

comment

These ministers set themselves up to fail, while piling further pressure on frontline clinicians and managers

ACUTE PERSPECTIVE David Oliver

Mixed sex wards may be inevitable

The “humiliation” of “wards of shame” was how a section of the media reported NHS England’s figures on mixed sex wards this spring. The figures showed 13 700 “mixed sex breaches” in 2017-18. This was the highest level since 2010, when the collection of monthly mixed section accommodation “breaches” of “unjustified mixing in relation to sleeping accommodation” was introduced. Since 2012-13 NHS England has required in its operating framework that “all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient.”

To put that number in context, over 14 million admissions were made to NHS hospitals in England in 2016-17. I don’t seek to minimise the possible distress to patients staying in mixed sex bays or wards. Many—already sick, vulnerable, and in a dehumanising hospital environment—find mixed sex clinical areas undignified or threatening. The public reaction is what drove a Labour health secretary to make pledges on mixed sex accommodation in 2008 and a Conservative one to repeat them in 2010.

But to me it seems a stellar achievement to have had only 13 700 official breaches in a health system with the fewest beds per 1000 people among all European and OECD nations, with midnight bed occupancy well over 90%, with acute demand at record levels, and with performance worsening against A&E waiting time targets.

I think it’s unwise for ministers to make such bold pledges on operational performance targets in an overstretched public service such as the NHS—especially pledges to “eliminate” phenomena such as mixed sex overnight accommodation and to make it some kind of “never” event. These ministers set themselves up to fail, while piling further pressure



on frontline clinicians and managers.

More broadly, campaigners, commentators, or regulators—none charged with delivering daily hands-on care—surely realise that bedded areas must be used flexibly. Every day, clinical and operational teams must balance a range and hierarchy of competing priorities, responsibilities, and accountabilities. Is it really worse to be

admitted to a mixed sex bay than to face delays to an operation, be stranded in an overcrowded A&E for hours, be denied access to specialist clinical areas, or be moved repeatedly between wards?

Do we ask patients and families that question? Do we explain that, even if the answer is yes, we must balance their individual preferences and worries with the (sometimes greater) needs of all patients requiring beds?

Sometimes we simply have to make pragmatic decisions in the broader interest and then apologise for them. It’s easier to ask for forgiveness than permission. We can also take some common sense steps to reduce the indignity, distress, and loss of privacy that being on mixed sex wards can cause, such as those set out by the chief nursing officer in 2007—for instance, segregated toilets, use of bays, privacy screening, and better hospital clothing.

I’d also say that we should be robust in defending staff involved in formal or informal complaints regarding admission to mixed sex areas, and we should be transparent and candid about the reasons. A universal service for the many will have occasions when the few—and in this case it is the very few—won’t have what ought to be their reasonable expectations met.

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Is doctor-patient confidentiality dying a slow death?

The threshold for divulging information to other professionals should remain very high

Mary, an acquaintance, called me early one morning. She said her husband had grabbed her throat and slapped her a few days previously. Their children were asleep at the time, oblivious to the incident. That same evening Mary read online that victims of domestic abuse should visit their GP.

Mary shared her story with her GP. Despite the GP's encouragement to disclose the incident to the authorities, Mary insisted that nothing be said to anyone. She wanted the marriage to work. Her husband had never hit her before; the injuries were limited to minor bruising; and the children were not in any danger.

A few days later some police officers knocked on Mary's door. When Mary let them in, the police officers arrested her husband in the presence of her terrified children.

"Where are you taking my daddy? Leave him alone," one of their children shouted in tears. As he was leaving, one of the policemen told Mary, "The doctor wants you to know that she's not the one who called the police."

Although the GP had reassured Mary during the consultation that she would not breach her confidentiality, she had later changed her mind and called social services, who then called the police.

The family is now in turmoil. Mary felt betrayed by the GP and has lost all faith in the medical profession.

There is no doubt that the GP had good intentions, but did she act ethically?

One moral justification for keeping patients' secrets is that it tends to lead to better health. The promise of confidentiality helps patients overcome their natural reluctance to divulge sensitive information, such as bodily functions and personal feelings, which may assist the doctor



Mary felt betrayed by the GP and lost all faith in the profession

in treating the patient. Remove confidentiality, and patients may withhold medically important information or not visit at all. This could harm the patient and, in the case of certain transmissible or psychiatric disease, other people.

Implicit promise

Another moral reason for respecting a patient's confidence is the implicit promise that the patient can entrust secrets to the doctor without fear of disclosure. Armed with this trust, the patient can run her life safely in the belief that the doctor will not break her promise and infringe her autonomy. This is why Mary felt so betrayed. The doctor broke a promise.

BMJ OPINION

Petra Boynton

How we can improve care to help patients cope with a lost pregnancy

Anyone who has had training on pregnancy loss will be familiar with the figures that one in four pregnancies end in miscarriage, and that every day in the UK 15 babies die before, during, or soon after birth.

