

this week

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Whistleblower trainee drops claim

A junior doctor who claimed that he was unfairly dismissed by an NHS trust for whistleblowing about unsafe staffing levels and that his career was subsequently destroyed by Health Education England has withdrawn his claims part way through an employment tribunal hearing.

Chris Day, 33, fought a four year legal battle to have his claims heard after raising concerns in 2014 about understaffing and safety at the intensive care unit of the Queen Elizabeth Hospital in Woolwich, London, where he was a specialist registrar in emergency medicine. He claimed that after he repeated the concerns to HEE it deleted his training number, making it impossible for him to continue training.

HEE claimed that it was not legally his employer, so no case could be brought against it under employment law. But in 2017 the Court of Appeal ruled that HEE does employ junior doctors, along with the trust at which they are placed, opening the way for junior doctors to bring claims against HEE at an employment tribunal.

The tribunal opened this month and was expected to last 21 days. Day gave evidence and was cross examined, but after six days a statement withdrawing his claims, agreed by all three parties, was read out.

The statement agreed that Day had blown the whistle by raising patient safety concerns in good faith and had “performed a public service in establishing additional whistleblowing protection for junior doctors.” But, it added, “The tribunal is likely to find that both the trust and HEE acted in good faith towards Dr Day following the whistleblowing and that Dr Day has not been treated detrimentally on the grounds of whistleblowing.” The claims were “dismissed upon withdrawal.”

HEE said in a statement, “We have always been clear we did not act against Dr Day because of his protected disclosures or cause him any detriment. HEE has always supported healthcare staff blowing the whistle. It is part of the education and training we oversee for new clinicians.”

A BMA spokesperson said that it had secured legally binding protections, in force since August 2016, that “ensure that doctors, whether they are BMA members or not, can raise relevant issues in the workplace, knowing that there is a robust legal apparatus in place to safeguard them from any detriment that they may suffer from HEE as a consequence.”

Clare Dyer, *The BMJ*

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Chris Day, who worked at Queen Elizabeth Hospital in Woolwich, fought his claim for unfair dismissal for four years

LATEST ONLINE

- Physician associates will be regulated along same lines as doctors and nurses
- Drug companies are incentivised not to improve health
- Number of US children who are completely unvaccinated has quadrupled since 2001





Experts say that folic acid fortification will help prevent birth defects such as spina bifida

Wald led research that found that there was no need for an upper limit of folate intake and was seen as removing any final barriers to folic acid fortification of foods such as flour.

He said that if the government action was confirmed, “there will undoubtedly now be discussion over the level of fortification, which should be high enough to prevent an estimated half of cases of spina bifida and anencephaly. “Fortification of flour with folic acid provides a safety net; it does not mean that women no longer need to take a folic acid supplement, and this should be 5 mg a day, to obtain the full protection.”

Clare Murphy, director of external

affairs for the British Pregnancy Advice Service, said that fortification “will spare hundreds of women the heartbreak of receiving the news that their baby has a serious condition.” She said that the measure should be brought forward “as soon as possible.”

The Labour MP Owen Smith, who has campaigned on folic acid fortification, said, “I have today written to the health minister seeking confirmation that this measure will go ahead and called on him to make a statement in parliament ahead of a debate we have secured for spina bifida awareness week next week.”

Matthew Limb, London

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Deaths from medicines: lessons from coroners’ reports are missed

Coroners’ reports often do not fulfil their statutory aim to prevent future deaths in the case of fatalities related to drugs, a report concludes.

The researchers, led by Robin Ferner of the West Midlands Centre for Adverse Drug Reactions, said that alerting national rather than local organisations to the reports would ensure that important lessons about patient safety were learnt.

The law in England and Wales requires coroners to write “regulation 28” reports to the appropriate bodies if an inquest reveals information that

could be used to prevent future deaths. The report outlines the coroner’s recommendations for action and requires a response within 56 days, outlining action.

Responses not published

The researchers found that reports of national importance were usually sent only to local bodies. Despite calls for more openness to help boost patient safety, many organisations did not publish their responses.

