> This degree of rancour will not help to make services more person centred or inclusive

ACUTE PERSPECTIVE David Oliver

Incendiary healthcare hashtags

I probably spend too much time on "healthcare" Twitter. Twitter is a fantastic place for learning, sharing, networking, and debate. It can be compulsive, joyous, warm, and enlightening. It's also sometimes fractious, factional, and shouty, leaving users upset. The ongoing saga of the #doctorsaredickheads hashtag is a prime example.

Healthcare workers, researchers, reporters, and policy makers can use Twitter to engage directly with the wider public, who in turn use Twitter for peer support, discussion, lobbying, and speaking directly to people in power (including clinical professionals). They also use it for sharing experiences of illness, including frustrations with health services. Sometimes on Twitter these professional and patient circles intersect and something sparks, as with #doctorsaredickheads.

This hashtag seems to have started as a tweet in response to Stevie Boebi about her experiences with Ehlers-Danlos syndrome, including a long wait for diagnosis and doctors' repeated dismissal of symptoms. The spark quickly ignited and spread internationally, such as when an Australian writer, Asher Wolf, tweeted about her own distressing experiences.

My unscientific sample of the tweets that then set the hashtag ablaze suggests that most of the posters were female, often from ethnic minorities, and often with a physical disability or longstanding mental health problem. Ehlers-Danlos syndrome featured prominently, especially regarding long delays in diagnosis and expert support. Other problems doctors seemed to find it hard to recognise or treat included chronic pain, chronic fatigue syndrome and fibromyalgia, endometriosis, irritable bowel syndrome, Lyme disease, and dysautonomia.

Some patients said that many doctors had dismissed patients' own expertise in living with a condition, trivialised their symptoms, and even dismissed them as hypochondriacs and troublemakers. The doctors may well have a different narrative, but we can't dismiss or invalidate those patients' accounts, experiences, and feelings.

Members of the public weighed in to praise doctors who had helped them, and they criticised the incendiary language of the hashtag.

Some doctors thought that their integrity and dedication were being attacked and said that people didn't understand the conditions they work in.

The hashtag certainly got people talking. It gave people a voice and some peer solidarity, it attracted comment, and it simultaneously engaged, antagonised, distanced, and upset doctors. There's much to be learnt if doctors can get beyond the inflammatory language, read the patients' stories, and avoid trying to defend or attack. But, in the long run, I suspect that this degree of rancour will not help to make services more person centred or inclusive, more prepared to listen to feedback, or more willing to engage with patients.

Social media can cause more heat than light. In this case I wonder whether, if those arguing online had been sitting in the same room discussing the issues in person, the anger would have diminished and some mutual understanding would have emerged as the fire was damped down. Online, it became a conflagration.

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

Cite this as: *BMJ* 2018;363:k4593

PERSONAL VIEW Mark Taubert

Doctors need to talk about dying, but what if patients start the conversation?

A recent report highlighted how difficult it can be to introduce the topic of end-of-life care, but a change in culture would help break the taboo on both sides

I was talking to Neil, an IT worker in his 50s with advanced cancer, about his wishes for when things got worse over the coming year. What would he want medics to try if he was unable to communicate; were there any interventions he'd want to forgo? Neil and I had never met before and already we were talking about the big taboo topic: our dying moments and death.

A recent report by the Royal College of Physicians (RCP) highlighted how doctors struggle with talking about dying, making them reluctant to broach the subject. It concluded that many people are so focused on the benefits of modern medicine that talking about the inevitable—dying—seems like an unpleasant distraction, a waste of time.

Doctors and nurses can be willing colluders in patients' and their families' narrative ("Let's fight this and beat cancer"). Some patients may even feel that talking about death and dying implies that a doctor knows something they don't.

I've often been mildly apologetic when I start talking about advance care planning and what lies ahead, but acknowledging this is sometimes a good way in: "I'm sorry to bring something up that may seem a bit alien—especially since you're feeling better at the moment—but have you thought about what you'd like to happen, and not happen, when you get very unwell in the future?"

When I raised this with Neil, he understandably needed time to think things through and talk with his family—these conversations often don't take place in just one sitting. Neil had questions about what each intervention might do and what the pros and cons were. We talked; I gave him my views and a video about cardiopulmonary resuscitation.