Knowing the numbers is not quite the same as being faced with someone going through a loss. Although healthcare workers are prepared to treat a physical loss, responding to emotional reactions may be far more complex. Helping someone who has lost a baby is never going to be easy. Much, however, can be done to minimise further distress and ensure that those going through loss feel supported and respected.

Care has been steadily improving thanks to initiatives such as the national bereavement care pathway. Having compassionate and flexible support for everyone is vital. That particularly includes care tailored to those who are disabled, people from lower socioeconomic groups, people from ethnic minorities, same sex couples, partners of those who have had a loss, and very young parents.

However, healthcare staff still have concerns. Yes, they have training in physical care, but less on how to tackle trauma, grief, and bereavement. They have little time to keep up to date with the latest evidence, and even though training would have been welcomed,



Parents leave hospital with empty arms and breaking hearts



Those moral justifications for confidentiality do not trump all considerations. Doctors should breach the confidence of a suicidal commercial pilot or a driver who is unfit to drive, for example, even if the patient refuses to consent to the disclosure. Though not an absolute moral obligation, the threshold for breaching confidentiality should still be very high.

Mary's case did not reach that high threshold. There was no credible risk of significant harm to others. To find otherwise would set a worrying precedent: many victims of domestic abuse would refuse to see their GP or would lie to them about the true cause of their injuries. This would be undesirable on a personal and societal

level. It would further damage the reputation of doctors, earned over centuries, as professionals who can be trusted with secrets.

The GP, undoubtedly with good intentions, tried to salvage the relationship by inviting Mary to a follow-up appointment. This served only to infuriate Mary, who didn't want to see the GP again. An apology would have been more helpful.

When I put the phone down I wondered if doctor-patient confidentiality, once so robust, was dying a slow death. If so, it needs urgent treatment.

Patient consent obtained.

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accessing it within a busy work schedule is complicated. Aftercare to allow staff to process the stresses of their job is also inadequate.

As a consequence, parents leave hospital with empty arms and breaking hearts. A book, website, phone number, or details of an app or support group is not a replacement for a loss—but may ensure that bereaved parents don't go home unsupported and alone.

It is easier than ever before to recommend assistance. Initiatives such as the recent baby loss awareness week, the growth in the number of charities dedicated to baby loss and in relevant books, the use of

social media to share stories of loss, and opportunities to remember lost babies with photographs or memory boxes all make for a more creative, inclusive, and empowered space.

For healthcare workers it can be time consuming to find out about such resources, and fitting this work into a busy schedule can be impossible. And although some hospitals share sources of additional support within their organisation or through external charities, many do not.

Pregnancy loss is not easy, but poor care can make what is a sad experience that most of us can cope with, in one way or another, into a deeper crisis.

Petra Boynton is a clinical psychologist

BMJ OPINION Kate Lovett

View from the mental health frontline

One of the most difficult parts of my job as a psychiatrist is speaking to patients who have had to wait a long time for treatment.

When people have to wait for the help they desperately need, it's hard not to feel that we're letting them down. I'd be lying if I said this wasn't stressful and that it didn't detract, at times, from the sense of satisfaction that goes with the job.

Recent research by the Royal College of Psychiatrists found that one in four people with a diagnosed mental illness had to wait more than three months to get help. For some, when help did arrive it was in the shape of an appointment for assessment, but this didn't mean that they were automatically given a treatment programme.

It's no secret that we need a stronger mental health workforce in the NHS; and within that, we need more psychiatrists. Given that it takes several years' training to become a psychiatrist, there are no simple solutions to plug the gap. As well as attracting more people to the specialty, we need to make sure that the specialty becomes attractive enough to keep them there.

Patients waiting without support is one of those morale zapping problems that deeply affects NHS workers. We need to make sure we're recruiting to posts around the country so that patients don't wait unfairly for an appointment or have to travel miles for treatment.

The money promised for clinical commissioning groups must be spent on workforce and not diverted elsewhere—this puts existing staff under increasing pressure and creates a vicious cycle where it can be hard to recruit and retain staff. We must continue to scrutinise those who have control over planning our NHS workforce and commissioning and delivering mental health services to ensure they're keeping their promises.

When I look back at my career and all its challenges, would I have chosen differently? No way. I believe that as a psychiatrist I have the best job going, and the pleasure of seeing people recover from the ravages of mental illness never leaves me. It's a message we're keen to shout from the rafters—psychiatry is immensely rewarding; we can, and do, help people recover and enable them to get on with their lives. It doesn't get much better than that.

Kate Lovett is a consultant psychiatrist and dean of the Royal College of Psychiatrists



One in four people had to wait more than three months

ANALYSIS

Clinical guidelines should recognise the burden of treatment on patients

Claudia Dobler and colleagues argue that clear information on treatment burden in guidelines could improve decision making



MALCOLM WILLETT

Implementation of medical treatment regimens demands a lot of time and effort and can result in substantial burden for patients with chronic conditions. Guideline recommendations, however, are traditionally made from a perspective that places the highest value on achieving certain clinical outcomes (such as reducing shortness of breath or increasing survival). More recent guidelines may consider patients' values and the acceptability and feasibility of the recommended action, but the treatment burden is not made explicit. This makes it hard for patients to make informed decisions about treatments in line with their values and capacity.