In addition, said the authors, “there appears to be no system for auditing concerns and responses

to them. So, it is difficult to know whether—with regards to medicines—the coronial system prevents future deaths. Only a minority of the responses that we analysed appear to provide robust and generally applicable ways to prevent future deaths.”

If coroners’ reports were routinely sent to bodies such as NHS Improvement, the researchers said, “important information to prevent future deaths would be available to the whole NHS and lessons less easily forgotten.”

Clare Dyer, *The BMJ*

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FIVE MINUTES WITH . . .

Nicola McKinley

The surgical trainee discusses why she is conducting a nationwide survey of doctors’ resilience

“Currently, the only study on how resilient NHS doctors are is our pilot study. Our team at Queen’s University Belfast ran a survey in a single NHS trust in Northern Ireland in August 2016. Overall, 283 doctors were surveyed, and we found that, despite being resilient, 37% of them were still really burnt out and 72% had high traumatic stress from their job.

“These findings gave us limited information, which is the reason for the nationwide survey.

“There is no universal definition of resilience, but I think it would be generally accepted that it’s the ability to recover from stress or bounce back from an adverse incident.

“We are using three questionnaires that have a good evidence base. The Connor-Davidson Resilience Scale asks clinicians to think about the past 30 days and rate themselves on a scale. We also use the professional quality of life scale, ProQOL 5, which measures burnout, secondary traumatic stress, and compassion satisfaction—which is the pleasure you derive from doing your job well. The final test we use is the Brief COPE coping scale, which asks people to think about how they managed difficult events in the past 30 days.

“We hope that our survey will help to target interventions at people who have less resilience. Or, if we find that people are identifying reduced resilience at certain points in their career, then interventions could be put in place at different career stages to tackle that. If we find that doctors are using dysfunctional coping strategies, then we could focus on how we can improve those strategies; for example, it could help deaneries to know how best to help their trainees.

“I want to encourage doctors to fill the survey in. Getting a good response rate could really change things. If we can target interventions at specific career stages or at specific groups of doctors, then we could really make a difference.”

The survey is at www.surveymonkey.com/r/GVWC9GT.

Nicola McKinley is a core surgical trainee and a member of the Quality of Life, Coping, and Resilience (QOLCARE) study group at the centre for public health, Queen’s University Belfast.

Abi Rimmer, *The BMJ*

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GETTING A GOOD RESPONSE RATE COULD REALLY MAKE A DIFFERENCE





THE BIG PICTURE

Outrunning child obesity trends

London mayor Sadiq Khan and Olympic champion Mo Farah take to the track with schoolchildren in east London this week to promote an anti-obesity programme that is gaining in popularity across Europe. Children from Cubitt Town Junior School are pictured taking part in the Daily Mile, a 15 minute session to get pupils walking or running a mile.

The brainchild of a head teacher in Scotland, the idea has spread to more than 3460 schools in the UK and a further 1350 schools in Europe since 2012. There is some evidence behind the scheme. Earlier this year a team from Edinburgh and Stirling universities published a study that found positive changes in fitness, body composition, and activity in children who did the daily mile when compared with those who didn't. A cluster randomised study of 40 schools in Birmingham completed earlier this year looked at body mass index a year after the Daily Mile was introduced. The study, which has yet to report, is also investigating cost effectiveness.

The push to get more London schools to adapt the daily activity came as doctors warned that, given current trends, around 23% of 11 year old boys in England are projected to be obese in 2030, the number having increased by 13% since 2016. Nearly a third of the most deprived boys would be obese in 10 years' time, the analysis from the Royal College of Paediatrics and Child Health found.

International comparison indicates that the UK currently has a higher prevalence of obesity than other northwestern European countries, though the trend seems to be flattening and the UK may see smaller increases than these countries over the next decade.

