACUTE PERSPECTIVE David Oliver

Accountability—individual blame versus a "just culture"

I'd love to stop the constant talk of "accountability" and individuals being "held to account" in state provided, free at point of use healthcare. Now, I don't doubt that NHS clinicians and managers who wilfully break criminal law should face the same consequences as others. And I believe that NHS clinicians are personally responsible for their decisions and behaviours and for keeping their skills and knowledge up to date.

But the clamour for accountability goes well beyond this. Public debate in mainstream and social media is obsessed with the notion that, when things go wrong in healthcare, this must indicate failures by individuals. In such a narrative, systemic factors such as workforce shortages, poor logistics, insufficient capacity, or unmanageable workloads are seen as convenient excuses for individual error.

The adversarial, rather than investigatory, nature of the law is skewed towards pinning blame on individuals

It's the same for hospital managers, repeatedly "held to account" by national bodies for factors outside their control such as workforce supply and gaps, funding, or lack of capacity in community and social care services. Clinicians and managers then face trial by media, often with no right of redress and no way to contest allegations without breaching patient confidentiality or appearing uncaring.

What many commentators seem to mean by "accountability" is that people should lose their jobs, be subject to legal action, or face punitive regulatory action. The adversarial, rather than investigatory, nature of the law is skewed towards pinning blame on individuals rather than on systems or organisations.

None of this helps. Literature abounds on the importance of a "no blame" and open culture in improving patient outcomes and safety. We must not scare people away from taking inherently difficult roles or drive them from practice, compounding the workforce shortage

VICTORIA JONES/PA

within the law. The police and crime commissioner of Durham, Ron Hogg, who gave a speech at LEAP UK's launch in 2016, has maintained a policy of not arresting people for drug possession and low level dealing. Instead, he advocates for education and intervention, to develop responses to reduce the harms associated with drugs, and to promote drug treatment and recovery programmes as well as to support alternatives to criminalisation.

Despite PCCs' different priorities, the Home Office has consistently called for the full application of current law. Proponents of prohibition argue that deviation may lead to increased drug use, but international examples suggest otherwise. In Portugal, drug supply is still illegal, but in 2001 criminal sanctions were removed for non-violent possession of small amounts of drugs. There has been no increase in consumption, and a huge fall in overdose deaths.

Control and regulation

LEAP UK is careful about terminology: we are calling not only for legalisation, but also for control and regulation. We need a range of legal, regulatory models for all drugs that focus on quality control, child protection, and taxation to fund education and treatment services.

Existing legal markets, such as tobacco and alcohol, show the need for marketing restrictions and for sensible distribution models, such as those seen in Canada's emerging legal cannabis industry. A regulated market can provide lower risk cannabis strains, which organised crime groups are not concerned about. The UK now has the ironic accolade of being the largest exporter of legal cannabis and yet still criminalises responsible adult consumers and medical users.

Rudd's "new" strategy is already outdated. To reduce the violence we should replace our enforcement led approach with regulation, taxation, and education in a health based strategy. When so many law enforcement voices are calling for drug law reform, we have to ask why legislators are not listening.

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Paul Whitehouse, former chief constable of Sussex, LEAP UK

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and thereby worsening care for other patients. Over the course of a long career we all make mistakes. It's inherent in clinical practice. Some will be serious and cause harm. They will generally be made while acting in good faith, working to the best of our abilities, and trying to treat people.

We need to move towards what's been described as a "just culture." The implementation of this is set out wonderfully in a recent NHS Improvement guide. When things go wrong, when patients are harmed, the guide makes it clear that people should face consequences for committing deliberately criminal acts or wilfully ignoring best practice guidance they're well aware of. And support should be given to those whose performance is affected by mental or physical health problems or addiction. For everyone else, we need to understand the mitigating systemic factors behind most errors or harm and must work to reduce their impact on future care.

For NHS executives in difficult operational roles, which are often far more politicised than private sector equivalents and harder to recruit to, a move towards a just culture is equally relevant if we want to recruit and retain the right people. If they feel demoralised and threatened it won't help practitioners to deliver better care to patients.