What is burden of treatment?

Although the burden of disease is a well known epidemiological concept, the burden of treatment is a less known and fairly recently coined term. Burden of treatment is the workload of healthcare and its effect on patient functioning and wellbeing.¹ The cumulative treatment workload for patients with chronic conditions when enacting all recommendations in disease specific guidelines can be overwhelming.²

To cope with the demands of complex self care, patients rely on

The work that patients do to manage their health often remains invisible to health professionals

a range of personal, social, and healthcare resources.³ Disease treatment can occupy a large part of a patient's day and limit the amount of time they can spend on other activities such as work, studying, leisure, childcare, and being with friends and family. A study found that in order to comply with all disease specific guidelines patients with three chronic conditions (any combination of chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, osteoarthritis, hypertension, and depression) would take from six to 13 different drugs a day, visit a health professional 1.2 to 5.9 times a month, and spend a mean (SD) of 49.6 (27.3) to 71.0 (34.5) hours each month in health related activities.² In patients with all six chronic conditions, the workload rose to 18 medications a day, 6.6 healthcare visits a month, and 80.7 (35.8) hours a month in health related activities.²

The work that patients do to manage their health often remains invisible to health professionals, who only see the results (eg, attended exercise programme, achieved weight loss, glucose measurement log).⁴ This means that they often underestimate the workload and overestimate patients' capacity for more interventions.⁵ Components of

KEY MESSAGES

- Treatment burden, the work that patients need to do to care for their health and its effect on their life, is often substantial for people with chronic conditions
- Although modern clinical guidelines may consider acceptability to patients, evaluations of treatment burden are not included
- Information on treatment burden would enable patients to make informed decisions about treatments
- High quality methods for assessing treatment burden need to be identified and meaningful ways of adding this information to clinical practice guidelines need to be explored

the work that patients must do to care for their health include learning about their conditions and care, getting prescriptions, taking medications, attending medical appointments, monitoring their health (eg, measuring lung function or glucose monitoring), making lifestyle or behavioural changes (exercise, diet, smoking cessation), and managing medical equipment or devices (eg, regularly cleaning a nebuliser).⁶

Consequences of overburden

Patients who do not take prescribed medications or perform the prescribed daily exercises may be viewed as irresponsible, neglectful, or lacking motivation or insight into the importance of these treatments. Many patients who do not adhere to prescribed treatments, however, say that they know that they should do differently but that they lack the information and support to do so.⁷ Patients will also reject medical advice if the perceived benefit is considered insufficient in relation to the required investment of time, energy, and cost.⁸ These assessments about return on investment may be done consciously or intuitively, particularly when patients are overburdened by their treatment workload. In this case, they may resort to treatment prioritisation without discussing these choices with a health professional.

Shared decision making is therefore important because it enables patients, in collaboration with their clinician, to make conscious decisions about treatments using evidence based information.

How do guidelines handle burden of treatment?

The modern process of developing clinical practice guidelines starts by forming a panel that includes content and methodological experts and sometimes patient representatives. The panel develops clinical questions, which are examined in a systematic review focused on benefits and adverse effects of the interventions. The panel incorporates this evidence with other factors such as patients' values and preferences to generate recommendations. Each recommendation is denoted by the

Clinicians should discuss values and preferences with patients, especially for treatments associated with a high workload

grade of evidence (certainty or quality of evidence) and the strength of the recommendation (how compelling is the recommendation).⁹

Patients' work to enact specific treatment recommendations is usually ignored in older guidelines, which have typically emphasised the evidence for the effectiveness of an intervention (or lack thereof). Modern guideline frameworks such as GRADE (Grading of Recommendations Assessment, Development, and Evaluation), which is the most used guideline approach, do attempt to capture the patient perspective. The evidence to decision (EtD) framework developed by the GRADE Working Group acknowledges the importance of patients' values and preferences.¹⁰ Following this framework, the 2017 guidelines on prevention of COPD exacerbations published by the European Respiratory Society and the American Thoracic Society added a paragraph on "values and preferences" to every treatment recommendation.¹¹ For example, the statement accompanying the conditional recommendation to use oral mucolytic agents to prevent future COPD exacerbations reads: "This recommendation places a high value on avoiding hospitalisations and a lower value on the cost and burden of taking daily medication."

The EtD framework also incorporates some parts of the construct of burden of treatment in the domains of acceptability and feasibility.¹⁰ A strong recommendation for an intervention is contingent on the intervention being feasible to implement (by patients and clinicians) and acceptable (by patients and clinicians). Yet, the framework does not include the burden of treatment as a discrete construct.