Rebecca Coombes, *The BMJ*

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NEIL HALL/EPA-EFE/SHUTTERSTOCK

Alcohol must be recognised as a drug

To strengthen policy responses to harms caused by addiction industries

Alcohol, actually ethanol (C₂H₅OH), is a psychoactive molecule ingested by 2.4 billion people globally.¹ A central nervous system depressant, it exists naturally and can be produced in people's homes. Any alcohol consumption confers health risks, including for a range of cancers,² and any possible cardiovascular benefits are smaller than was previously understood.³ Alcohol harms users through intoxication, organ toxicity, and addiction, which cause an estimated 2.8 million deaths every year.¹ In a recent systematic review and meta-analysis the Global Burden of Disease Alcohol Collaborators concluded that "the level of alcohol consumption that minimised harm across health outcomes was zero."¹

Greater access to alcohol increases consumption and a wide range of health and social problems in a dose-response manner, and the most effective policies are those that increase the price and reduce the availability of alcohol.⁴ Because such measures threaten commercial interests they are challenging to adopt, and ineffectual policy responses often prevail.⁵ Broadening how we think about alcohol policies based on clear recognition that alcohol is a drug could have important benefits for public health.

Treating alcohol as a drug

Tobacco companies for decades deflected attention from the fact that their products were addictive drugs. When forced to recognise that alcohol is a drug, industry actors ask, "Why does it matter?"⁶ Words do matter in the shaping of public

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CHRISTOPHER FURLONG/GETTY IMAGES

The merger of the world's two biggest brewers means a single company now produces one third of all beer sold globally

policy,⁷ and the clear identification of alcohol as a drug matters a great deal to the alcohol industry, and to society, because the policy implications are so important.

According to expert opinion, alcohol is the drug that causes most harm in the UK—more than heroin, crack, or tobacco.⁸ Like tobacco, alcohol kills some users slowly through the diseases it causes. Unlike tobacco, alcohol also kills quickly, through injury and poisoning. Consequently, deaths occur at younger ages on average than those caused by tobacco. As is the case for many illegal drugs, alcohol intoxication also causes harm to others, including injury and sexually transmitted infection.

Accordingly, although there is a large difference in the overall number of deaths from alcohol and tobacco, the difference in overall years of life lost is much smaller. In England these were estimated to be 301 000 years for alcohol compared with 360 000 for tobacco in 2015. That year, alcohol alone accounted for 16% of all working years lost in England.⁹

Drug production and distribution industries that are legal and those

that are illegal are clearly different. But there are commonalities among what have been described as addiction industries—those involved in promoting products and activities known to cause addiction and associated problems¹⁰ such as tobacco, alcohol, and gambling. Profiting from addiction is a defining feature of these industries, along with obstructing the implementation of effective countermeasures.¹⁰

The merger of the world's two biggest brewers, the third largest merger in any industrial sector, means a single company now produces one third of all beer sold globally.¹¹ Its second largest shareholder, Altria, owns Philip Morris, a tobacco company.¹² The rationale for this merger was to develop alcohol markets in Africa—the smaller of the two companies has helped to draft the alcohol policies of four sub-Saharan countries.¹³

Coordinated approach

Contemporary addiction policy science finds that dichotomies based on the legal status of drugs obstruct learning about management of drug use in populations.¹⁴ Bringing alcohol, tobacco, and other drugs together in unified policies may support policy coherence, stimulate creative thinking about new countermeasures, and improve societal outcomes.

Another feature of the addiction industries is that they provide psychosocial benefits to their users. A more holistic approach must take this into account and could be helped by new forms of public involvement in policy development.¹⁶ Clearer recognition of alcohol as a drug will help inform global public health and wider society's management of this costly and growing problem.

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Measles: neither gone nor forgotten

Antivaccine sentiment isn't the only problem

It is 50 years since measles vaccine was introduced in the UK and 20 years since it was replaced with the highly effective measles, mumps, and rubella (MMR) vaccine. In 2017, the World Health Organization declared that measles had been eliminated from the UK; this means that measles is no longer endemic, not that it has disappeared.¹

Another 42 of the 53 member states in the WHO European region have been reported as having interrupted the endemic spread of measles, yet epidemics of measles are occurring across Europe.² The region saw more cases of measles (over 41 000, including at least 37 deaths) in the first six months of 2018 than in any other complete year of the decade.³ In England, three times as many cases of laboratory confirmed measles have been recorded up to 10 September 2018 than in the whole of 2017 (876 v 267).⁴