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BMJ OPINION

Laurie Laybourn-Langton

Leadership on climate change is leadership on health

The millennial generation will be the first to grapple with the full force of climate change. Until now, the outcomes of human damage to the environment have largely been associated with the distant future—the burden of generations yet unborn—and the far away, low lying island states. By October, this view shall become increasingly inappropriate with the publication of a UN report likely confirming that the world will, by the 2040s, have warmed by 1.5°C above pre-industrial levels.

Any absence of urgency must now end. Decades of warnings are being vindicated as the impacts of climate change—the floods, hurricanes, and droughts that batter television screens and agitate the conscience—multiply. Crucially, these climate "disruptions" pose an unacceptable risk to the health of populations in the UK and around the world, undermining the environmental and social determinants of good health. This can be directly, through harm arising from extreme weather, or indirectly, as the foundations for good health are eroded, including reductions in our capacity to grow nutritious food and supply safe water. As such, climate change is the greatest threat to global health in the 21st century, as the World Health Organization and others have said.

Actions to limit climate change offer some of the most powerful tools to improve social and economic outcomes. The UK provides a good example. In 2008, it led the world by passing the Climate Change Act, which requires the government to reduce greenhouse gas emissions by at least 80% on 1990 levels by 2050. Since then, the UK has made much progress and, in the process, has shown that the economy can grow as greenhouse gases fall.

"Any absence of urgency must now end"

Climate action must be complemented with policies to ensure health benefits are realised. Take transport. The number of vehicles and their use is expected to grow. Even if all vehicles become electric, poor air quality will still be a problem, as braking, tyre wear and tear, and resuspension of road dust all increase particulate matter. This is a lost opportunity for health. As is the fact that deprived groups are, and will remain, at greatest risk of the health impacts of air pollution. Reducing vehicle use and switching to cycling and walking not only reduces air pollution and its health burden, but improves health in general through increases in physical activity.

These benefits have repercussions through a health system that must help people live better as well as longer. Climate change mitigation confers upon us the opportunity to realise a better world.

Laurie Laybourn-Langton is director of the UK Health Alliance on Climate Change

OBITUARIES

Margaret Elizabeth Abel

General practitioner Rookery Medical Centre, Newmarket (b 1937; q Cambridge/London 1962; MRCS Eng, DObst RCOG), died from Alzheimer's disease on 4 October 2017

Margaret Elizabeth Abel, whose married name was Bright, gained a state scholarship to Girton College, Cambridge, to read for the Natural Sciences Tripos in 1956. She was awarded an exhibition by Girton after her first year. She completed the degree course in two years and read pathology in her third year. While at Cambridge Margaret was also a keen sportswoman. She moved to Guy's Hospital in London for the clinical part of her medical training. After qualifying and training as a junior doctor, she became a partner in a medical practice in Newmarket, where she worked for 20 years until she retired in 1996. In retirement she completed seven London marathons, raising money for charities. She leaves her husband, Michael Bright; three daughters; and 10 grandchildren.

Michael Bright

Cite this as: *BMJ* 2018;361:k1489

Thomas Charles Dann

Former chief medical officer Warwick University (b 1932; q Cambridge/University College Hospital, London, 1958; Cert Av Med MoD (Air), BA, MRCS Eng, MD Camb, MA, DObst RCOG), died from prostate cancer on 7 August 2017

Thomas Charles Dann combined a career as a physician with his interests in academia and the health of young people. In his writings he criticised the psychological pressures faced by some young people as a result of excessive expectations imposed on them in both academic and other areas. He also bemoaned the decimation of dedicated university health services, believing they were far more appropriate for the needs of students than the general practices that replaced them. He enjoyed writing and won Hunterian Society gold medals in 1970 and 1974. In retirement he was a practitioner for the British Association for Performing Arts Medicine. He leaves his wife, Jean; two children; and five grandchildren.

Nicholas Dann

Cite this as: *BMJ* 2018;361:k1491

Lynn Ramage

Consultant geriatrician Dundee (b 1960; q Aberdeen 1983; MD FRCP), died from metastatic breast cancer on 28 January 2018

Lynn Ramage ("Dr Lynn") joined the medicine for the elderly service in Dundee in 1993. She had a talent for homing in on what mattered most to individual patients and was a skilled proponent of "if it ain't broke, don't fix it." Her humane clinical pragmatism inspired many juniors to follow her career path. She believed there was no problem that could not be addressed by a "blether," a cup of coffee, and several Jaffa cakes. Her passions included travel, sport, tap dancing, family, and friends. A lifelong devotion to football and the Aberdeen team took her all over Europe. Her sharp wit, pithy observations, and genuine interest in the lives of those around her made her a brilliant companion and friend. She leaves two sisters, her parents, godchildren, and many friends.