Integration of treatment burden into guidelines

If future guidelines are to help clinicians and patients to make treatment decisions taking into account patients' values and preferences, they should explicitly state the treatment burden associated with enacting different recommendations (the quantifiable

workload as well as the potential effect on a patient's life).

The information currently available on treatment burden for specific conditions and interventions is sparse and probably insufficient for most guidelines. The major challenges to including information on treatment burden in guidelines are therefore finding robust high quality methods for assessing treatment burden and meaningful ways of adding this information to clinical practice guidelines.

At least two validated measurement tools exist for self reported burden of treatment for patients with chronic conditions.¹²⁻¹⁴ The Treatment Burden Questionnaire (TBQ) consists of seven items (two of which have four subitems), evaluating quantifiable workload as well as the effect of this workload on patients' lives such as the frequency, time spent, and inconvenience of lab tests and other examinations.¹² The Patient Experience with Treatment and Self-management (PETS) is a 48 item tool that focuses on the effect of treatment workload on patients' lives and wellbeing—for example, "How much of a problem has it been for you to plan your daily activities around your medicine schedule?" (Responses: not at all, a little, somewhat, quite a bit, very much.) The suitability of these tools to collect information for use in clinical practice guidelines has yet to be evaluated, and they might have to be adjusted for this purpose.

Questionnaires that collect patient reported outcome measures have the advantage that they can be used in large scale surveys. They are not the best way to measure time spent on treatments, however, and a time and motion study might be useful to collect this information. Time and motion studies using observers have been used in healthcare mainly for understanding workflow of healthcare professionals and time spent on different activities.^{15 16} Further research would be required to determine the feasibility of using this study design to document patients' treatment workload around the clock, as using observers in this context does not seem feasible.

EXAMPLES OF HOW TREATMENT BURDEN COULD BE INCLUDED IN GUIDELINES

Chronic obstructive pulmonary disease (COPD)

The 2017 guidelines on prevention of COPD exacerbations make a conditional recommendation for initiation of pulmonary rehabilitation within three weeks after hospital discharge.¹¹ The current “values and preferences” section states: “This recommendation places a high value on improving clinical outcomes and a lower value on the burden and cost of pulmonary rehabilitation.”



Proposed approach

If the treatment burden was made explicit, the guideline could include a statement like this: “A typical effective pulmonary rehabilitation programme lasts 8 to 12 weeks with two to three sessions a week, lasting one hour each. Many pulmonary rehabilitation programmes are fully or partially conducted at hospitals, therefore travel time to exercise classes may be added to the treatment burden. Although exercise is beneficial, more strenuous exercise is likely to be associated with (temporary) discomfort from shortness of breath.”

Type 2 diabetes

The 2015 NICE guideline on management of type 2 diabetes in adults says: “In adults with type 2 diabetes, if metformin is contraindicated or not tolerated, and if dual therapy with 2 oral drugs ... has not continued to control HbA_{1c} to below the person’s individually agreed threshold for intensification, consider insulin-based treatment.”¹⁸



Proposed approach

Information on treatment burden could include information on how daily routines need to be changed with the initiation of insulin therapy (potential effect on working life, dietary choices, etc), the frequency and average time required for insulin injections and blood sugar controls, discomfort associated with insulin injection, risk of hypoglycaemia, and its potential impact on patients’ quality of life.

Chronic kidney disease

The 2014 NICE guidelines on assessment and management of chronic kidney disease in adults state: “Offer dietary advice about potassium, phosphate, calorie and salt intake appropriate to the severity of CKD. Where dietary intervention is agreed this should occur within the context of education, detailed dietary assessment and supervision to ensure malnutrition is prevented.”¹⁹



Proposed approach

Information on treatment burden could include information on foods that should be avoided, extra time spent on grocery shopping and cooking, challenges when eating out, the typical number of consultations with a dietitian, transport requirements to see a dietitian, time spent documenting the diet, and required intensity of blood tests to monitor electrolytes.

Drug companies are likely to have limited interest in measuring treatment burden in sponsored randomised controlled trials. Also, information collected in a real life setting may differ from that in a trial. Patient advocacy groups may have greater interest in information on treatment burden, and research partnerships between patient advocacy groups and investigators might be a good way to develop the research.

Treatment burden is not the same for all patients with the same condition. It depends on numerous factors such as age, disease burden, comorbidities, social support network, and patients’ values and preferences. For example, one patient may perceive the need for regular exercise as a burden whereas another patient may experience it as empowering action that improves their situation.¹⁷ Research is required to determine the best way to integrate information on treatment burden into guidelines so that it reflects the variations in experiences and is robust and useful to guideline developers and users. The value of integrating information on the potential burden for carers should also be explored. The box gives some examples of how information on treatment burden could be included in guidelines.