Why is this happening? Detailed examination of the cases occurring in the European Economic Area (EEA) in the 12 months from July 2017 to June 2018 showed that in the 90% of cases where immunisation status was known, 82% had received no measles-containing vaccine and only 2% had received at least two doses.⁵ In 2017, only four EEA countries recorded an uptake of 95% or more for two doses of a measles-containing vaccine, and even countries with a current high uptake overall may have gaps in immunity because of variation within the country or earlier lower uptake.⁶

In the UK, the uptake of one dose at 2 years of age has steadily fallen from a high of 92.7% in 2013-14 to 91.2% in 2017-18⁷; the reasons

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ALEXANDER CAMINADA/SHUTTERSTOCK

Poor uptake should not always be assumed to be because of parental doubts about vaccines

for this small decline are not clear. Uptake of MMR shows regional variation, some of which is likely to be due to inaccurate data collection, but the different reasons for non-immunisation will require tailored actions to improve uptake.^{8,9}

Access problems

In the UK, when children are not fully immunised this is usually because accessing services is difficult rather than because their parents have actively declined the vaccine. A study of an orthodox Jewish community in north London showed that, contrary to preconceptions, the relatively poor uptake of vaccination in the community was not due to antivaccination sentiments but to access problems.¹¹ Until these have been tackled, poor uptake should not always be assumed to be because of parental doubts about vaccines.

In many countries, funding for preventive measures has fallen. In Italy, researchers found that for each 1% reduction in public health expenditure there was a 0.5% fall in MMR uptake.¹²

Countering misinformation

MMR uptake dropped sharply in the early 2000s after publication of the now discredited 1998 *Lancet* paper widely interpreted as suggesting a link between MMR vaccine and autism and bowel disease.¹³ Although uptake has now recovered, many older children and young adults remain unprotected, and this partly explains the age distribution of current measles cases, with a large proportion in people older than 15 years.⁴

Unfortunately, vaccines have become even more of a political issue recently and are now on the agenda of right wing populist groups in Europe—for example, the National Rally party in France and the Five Star party in Italy. Before he was elected US president in 2016, Donald Trump tweeted on numerous occasions that MMR vaccine causes autism. Antivaccine sentiment on social media undoubtedly plays a part in some distrust of vaccines, but how much it contributes is unknown. In August 2018, it transpired that Russian backed bots and trolls have been spreading misinformation about vaccines.¹⁵ Countering such activities effectively presents challenges. Government information is a useful adjunct but cannot replace discussion with knowledgeable, trusted healthcare professionals who are equipped to respond to parents' specific questions and concerns.

Timely high uptake of vaccines is important, not only for individuals but to create herd immunity to protect vulnerable people who cannot be immunised.

Whenever a healthcare professional has contact with a patient, child, or adult, in whatever setting, the opportunity should be taken to check their immunisation status and offer any missing immunisations.

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CONSULTATION SKILLS

Should doctors share their personal experiences of healthcare with patients?

It's a divisive topic, finds **Fran Robinson**: some doctors insist it can help when done carefully, but others struggle with its potential to detract from the patient

GMC and medicolegal advice

The General Medical Council's guidance on personal beliefs says: "During a consultation, you should keep the discussion relevant to the patient's care and treatment. If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the professional boundary that exists between you. These boundaries are essential to maintaining a relationship of trust between a doctor and a patient."

A GMC spokesman says: "Personal information could include details of the doctor's medical treatment. Doctors need to use their judgment depending on the specific circumstances but in general they should be cautious about sharing information about their own treatment because there is a risk patients might give it more weight than would be justified in their own specific circumstances."

Ellie Mein, a medicolegal adviser at the Medical Defence Union (MDU), warns of three potential pitfalls:

- It could take the focus off the patient, leaving them feeling that their consultation has been hijacked
- The doctor's story could influence the patient so that they do not make an objective decision about their treatment
- A doctor's experience that had a positive outcome could make the patient feel awkward for worrying about their condition.

She says: "It is understandable that doctors will share personal experiences because they want to relate to their patients and they are human. There will be times when patients will find it helpful.

"We would never say don't share an experience. If you do, make sure you keep the discussion relevant to the patient's care, be guided by your knowledge of the patient, be mindful of the ways it could go wrong, and be careful not to breach any professional boundaries. For each patient and doctor that boundary is probably going to be a grey area."