Some patients may feel that talking about dying implies that a doctor knows something they don't

Societal attitude

My patients and their loved ones react quite differently to this kind of conversation. It must feel like the rug is being pulled out from under you. But then has society not informed this reaction? If so, then perhaps a societal change in attitude can help.

BMJ OPINION Kent Buse and Sarah Hawkes

Do health services lead or lag on gender equality?

Former US president George HW Bush may have declared that "this gender thing is history," but current political discourse suggests that the matter of gender is alive and kicking.

Governments have signalled their intention to move away from the idea that gender is a lens through which we understand people's opportunities to realise their own health and wellbeing. We have seen a range of such interventions, from the withdrawal of funding for academic departments that study gender, to threats to replace the word "gender" with "woman" in UN human rights documents. Through such moves, states have confirmed their disavowal of gender as a social construction

that highlights how position, power, and interpersonal relationships affect the health outcomes of people throughout their lives.

Against this ideological backdrop, there are signs that global health organisations are moving in the opposite direction, embracing gender equality as a way to improve health outcomes. The inaugural report of the Global Health 50/50 (GH5050) initiative, which seeks to advance action and accountability for gender equality in global health, reviewed the policies and practices of 140 organisations with an influence on or interest in health. It revealed significant variation, with scope for improvement across the board.

We contacted those organisations' leaders and asked them to make one public commitment to improve gender equality in the coming year. This "GH5050 Challenge" has triggered solid commitment from around 20 organisations.

This week, to coincide with the Women Leaders in Global Health conference in London, GH5050 launched a report with a snapshot of the commitments. These include publicly committing to gender equality and clarifying how the organisation defines gender and gender equality. They also involve adopting policies to create gender responsive programmes, such as disaggregating data by sex, and a

I spoke to our hospital's patient and carer liaison group recently, and one of them believed that the taboo around this conversation may be decreasing. She felt that patients and their families can be well placed to turn the tables on their doctor and ask the question themselves: "Can we talk about dying?"

I hope that the report by the RCP, with its recommendations for doctors and other healthcare practitioners on how best to begin this conversation, starts a separate debate on whether patients can bring this up with their doctor. Twitter has been very vocal on this topic recently, with many patients recounting how they took control of the consultation.

Turning the tables

When Neil came to the hospital after my initial chat, he had made up his mind. He saw a different doctor who later came to me and said he was taken aback by Neil's frankness and expertise on this topic. "I thought he wanted to chat about chemo. He did, but he also said that he wanted a DNACPR (Do not attempt cardiopulmonary resuscitation) form filling in and he talked about where he wants to spend the last days of his life. It thrust me into a conversation I don't often have. But it was good."

Perhaps, when patients turn the tables on doctors and start the advance care planning discussion themselves, we will see the start of a change in culture. Until then, doctors must do all that we can to find good ways of starting compassionate, but realistic, conversations about serious illness.

Mark Taubert is a consultant in palliative medicine, Cardiff University School of Medicine
mtaubert@doctors.org.uk

Cite this as: *BMJ* 2018;363:k4648

range of measures to create gender equitable workplaces.

The leadership shown by some global health actors should be celebrated. They have taken steps to improve the working environment for women, including measures that help to improve equality and parity in the workplace. Our report also showed that only a fifth of organisations had gender parity on governing bodies or female board leaders. Fewer than a third had women executive directors.

The gendered nature of roles, behaviours, activities, attributes, and opportunities that any society considers appropriate for women and men, girls and boys, and people with non-binary identities exerts a significant impact on health outcomes. It also determines how institutions respond to the needs, health, and career of every person.

There are signs of gender equality being embraced as a way to improve outcomes

The commitments being made to improve practice suggest that the tide is turning towards greater recognition of the importance of both gender and the goal of gender equality in global health. Signs are indeed encouraging that together we can make this gender inequality thing history.

Kent Buse, PhD, Chief, Strategic Policy Directions, UNAIDS, Co-Founder GH5050 supported through UNAIDS agreement

Sarah Hawkes, co-founder and director GH5050 and professor of global public health, University College London

BMJ OPINION Matt Morgan

Health is not a lack of disease

I am standing in my pyjamas looking into the bright white interior of my refrigerator after a gruelling seven days at work. To help nourish my tired body, I don't know whether I should reach for the eggs to make an omelette or the milk to add to cereal.