Clinical practice guidelines should also explicitly recommend that clinicians discuss values and preferences with patients, especially for treatments associated with a high workload. This would help clinicians to understand how individual patients prioritise different outcomes and treatment burden and would help patients to understand what components of their treatment are the essentials, even on a bad day, so that they can prioritise treatments appropriately.

Individualised treatment and shared decision making

The process of weighing pros and cons (including treatment burden) of different treatments happens during shared decision making

between patient and clinician. This should ensure that the final choice for or against a medical intervention aligns with the patient’s values and preferences rather than being driven by the clinician’s agenda. Information on treatment burden in guidelines could provide high quality information for developers of decision aids and facilitate shared decision making when a decision aid is not available for the specific clinical scenario.

Clinical decision making, particularly for patients with multimorbidity, has to consider trade-offs between competing outcomes and prioritisation. The Ariadne principles on how to handle multimorbidity in primary care consultations emphasise the careful and critical use of guidelines in multimorbidity and promote sharing of realistic treatment goals by physicians and patients and prioritising health problems in accordance with the patient’s preferences.²⁰ Including information on treatment burden in guidelines would increase their applicability to patients with multimorbidity in line with these principles. Better understanding of the work required to follow treatment recommendations would help to improve treatment decisions and avoid overburdening patients.

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HEALTH IN GAZA

Antibiotic resistance in Palestine

Médecins Sans Frontières has received 2228 trauma patients in Gaza from April to September (Letters, 18-25 August).

Antibiotic resistant infections are a certainty: poor infection control, irrational prescription practices, and easy antibiotic availability are widespread, and previous outbreaks have been documented. Adding an overwhelming number of surgical cases to a health system already in crisis risks an epidemic of antibiotic resistant infection.

Action must be taken: improving laboratory supply chains, processing of bone and tissue samples, internal quality controls, standardised antibiotic sensitivity testing, guideline availability, surveillance of antibiotic resistance, rational antibiotic use, and robust infection control procedures are critical, as is providing clinical and surgical support. Patients must be transferred outside of Gaza when the complexity of their injuries exceeds the capacity of local hospitals.

Multidisciplinary expertise is needed to manage the immediate and longer term consequences of this unique trauma. The enormous need for surgery, rehabilitation, and infection management requires urgent, on-site, external support.

Rupa Kanapathipillai, infectious diseases adviser, Nada Malou, microbiology adviser, Kate Baldwin, microbiologist, Pascale Marty, medical team leader, Camille Rodaix, orthopaedic surgeon, Clair Mills, medical director, Patrick Herard, orthopaedic surgery adviser, Malika Saim, program manager, Médecins Sans Frontières

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A CREATIVE FUTURE

Compassionate Frome

Black is right to look to creativity to solve the current tangle of the NHS (Cover, 1 September).



LETTER OF THE WEEK

Concerns about cardboard baby boxes

Providing a cardboard box full of free unbranded infant care items to expectant mothers is a welcome public health initiative, but we are concerned about the box being promoted as a safe alternative to traditional cots or bassinets.

Little observational evidence shows that the box can be used safely, no evidence shows that it reduces sudden infant death syndrome, and no safety standard regulations are currently in place. Cots (with their bars and raised surface) and bassinets (with their low sides) allow the infant to be easily seen by the parent, whereas the cardboard box (with its higher opaque sides) does not. Some of the boxes come with lids, are potentially flammable (especially if not laminated), and if placed on a floor are susceptible to low level draughts, domestic pets, and young siblings. If placed at a suitable height, the box may fall, and no data exist on the durability of the box (especially if it becomes wet or dirty).

Population-wide initiatives should have to meet high standards of safety and efficacy and should be subject to rigorous evaluation before implementation, because the potential to cause inadvertent and unintended harm is much greater than for initiatives that target a selected population

Peter S Blair, professor of epidemiology and statistics, Anna Pease, senior research associate, Bristol; Francine Bates, chief executive, Lullaby Trust; Helen Ball, professor of anthropology, Durham; John M D Thompson, associate professor, Auckland; Fern R Hauck, professor of public health sciences, Rachel Moon, professor of paediatrics, Charlottesville; Betty McEntire, CEO and executive director, American SIDS Institute; Anat Shatz, chief executive, Israeli Foundation for the Study and Prevention of Sudden Infant Death; Marta Cohen, consultant paediatric pathologist, Sheffield; Trina C Salm Ward, assistant professor of social work, Milwaukee; Peter Fleming, professor of infant health and developmental physiology, Bristol

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The difference between the Compassionate Frome project and other interventions is that the reduction in emergency admissions is across the whole town, rather than in a cohort such as frail older people with multiple long term conditions.

Uniting a community project with primary care has had profound outcomes. Having good social relationships is more effective than giving up smoking or drinking, improving diet, and exercising. We have learnt how to bring this into clinical practice.

Julian Abel, director, Compassionate Communities UK

Cite this as: *BMJ* 2018;363:k4299

Connectedness benefits staff as well as patients

We need to acknowledge that we are inherently social beings. At the heart of any care must be recognition of what is most important to the individual—the patient is the expert in their life.