Be guided by your knowledge of the patient, and be mindful of the ways it could go wrong

Ellie Mein, MDU



When the upper gastrointestinal surgeon Tim Underwood wants to help his cancer patients deal with feelings of loss he sometimes tells them how he coped with losing a child at 24 weeks' gestation. The same night he had to consent to his wife having an emergency hysterectomy after a massive bleed.

Some doctors might raise their eyebrows at the thought of sharing personal experiences like this with their patients. But the limited research shows that self disclosure, when doctors reveal something personal, is common in medical practice.

Underwood, professor of gastrointestinal surgery at the University of Southampton, tells this story to patients very infrequently, and only if he feels it is appropriate. He uses it to articulate not only that he understands what loss is about but that something positive can come out of a distressing time: four years later he and his wife adopted a little boy.

He sometimes uses the story to help patients facing a recurrence of their cancer. Patients with young children may be concerned about telling them about their illness because they don't want them to worry that they will die. "We had a daughter and were completely honest with her about everything, so I use my experience as an example of how I reacted to the situation and how to be open with children," he says.

Interpreting risk

Underwood also uses his experience of consenting to a cardiac ablation to explain to patients the risks of an oesophageal cancer operation. "I say to them, I have sat where you are, and, although I could have died or been catastrophically injured if the operation had gone wrong, I still signed the form because I understood the risks and because I am human I assumed it wouldn't be me. I tell the story because I want them to understand how I interpreted the complexity of that risk and that these problems happen to somebody; it could be them."

He says he shares his experiences to show patients that although it says professor on the door of his office, he is also a husband, a father, and a son who has feelings and has some understanding of what his patients are going through.

"My nature is to be direct, open, and honest with everyone. But I tend to share personal experiences with only a select few patients when I feel the timing is right. If I use a personal story it's to help patients understand that the decisions they have to make are complicated. We all make them differently, but it can be done."

Underwood says his perception is that doctors are generally wary about sharing personal stories. "It's a personal thing, and each individual is different. I am probably at one end of the spectrum. I don't know whether it is right or wrong, but none of my patients has ever complained."

GPs' experience of self disclosure in primary care

A study comprising interviews with 16 GPs in New Zealand found that self disclosure was common and was seen as a positive activity that had the capacity to improve the doctor-patient relationship.

- Family and physical topics were most commonly discussed, but psychological and relationship problems were also shared
- Physical health problems disclosed by GPs included musculoskeletal and skin problems, diabetes, and weight management
- Only two GPs said they would disclose mental health or psychological problems, and then only to guide patients down a particular therapeutic path by offering real life examples of success
- Knowing the patient made self disclosure more likely, but a GP's decision to disclose was mainly based on intuition
- The doctors thought that sharing personal experiences made them seem more human and approachable; helped to support the patient; created a sense of closeness and trust; made the patient more receptive to advice and more motivated to adhere to treatment; helped the patient to be more forthcoming with information; and helped reduce any power imbalance in the relationship
- Potential disadvantages of self disclosure were considered to be that it could skew the doctor-patient relationship; burden the patient; take the focus away from the patient's needs; risk expanding the professional relationship into a more personal or intimate one; invoke curiosity and dependency in the patient; and reduce the doctor's credibility
- GPs' perceptions of their disclosures were very positive, and none had experienced an adverse response
- The study concluded that training would be helpful to prevent future mistakes and to protect the doctor and patient from unintended harm, such as developing a dependent relationship.

Providing a role model

Thomas Jones, a general practitioner at Lockside Medical Centre, Stalybridge, shares with patients his experience of coping with anxiety, which he learnt to control in his mid-20s through cognitive behavioural therapy.

"I hope that by admitting to having had these issues and by demonstrating that they can be overcome and consigned to the past, I'm providing a positive role model for patients. I don't dive in with my experiences, and only tend to mention them in a second or third consultation.

"I do it only if I sense that the patient feels really alone with their anxiety, and I try to say it in a 'this can happen to anybody' way."

Normally private about his personal life when talking to patients, Jones says he doesn't talk through specifics, he just explains enough to help the patient realise that he has been through something similar. He finds it helps patients to feel that it isn't a sign of weakness to disclose something personal. "It helps them to hear the message, 'we can get through this—I want to see you overcome it.'