Marion McMurdo

Cite this as: *BMJ* 2018;361:k1513

Edward Wilson Knox

Consultant in geriatric medicine (b 1925; q 1947; FRCPI), died from prostate cancer on 13 January 2018

Edward Wilson Knox ("Eddie") was brought up above his father's grocery shop off the Shankill Road, Belfast. He qualified in medicine from Queen's University Belfast. After three years in general practice in Kilkeel, County Down, he trained in chest medicine. He spent a year in Philadelphia and then changed course, to be appointed the first consultant in geriatric medicine at the Ulster and North Down hospitals. For the remainder of his career he was responsible for 340 beds in five hospitals, as well as outpatient clinics, domiciliary consultations, and, later, a day hospital. Eddie was a skilful, conscientious, and caring doctor and a popular teacher, highly respected by his patients, colleagues, students, and friends. Predeceased by one of his sons and by his wife, Mabel, he leaves three sons.

Robert Stout

Cite this as: *BMJ* 2018;361:k1495

Michael McFadyean

General practitioner (b 1926; q Cambridge/London 1949), died from sepsis, kidney failure, and heart problems on 20 December 2017

Michael McFadyean was a GP for 32 years, a partner in the Herne Hill practice his father had created. He was also visiting medical officer for several old people's homes, clinical assistant at the dermatology clinic at King's College Hospital for 18 years, and he later worked in the fracture clinic there. In the late 60s and early 70s, Michael was a part time volunteer police inspector in the City of London Special Constabulary. He later undertook the theological training that allowed him to be licensed as a reader. In his retirement in Winchelsea, Michael was an active member of the local community. Michael leaves his wife, Barbara (aged 93); three sons; and four grandchildren.

NB: The Reverend David Page compiled this obituary with the help of the McFadyean family.

David Page

Cite this as: *BMJ* 2018;361:k1496

Frank Eyvind Hytten

Head of division of perinatal medicine MRC Clinical Research Centre, Harrow, and honorary consultant North West Thames Regional Health Authority, Northwick Park Hospital (b 1923; q University of Sydney 1946; MD, PhD, FRCOG), died from chronic heart failure on 21 January 2018.

In the 1950s Frank Eyvind Hytten joined the Medical Research Council unit in Aberdeen, which moved to Newcastle in 1965 and to Northwick Park, Harrow, in 1975. Between 1979 and 1989, Frank used his position as editor of the *British Journal of Obstetrics and Gynaecology* to encourage a modern scientific mindset, sound research and better clinical practice in obstetrics and gynaecology. Frank's first wife, Cath, predeceased him in 1984 and he married Jonna (also widowed). He leaves Jonna, three children, six grandchildren, and two great grandchildren.

John Davison

Cite this as: *BMJ* 2018;361:k1518

Nico van Hasselt

The oldest practising GP in the Netherlands

Nicolaas Johannes Hendrikus van Hasselt (b 1924; q 1956), died from old age and exhaustion on 14 February 2018

When Nico van Hasselt died in Amsterdam, days before his 94th birthday, he was the Netherlands' oldest practising general practitioner. To the end, he met the commitment he made while in a cell during the Nazi occupation of the Netherlands in the second world war: if he survived he would dedicate his life to helping others through medicine.

He did exactly that: he became a doctor, and despite the best intentions of some to persuade him to stop working, he refused. In doing so he won a legal battle which meant that GPs could no longer be asked to retire solely on the grounds of age. He was still seeing patients in the week before his death.

Lucky escape

Van Hasselt had been set to follow his father into banking in the quiet eastern town of Deventer when war interrupted his education. He progressed from protesting against the sacking of his Jewish school headmaster to stealing a German soldier's revolver. He was betrayed and sent to a concentration camp in Vught, from which he escaped. He was then recaptured by the German navy when trying to cross the North Sea.