Connectedness matters too for our workforce. Working in the NHS today is intense and unrelenting. What sustains us is the sense of making a difference and of working together.

The Compassionate Frome project has focused on improving connectedness for

staff and patients. Reintegration of care and collaboration between healthcare, social care, and our community empower staff to take a holistic approach and to do what is right for the individual.

This approach can improve both the care we provide and the working lives of the people who are providing it. Our results indicate that a coordinated, person centred approach can also be cost effective through a reduction in numbers of emergency admissions.

Helen M Kingston, lead GP, Compassionate Frome

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Local government can deliver change

Black says that central authorities will have to relinquish some control to enable local creativity to flourish.

Local government has delivered substantial changes. Diversity is built into local government by local democratic control, and the public's concerns about change can be voiced through petitions, public questions to councils, and local media.

In central London, we brought together acute hospital teams, community healthcare commissioners and providers, social workers, academics, and the third sector to form a community of practice, to map local pathways across all sectors and to communicate about the most effective ways of working. The aim is to reduce the number of residents' falls.

Although the project is still in its early days, the feedback has been outstanding. Local government can facilitate and champion integrated working while building on skills and assets already in place.

Mike Robinson, public health consultant and GP

Kate Mtandabari, professional development consultant, London

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OBITUARIES

Peter George Reed Dawe

General practitioner (b 1927; q Otago University, Dunedin, New Zealand, 1954), died from old age on 8 September 2018

Peter George Reed Dawe and his family moved from New Zealand to the UK in 1958. In 1961 Peter joined the Blackheath Standard Surgery in Charlton Road as a general practitioner. He stayed there for the remaining 36 years of his professional career and eventually retired as senior partner in 1997. In 1980 the family moved to Eltham, where his wife died in 1991. Their eldest daughter, who had Friedreich's ataxia, also predeceased him in 2016. Peter Dawe continued to live in Eltham by himself until he moved into a care home at Morden College, Blackheath. He enjoyed travelling and was a member of several societies in London and the Stewards' Enclosure at Henley Royal Regatta. He died peacefully in his sleep and leaves three children and eight grandchildren.

John Dawe

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Jennifer Pugh

Consultant anaesthetist (b 26 May 1931, q Oxford/Middlesex Hospital Medical School, 1956; FFA), died from pneumonia (after a fall) on 25 September 2015

Jennifer Murray won the Nuffield Prize in the first part of the fellowship examination of the Faculty of Anaesthetists. She bought a Kenwood hand mixer with the prize money, which was forever after known as the Nuffield. She met Mike Pugh, a fellow registrar at the Middlesex, in 1963; they were married in 1965. Jennifer mainly worked in private practice, but she did some consultant locums at several hospitals. She gave many anaesthetics at St Luke's Hospital for the Clergy, which she called her celestial insurance. She enjoyed cooking and gardening. Crippled with osteoporosis in her later years, she died a month after her golden wedding anniversary, leaving Mike, two children, and three grandchildren.

Emma Pugh

Cite this as: *BMJ* 2018;362:k3959



Michael Arthur Pugh

Consultant obstetrician and gynaecologist Whittington Hospital, London (b 1929; q St Bartholomew's Hospital, University of London, 1953; FRCS, FRCOG), died from prostate cancer on 10 June 2018

Michael Arthur Pugh ("Mike") always wanted to practise obstetrics and gynaecology, which he pursued with determination after his return from national service in the Far East. He was a registrar at the Middlesex, where he met Jennifer Murray, a registrar in anaesthetics. Mike moved to London as a consultant in 1967. He often wondered if he had a death wish for places he worked at: the Royal Northern, Soho, and Elizabeth Garrett Anderson hospitals all closed while he was on the staff. He developed an interest in the menopause, and set up a menopause clinic. Jennifer predeceased him in 2015. He leaves two children and three grandchildren.

Emma Pugh

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Peter John Bowers

Consultant in child and adolescent psychiatry, former medical director Pennine Care NHS Specialist Mental Health Trust, and chair of regional group of child psychiatrists (b 1946; q University of Manchester Medical School 1973; FRCPSych), died from complications of flu and pneumonia on 15 May 2018

Peter John Bowers was consultant in child and adolescent psychiatry in Tameside and Glossop from 1983 to 2008. He held extensive leadership roles regionally and nationally. As medical director for the trust, he made patient care his central focus. He was an expert witness in family court proceedings and a trainer for North Western Deanery's higher training scheme. Bowers held a lifelong passion for music and performing arts. With his wife and children he performed in or directed theatre productions, up to his illness in February 2018. He leaves his wife, Lesley; three children; and a grandson.