"It's an incredibly personal judgment on behalf of the doctor as to how much gets shared, to whom, on any particular day."

He believes that patients usually want doctors to be objective during the consultation. "In other words, we need to preserve boundaries in order to provide that objectivity. However, on occasion, it feels the right thing to do to break down those boundaries just enough to help the patient over a hurdle. If we can bring some personal experience to achieve that, then that can go a very long way."

Patient advocate versus doctor

Liz O'Riordan, a consultant breast surgeon at Ipswich Hospital who has recurrent breast cancer, says she finds it difficult to be a patient in her own specialty while returning to work and being a doctor again.

A natural communicator, she has already shared her experience of cancer in a blog, on social media, and in a recent book on breast cancer. But she struggles to work out how to help

her patients without talking about her own experience. She is conscious that she should not influence her patients' decision making because they might compare themselves with her about the choices she has made and the way she has handled her illness.

"I can't be a patient advocate while I'm trying to be a doctor again," she says. "It would be a mistake to try to be the patient's friend and tell them you coped, especially when they are dealing with cancer. They might not be in the right place to hear it from you. The consultation must always be all about that person in the room. The minute I say, 'I've had it, I know what it's like,' I'm detracting from them."

O'Riordan admits that she can feel vulnerable when she is in the consulting room doing follow-ups with a patient. "When it's just the two of you, it is easy to say things you later think you shouldn't have said. There are times when it may feel right to let them in and say, 'Actually I found this really hard, try this.' I worry about the ethics of there being two patients in the consultation. Often it's just me and the patient and there is no one else listening in to tell me if I have overstepped the boundary.

"I'm learning from my mistakes and am very much aware that I need to have checks in place to remember I am a doctor."

Few studies have investigated the effect on patients of doctors disclosing personal experiences (box, left). But Richard Baines, a patient from Winchester, says that after he had a stroke he felt that his GP was reaching out to him as a fellow human when he told him how his family had been affected by his father's stroke.

"He was giving me a message about the importance of staying active and was expressing that he understood the daily difficulties and humiliations that people who survive stroke have to cope with.

"He was offering me psychological support and empathy, and he left me feeling that he would remember me after I had gone out of the door."

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None of my patients has ever complained

Tim Underwood,
upper gastro-intestinal surgeon



I do it only if I sense that the patient feels really alone

Thomas Jones,
GP



I worry about the ethics of there being two patients in the consultation

Liz O'Riordan,
consultant breast surgeon

Back to the future: aspects of the NHS that should never change



ALL PICTURES/GETTY IMAGES



Social solidarity

The NHS was founded on the principle that comprehensive healthcare should be freely available to all, prioritised on the basis of need rather than the ability to pay, and funded through taxation. In the immediate post-war context of severe financial constraint and ruined towns and cities, the NHS represented a remarkable commitment to William Beveridge's insistence that "the purpose of victory is to live into a better world than the old one."

These founding commitments established one of the few social institutions in the UK which gives its citizens a sense of a moral foundation to our society that they recognise, take pride in, and wish to protect. WH Auden wrote that the role of art was to teach people to love not to hate. For the people of the UK, the NHS has seemed to fulfil a similar role.

It is not surprising that these foundations are being shaken by the predations of late capitalism, with its insistence on the pre-eminence of the market as the driving force of every aspect of society. Yet, despite the NHS's recent travails and the ideologically driven withdrawal of adequate resources, a large majority of patients, citizens, and professionals remain committed to

Many changes to the NHS in its first 70 years have been for the better. But not all change is good, writes **Iona Heath**, pointing out the aspects of the health service that should be preserved

the sense of justice and inclusion expressed by the existence of the NHS and a clear majority are willing to pay more tax to fund it.

Anyone who has worked in the NHS for some years will have noticed that sequential "reforming" reorganisations proceed in circles. These manifest the dangerous tendency to see change as progress, but all change involves loss and each cycle of reform seems to shave off a little more of the essential core of the service that is expressed in the founding principles.