Sentenced to death at just 19 years of age, he shared his cell with a doctor, Meindert Brouwer. During philosophical discussions, van Hasselt was deeply touched by his cellmate's passion for his profession. He explained: "I concluded that the meaning of my life was to serve others, and I swore that if I survived the war I would study medicine, become a GP. I have stayed true to that vow to this day."

Van Hasselt had two lucky escapes. His execution was set for 5 September 1944 but did not happen. It was "mad Tuesday," the day the Nazi occupiers panicked as the Allies rapidly advanced through neighbouring Belgium. Later, his name was crossed off a list of detainees to be transported to Neuengamme concentration camp in Germany, in which nine of the Dutch prisoners died. Red Cross official Loes van Overeem had declared—"with a wink"—that he was far too ill to travel.

Having survived the war, van Hasselt studied medicine in Amsterdam and Leiden. He qualified in 1956 and established his GP practice in Buitenveldert, a suburb in southern Amsterdam, three years later. For nearly 60 years he ran his family practice—with his wife, Ineke, acting as doctor's and pharmacist's assistant—with a workaholic dedication to his patients. He disliked taking holidays, paid regular (often free) house visits to his patients, and kept detailed records of their family histories on a card system in his practice.

Refusing to retire

In 1991, however, the Amsterdam and district national health insurance company ZAO, which reimbursed his patients' treatment costs, wrote to him suggesting he retire. He refused, arguing it was nonsense not to consider whether someone was physically and mentally able to continue. Eventually, by 1994, the company ended its contract with him on the grounds that he was older than 65. It meant that van Hasselt would eventually not be paid. He carried on treating patients free, reimbursing drugs out of his own pocket. It would be 11 years before the Equal Treatment Commission found that the health insurance company had contravened the Equal Treatment in Employment (Age Discrimination) Act by not signing a new contract. It stressed that the quality of GP care was protected by the requirement for GPs to be re-registered every five years and accredited annually by their professional bodies. Van Hasselt was, at the time, registered until December 2006.

MARC DRIESSEN

By 2016, a 92 year old van Hasselt celebrated 60 years as a doctor, his practice surgery still opening at 7 am

The chair of the Dutch Society of GPs, Bas Vos, praised his "passion and determination," which had shown that age is unimportant and GPs should be able to practise as long as they wish to and are able to. Van Hasselt, then 81, continued. The healthcare inspectorate later scrutinised his practice, but when he died he was still registered to practise until the end of 2018.

By 2016, a 92 year old van Hasselt celebrated 60 years as a doctor, his practice surgery still opening at 7 am. He still undertook up to eight house visits a day and never installed an answering machine. Of his 900 patients, 500 had attended his surgeries for 40 years or more. He said: "The patient comes first, for everything. I know them. I know what happened to them years ago."

Despite the return of a cancerous tumour on his face, which had been treated by surgery in 2008, he continued to work until, feeling unwell, he called for an ambulance and died in hospital two days later. He leaves his wife, Ineke van Hasselt-van Paassen; a daughter; and three granddaughters. His son predeceased him.

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Cite this as: *BMJ* 2018;360:k1275

CHILD HEALTH CRISIS

Understanding gestation specific mortality

The reported rise in infant mortality rates from 2015 onwards requires detailed analysis (News Analysis, 24 March).

Postneonatal (4 weeks to 1 year) mortality rates fell consistently over 30 years to 2016, whereas neonatal (0 to 28 days) rates decreased until 2014 before rising again. But this increase relates solely to additional deaths reported in the first day of life. The number of live born infants at less than 23 weeks' gestation has risen considerably over three years.

Concerns over differences in registration practices around extremely preterm birth limit the use of these data. The Europeristat group have said that routine data should exclude those born at less than 24 weeks. Since 2013, MBRRACE-UK has provided such data for the UK using these exclusions. Gestation specific mortality rates would enable more informed and accurate monitoring of mortality rates and, if accepted internationally, better direct comparisons of health systems.

Peter J Davis, consultant paediatric intensivist, Bristol
Alan C Fenton, consultant neonatal paediatrician, Newcastle
Christopher J Stutchfield, specialist registrar, Bristol
Elizabeth S Draper, professor of perinatal and paediatric epidemiology, Leicester

Cite this as: *BMJ* 2018;361:k1936

RADICAL PROSTATECTOMY

Robotic surgery could save the NHS millions

The discussion of cost effectiveness of robotic surgery continues (Personal View, December 2013). A 2011 health technology assessment to determine incremental cost effectiveness of robotic compared with laparoscopic radical prostatectomy found that 150 robotic prostatectomies a year would justify the expense of the technology, and NICE endorses this. But the paucity of functional outcome data meant they did not influence the economic evaluation.