Anna Kushlick, Sue Bailey

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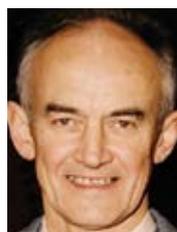


Michael John Leverton

Former general practitioner (b 1936; q Cambridge 1961; DRCOG), died suddenly at home on 18 January 2018

Michael John Leverton ("Mick") took a GP post in Millom, in the far south west of the Lake District, soon after falling in love with the area. He threw himself into work and into local life, not only helping build up the GP practice as a close and community focused team, but also acting as medical officer at Haverigg prison and at Millom ironworks. In 1968 the town's practices merged and moved into premises in the town's high street to form the Millom Waterloo House surgery, pooling about 8000 patient records. Mick's surviving partners recall him as practical and business minded. In retirement he continued supporting mountain rescue as well as working for the blood transfusion service. Predeceased by his first wife, Margaret, in 1993 and by their son in 2009, he leaves his second wife, Pam; six daughters; and 11 grandchildren. Ted Leverton, Jane Smith Ann Leverton, Clare Leverton

Cite this as: *BMJ* 2018;362:k3924



Razia Sultana Mir

General practitioner (b 1942; q 1965), died from multiple system atrophy on 9 July 2018

In 1965 Razia Sultana Mir married a doctor from Lahore, who at the time was working for the World Health Organization. They left Pakistan for the UK and arrived in Glasgow on Christmas Eve of that year and settled in Bearsden. Until 1968 Razia held various positions at hospitals in Glasgow. She completed a masters in immunology at the University of Glasgow in 1971. The family then moved to Northwood in north west London. Razia worked in partnership with her husband at an NHS practice in South Oxhey, Watford, as a GP specialising in obstetrics and gynaecology. From 2003 she worked as a locum doctor and in private practice in Harley Street. In 2015 she was diagnosed with multiple system atrophy. She leaves her husband, Saboor; three children; and seven grandchildren.

Sabuhi Gard

Cite this as: *BMJ* 2018;362:k4049



Klaus Riegel

Paediatrician, teacher, and scientist

Klaus Philipp Riegel (b 1926; q Tübingen, Germany, 1952), died on 4 June 2018

An observation by German paediatrician Klaus Riegel captures a key element of his clinical philosophy while sounding rather arch, coming as it did from a man admired for his amiability. Opposed to supposedly heroic intensive care interventions for neonates and infants, Riegel drew a distinction between “those who turned buttons at machines and those who knew why.” In both his teaching and his clinical work, he made clear his distaste for interventions that brought no obvious benefit to the sick infant.

His contemporaries think that Riegel’s key achievement was developing interdisciplinary quality control and surveys of perinatal and neonatal deaths. This work improved international understanding of perinatal and neonatal mortality and transformed the working relationships between obstetricians, paediatricians, and neonatologists in Riegel’s home country.

Cultural change

Riegel had to overcome a culture that indulged the hunt for blame between obstetricians and paediatricians whenever a baby died. Having achieved some cultural change by the mid-1970s, Riegel began working with epidemiology colleagues, notably H K Selbmann, professor of medical informatics at Tübingen university, on quality control studies around the causes of neonatal and infant deaths—among these the Arvo Ylppö longitudinal study, conducted in collaboration with Finnish researchers. This work was very much a Finnish-Bavarian partnership, reflecting Finland’s leading role in paediatrics at the time.

The findings were presented in a series of papers and studies published over nearly 20 years from 1975. Riegel’s mentor, Klaus Betke, whom Riegel had followed to the University of Munich in 1967, said that this work “had saved from death” several

thousand newborn babies in Bavaria.

With the lessons quickly adopted domestically and abroad, Riegel received the Republic of Germany’s highest honour for services to the nation, the Order of Merit.

Surprisingly, some criticised Riegel for showing undue modesty in how he set about building effective working relationships between paediatricians and obstetricians—a task that had proved beyond others. It was those relationships that allowed the surveys and analysis of mortality to go ahead.

Riegel was appointed professor of paediatrics at Munich in 1969, having spent two years working as an NIH research associate at Harvard Medical School, where he researched the physiology of neonates. (He exported his Harvard chair back to the former West Germany and used it throughout his life.) Riegel qualified as a doctor at the University of Tübingen in 1952, which was where he first encountered Betke.

Regarded as a modest and humble man, Riegel was most proud of his scientific contributions. With Betke and Enno Kleihauer he was involved in important early research at Tübingen in his main research interest—the oxygen transport between mother and fetus—that laid the groundwork for later studies.

That work built on his habilitation thesis that established him as an academic teacher and faculty member in 1963, which was based on research on oxygen transport and the function of fetal haemoglobin.

Artistic side

His leadership role in several scientific organisations included the presidency of the European Society of Paediatric Research in 1984. Somewhat to the surprise of colleagues gathered for the society’s conference in Munich, Riegel’s speech in the role was composed entirely of limericks.