Prioritisation on the basis of need

The pre-eminence of need is essentially an expression of social solidarity and justice, and yet both have been severely undermined and ought to be reasserted in healthcare policy. The problems began when Margaret Thatcher sought to recast NHS patients as consumers and legitimated demand alongside need. Successive time targets for waiting lists for elective treatment and for waits in emergency departments

The current wave of racism and xenophobia disfiguring our society undermines social solidarity and the NHS, damaging us all

have further undermined the ability of clinicians to prioritise on the basis of need. The effect has been to privilege the most demanding and to penalise those who are in greater clinical need. To me, and perhaps to others, the NHS now feels harder to understand and less fair.

Available to all

The original intention of the NHS was that everybody should be eligible for care, including temporary residents or visitors to the country. The politically motivated exaggeration of the costs of "health tourism" and the creation of a "hostile environment" for immigrants deemed to be here illegally has undermined this founding principle. It has also led to the denial of care to members of the ageing Windrush generation, Caribbean immigrants from the second half of the 20th century, so many of whom made major contributions to the functioning of the NHS, often in the vital but less remunerated roles of catering, cleaning, and portering. The reinstatement of the principle of universality would rid the NHS of a burdensome bureaucracy and minimise the possibility of similar scandals in the future. The cap on visa applications for skilled workers has exacerbated the severe



shortages of clinical staff within the NHS and has underlined the extent to which it has depended on immigration. Doctors have recently been removed from the cap but it will take considerable time to make up the shortages. The current wave of racism and xenophobia disfiguring our society undermines social solidarity and the NHS, damaging us all.

Relationship-based care

Since its inception, the NHS has operated a list system for general practice and has insisted on general practitioner referral to secondary care except in emergencies. From 1948 to 2004, every patient was registered with a GP, whose name appeared on their medical card. In 2004, as the drive towards competitive privatisation of the provision of service accelerated, this was replaced by the name of the practice. Predictably, this led to an unhelpful and unpopular dilution of individual responsibility, and the named GP was reinstated in 2016, so restoring a potent driver of relationship-based care which had been highly valued by doctors and patients alike. Sadly, successive governments have prioritised access to any doctor over the importance of continuity of care,

Since 1948 the NHS's founding principles, including universality and continuity of care, have built a social institution that gives UK citizens "a sense of a moral foundation to our society"

particularly for the most sick, needy, and vulnerable patients.

Yet healthcare must, by its very nature, be delivered within relationships and so it follows that the NHS can only fulfil its function if it is committed to sustaining human relationships between professionals and patients, and between differently skilled professionals. Joy, kindness, courage, thoughtfulness, and trust matter at every level of the organisation and within every interaction.

Trust v regulation

At the start of the NHS, Aneurin Bevan told the medical profession: "My job is to give you all the resources and help I can, and then leave you alone as professional men and women to use your skill and judgment without hindrance."

There could be no more telling contrast to the situation that has developed over recent years. Despite the warnings delivered by the philosopher Onora O'Neill in her 2002 Reith Lecture, the NHS has been subjected to an increasingly burdensome and expensive superstructure of regulation. This seems to have demoralised and disempowered professionals while the incidence of service failures and scandals, always low in relation

The devaluing of continuity of care makes it more difficult to engender trust and easier to disseminate fear

to the numbers of patients seen every day, has remained largely unchanged.

O'Neill saw clearly the future trajectory of regulation in general, which has been reflected over recent months in that of the General Medical Council in particular: "Underlying the ostensible aim of accountability to the public, the real requirements are for accountability to regulators, to departments of government, to funders, to legal standards."

And she might well have added, "to a sensationalist media," whose reporting makes both patients and professionals evermore fearful. Trust must be earned within an ongoing relationship and the devaluing of continuity of care makes it more difficult to engender trust and easier to disseminate fear. The NHS was founded in part to reduce fear and surely this should remain an aspiration. We need to explore much more carefully how this can be achieved. As the US patient safety expert Don Berwick and colleagues have argued, "Fear is toxic to both safety and improvement."



BIOGRAPHY

Iona Heath was a GP for 35 years in an inner London practice in Kentish Town and president of the Royal College of General Practitioners from 2009 to 2012. She wrote a regular column for *The BMJ* until 2013.