Randomised controlled trials show that, at 12 months, the rate of capability for intercourse was 77% for robotic and 32% for laparoscopic prostatectomy, and the rate of erection recovery was 80% for robotic and 54.2% for laparoscopic. In 2012, the NHS spent more than £80m on erectile dysfunction treatment. The trials show a 26-45% improvement of erectile function with robotic surgery, which may save the NHS between £21m and £36m. The threshold of robotic surgeries a year needed to justify the cost should fall.

Jasmesh Sandhu, medical student, Bristol

Cite this as: *BMJ* 2018;361:k1900

LETTER OF THE WEEK

Socioeconomic disparity is not a given

Thank you for the thought provoking debate on the tension between patient and population health (Editor's Choice, 31 March-7 April). Socioeconomic characteristics are too often taken as non-modifiable risk factors for health outcomes. Setting aside the role of health professionals as actors for social change, considering socioeconomic disparity a "given" is a major barrier to decreasing inequality. Socioeconomic variation in adverse outcomes is often, at least in part, due to disparities in access to services. These differences decrease when appropriate practice and policy changes are implemented.

In France, disparities in prenatal diagnosis of Down's syndrome decreased substantially as practice and policy changes provided widespread, reimbursed access to prenatal testing. A more recent study showed similar probabilities of prenatal diagnosis of congenital heart defects across socioeconomic groups in Paris.

Socioeconomic differences in health remain formidable foes of social justice. But claiming that they are "caused" by religion and culture and are impossible to change is unhelpful, and wrong. In France, the probability of a prenatal diagnosis of Down's syndrome increased more for women of north or sub-Saharan African origin than for women of French origin, resulting in a decrease in disparities over time. As Gandalf would say, there is hope in that.

Babak Khoshnood, senior researcher, Paris Cite this as: *BMJ* 2018;361:k1910

PALLIATIVE RADIOTHERAPY

Palliative radiotherapy and holistic palliative care

The last learning point of Spencer et al's excellent review of palliative radiotherapy (Clinical Updates, 31 March-7 April)—"holistic palliative care may be more appropriate" in the final weeks of life—may mislead readers that they must choose one or the other. Patients should be offered holistic palliative care and disease modifying treatments from diagnosis.

As GPs we may find raising palliative care challenging owing to current stigma, even when patients know they are getting palliative radiotherapy. Failing to embrace holistic palliative care early, when support may be timely and may prevent distress, is a major "opportunity loss."

We are studying whether early generalist palliative care by GPs, triggered by starting palliative chemotherapy or radiotherapy, is feasible. If you are thinking of referring for palliative radiotherapy, think also of holistic palliative care.

Scott A Murray, St Columba's Hospice chair of primary palliative care
Debbie Cavers, CSO research fellow, Edinburgh
Emma Carduff, research lead, Glasgow
Sebastien Moine, GP, Paris

Cite this as: *BMJ* 2018;361:k1875

TACKLING HEARING LOSS

Inconsistent availability of hearing aids

Hearing impairment affects shared decision making, particularly in vulnerable patients (Analysis, 20 January).

We surveyed 14 audiology departments in our region and selected departments across England and Scotland to clarify the availability of assistive devices. Device availability during admission to medical wards is, to some extent, dependent on co-location of audiology departments with emergency units and on the acute medical team being aware of such facilities.

We found several barriers to supply, including the initial cost of devices, their frequent disappearance, and infection control concerns. We identified isolated examples of proactive supply, such as Plymouth Hospitals NHS Trust, where devices are on every ward.

We encourage all doctors whose patients have hearing impairments, or potential hearing impairments masked by cognitive decline, to develop the provision of devices in their department with their audiology lead.

Michael W Mather, academic clinical fellow in otolaryngology, Newcastle
Nicholas Dawe, senior registrar in otolaryngology, Middlesbrough
Janet Wilson, professor of otolaryngology, Newcastle

Cite this as: *BMJ* 2018;361:k1944