That perhaps reflected his creative, artistic side: inseparable from his cello, Riegel also sketched and painted—a skill that allowed him to create his



Riegel had to overcome a culture that indulged the hunt for blame whenever a baby died

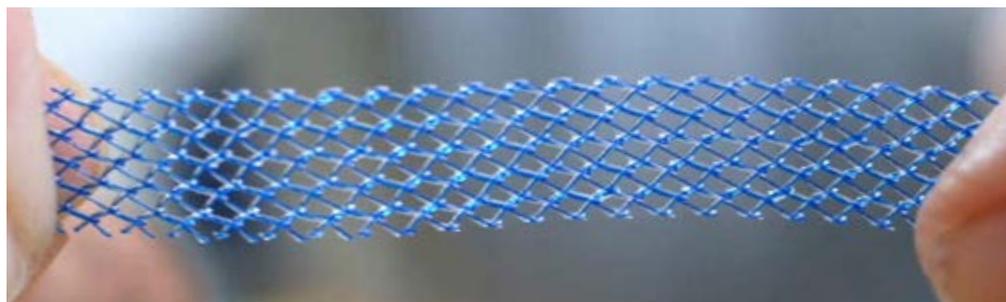
own birthday cards for friends and colleagues. Betke suggested that Riegel’s talent as a paediatrician stemmed from this range of skills and interests—music, art, poetry, and scientific curiosity.

Betke’s status as mentor even reportedly stretched to Riegel’s sartorial elegance. Having heard his professor voice concerns at the infection risk of dangling ties during his first clinical round at Tübingen, Riegel donned the first of the bow ties he wore throughout his career.

Born in Schorndorf in Swabia, Riegel was drafted into military service in the final days of the second world war before completing his baccalaureate. He was swiftly captured by the British and completed his school exams only after his release in 1946. Eight years later he married Elsbeth, with whom he had two children. Reflecting on his career, the modest Riegel said that his successes owed much to good fortune—with the most important slice of luck being meeting Elsbeth. He leaves her and their two children.

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LATEST PODCAST

What it's like to live with a vaginal mesh?

Last week *The BMJ* published a series of articles that examined the patient safety storm surrounding surgical mesh implants for vaginal prolapse and stress urinary incontinence. The series documents how thousands of women have been irreversibly harmed. In a podcast, Rebecca Coombes, head of news and views at *The BMJ*, talks to three women who've experienced negative consequences after having vaginal mesh implanted. Their stories underline how life altering this situation has been:

"The mental effect it has on you, apart from the physical effect, is awful and there's no services here that can cope with that. But I want this out before it gets worse and does more damage to me."
–Susan

"I feel silly really because I didn't ask questions. I guess I just totally trusted that the consultant knew what he was doing . . . If I'd have known any of these symptoms or complications might arise I'd, of course, have run a mile. I would never have had it implanted."

–Michelle

"My pain was off the scale. I was now having intense urethral burning, like constant burning. I felt like I'd been kicked really hard between the legs the whole time. And I had occasional, really sharp, stabbing pains. And it was just awful. It got to the point where I couldn't really do an awful lot because I was in so much pain."

–Fi

 Listen to the podcast in full at http://bit.ly/mesh_four_letter_word

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Mahua Chakrabarti: Blissful operator

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

FROM THE ARCHIVE

Caesarean section: taking the long view

Caesarean section use accounted for 21% of births globally in 2015 (26.2% in the UK)—a rate that experts have called alarming (*BMJ* 2018;363:k4319). Back in 1865, Thomas Radford, an honorary consulting physician, wrote about this operation when it was relatively rare (*Br Med J* 1865;1:211), with some contemporary doctors claiming that it "was universally and inevitably fatal."

"The caesarean section is not an operation of recent date," writes Radford, since "its performance is recorded before obstetric medicine and surgery were scientifically accepted." Yet, he says, "To my knowledge, there has been no subject connected with medicine which has created more bitterness



of feeling and animosity in the minds of those who may be classed as caesareanists and anti-caesareanists."

Radford describes how the induction of premature labour,

craniotomy, symphysiotomy, or combinations of these were proposed as alternatives that made the practice of caesarean section unnecessary. Yet he claims, "The caesarean section is doubtless required whenever the pelvic apertures, or its cavity, are so diminished" that vaginal delivery would not be possible. He cites cases where pelvic bones have been distorted by mollities ossium and rickets, and adds that it is quite possible for both the patient and practitioner to be "completely ignorant of these organic conditions until pregnancy has either been considerably advanced, or even completed, and labour commenced." For, "Surely, the most benighted opponent to the caesarean section cannot be

so mentally blind as not to know that young married women can not be compelled to submit to vaginal or other examinations in order that it may be ascertained whether there is sufficient pelvic capacity for a full grown infant to pass through."

Radford launches a staunch defence of "the necessity of the caesarean section as a recognised obstetric operation." Yet he acknowledges that it came with a high mortality rate. "The statistics of the results of the caesarean section, especially as concerns the mothers, are highly unfavourable. The general account stands as follows—of the seventy seven women whose cases are tabulated, sixty six, or 85.71%, died; eleven, or 14.28%, were saved."