Education and support of junior colleagues

The NHS has been providing the setting for the education of healthcare professionals since its inception. Most medical students have their first conversations with patients in an NHS general practice or hospital, and junior doctors complete their clinical training while being supported by more senior colleagues in NHS settings. This used to occur within a small consultant-led team.

Somehow, as we have lost sight of the importance of continuity of care for patients, we have also allowed the continuity of care of junior colleagues to wither away in many clinical settings and perhaps particularly in overstretched and under-resourced acute hospitals. The failure of a small minority of senior colleagues to take responsibility for juniors when things go wrong seems to have become more frequent and appears symptomatic of this particular breakdown of continuity of care. When I was a doctor in training, the NHS was less than half as old as it is now and, at that time, although I worked very long hours, I never felt unsupported, unprotected, or afraid. Regrettably, this is not the experience of too many junior doctors today, as the shocking treatment of Hadiza Bawa-Garba exemplifies.

Public provision

No British politician, however committed to the virtues of market economics, has yet had the courage to attack the founding principle of care being free at the point of use, although there has been considerable erosion of the scope of this provision with exclusions that include dental and optometry services. A system of charging for prescriptions, introduced within a year of the start of the NHS, remains unfair to those of working age who have a chronic condition that is not exempted from such charges. A system which capped the annual cost of prescriptions to any one person would be much more equitable.

Despite all this, the idea that the NHS is free at the point of use has remained largely untouched. However, the neoliberal faith in the power of



A human touch alongside new equipment: a premature baby cared for at Burtonwood in 1956

the market to provide better outcomes at lower cost has led to the provision of services being outsourced to the private sector at an increasing rate over the past three decades. This began with the outsourcing of non-medical support services including cleaning, finance, IT, contracting, and planning but has now spread to include whole hospitals, GP practices, and out-of-hours services. The obvious problem is that the NHS has always operated on a tight budget and private providers need to provide a profit for the owners or shareholders of the companies involved. This imperative means that private providers try to save money by reducing staff and resources and problems of quality and reliability have become increasingly obvious, most notably in the case of Hinchingsbrooke Hospital which had been privatised in its entirety and its care found “inadequate” by the CQC.

The NHS began with the nationalisation of the pre-existing network of teaching, charitable, and municipal hospitals and there is stark contrast with the recent financing of new hospital building through the notorious private finance initiative, which has leached huge amounts of taxpayers’ money into the private purse.

Most citizens intend that the tax they pay should be spent for the public good and resent the creaming off of part of the budget for private profit. Successive governments have argued that it does not matter who provides the services as long as they remain free at the point of use. The failures of a succession of big private companies suggest otherwise.

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Care and kindness in face of more technology

At the start of the NHS, doctors had a limited range of investigations and treatments available and had to rely much more on their clinical skills of history taking and examination. Over the succeeding 70 years the use of technologies, both investigative and pharmaceutical, has increased exponentially as the medical-industrial complex has flourished and generated enormous profits, which in turn have stimulated greed and corruption. Clinicians, patients, and the public are faced with an avalanche of “evidence,” much of which may be misleading, and we need perhaps to rediscover the culture of frugality which informed the early years of the NHS. This matter becomes more pressing as thresholds for diagnosis are lowered and the harms of overdiagnosis and overtreatment are documented. Machines have displaced listening and touch, numbers have displaced words, and care and kindness are slowly leaching out of the system.

All this, to a greater or lesser extent, seems to be a global phenomenon, but within the NHS, particularly in England, these tendencies have been exacerbated by the imposition of rules in the form of targets for clinical care that are blind to the context and aspirations of each patient and which have operated more in the interests of company profits than those of the sick and vulnerable.

It is entirely possible for the NHS to fund the care provided by a service that actively seeks to minimise waste, harm, and futility; prioritises on the basis of clinical need; and engenders trust by providing care and kindness. However, it will be impossible to meet levels of demand that are being artificially manufactured in the interests of the pharmaceutical and health technology companies. We need to provide health protection at the level of society rather than pursue the destructive seduction of prevention at the level of the individual and the absurd ambition of minimising every perceived statistical risk: an ambition that serves only to frighten the well, divert attention from the sick, and torture the frail and dying.