Although the dog needs to be walked, perhaps a high intensity training session in the gym would be better for my heart. At 3 pm, my week of poor sleep catches up with me. Should I take a nap, have an early night, or just stick to my normal sleep pattern to ensure maximum recovery? Although I have been caring for the sickest patients in the hospital all week, I don't know how to best promote my own health. It seems that as doctors we are experts at malfunction, but distinctly novice at promoting function.

However, health is not the opposite of disease. Many people are free of disease, but very unhealthy in both physical and psychological terms. The promotion of health to help reduce disease inequality and as a preventative measure needs, therefore, to be borne through a different route from me—a doctor of disease.

Perhaps we should admit that as "disease professionals" health is not our bag

How should discovery and dissemination of health be achieved? Perhaps we should admit that as "disease professionals" health is not our bag. My CrossFit instructor knows far more than I ever could about injury prevention, muscle strength, and cardiovascular health. Matt Walker's book *Why We Sleep* blows the average doctor's insight into the importance of rest out of the water. Perhaps this should be accepted, embraced, and promoted by health services to ensure better preventative medicine.

Of course, reliance on unregulated others also carries risks. The lack of regulation in the health industry gives much space to pseudoscience and personality based advice. I haven't seen many well conducted, double blind, randomised control trials on the use of vaginal eggs to promote "energy" for example.

An alternative is to develop a new breed of doctor who can concentrate on function rather than malfunction. A fusion of exercise physiology, occupational medicine, mental health, sleep medicine, and nutrition. They would not treat disease, but promote health. This could be delivered, not in hospitals or GP surgeries, but in coffee shops, gyms, and places of work. While they still may not be able to disentangle the answers to low *v* high carbs, they would at least be trained in the methods to try to do so. Concentrating on this function may reduce the burden on doctors like me who can only treat malfunctions.

Matt Morgan is a consultant in intensive care medicine and research and development head at University Hospital of Wales

ANALYSIS

Productivity in the NHS: why it matters and what to do next

A clear strategy for increasing staff output is vital for healthcare's sustainability, argue **Jennifer Dixon and colleagues**

KEY MESSAGES

- Sustainable increases in productivity don't necessarily mean working harder or cutting staff and resources
- Large gains can be made from good management and ensuring staff welfare and training in quality improvement methods
- Technology has a big potential role, but the NHS could be smarter in scanning for opportunities, evaluating them, and supporting staff to implement them
- Incremental changes over several years can add up to substantial improvements

Earlier this year, the prime minister announced a financial settlement for the NHS over the next five years of 3.4% real terms growth, or £20.5bn a year by 2023-24.[1] Although greater than the 1.5% growth over the past eight years, the settlement is less than the long term average of 3.7% and the 4% recommended after recent detailed analyses.[2] It will not be enough to modernise the service or head off difficult decisions about what services and treatments to provide. These decisions will be easier if the NHS is able to get more out of the funding it receives, which requires a focus on productivity.

Productivity is not normally a centrepiece of reforms to the NHS, but it should be. Paul Krugman, the distinguished US economist, put the issue starkly: "Productivity isn't everything, but in the long run it is almost everything. A country's ability to improve its standard of living over time depends almost entirely on its ability to raise output per worker."[3]

However, productivity is a subject guaranteed to kill the attention of clinicians and patients. Clinicians associate it with working harder—something viewed with derision in today's resource squeezed stressful working environment—and patients with cutting costs. Policy makers highlight new technologies that "disrupt" usual working practices as being the key to higher productivity—a narrative that can easily alienate staff and often omits the need to support staff to introduce and adapt new innovations, without which diffusion is slow. It is true but a cliché that increasing productivity means working more effectively not necessarily harder, reducing waste not sacrificing quality.[4]

Consistent with the rest of the economy[5] and international best practice,[6] productivity of the NHS is calculated by measuring how much output is produced from resources (inputs). The output measure attempts to capture both the amount and the quality of care, including waiting times, survival rates, patient reported outcomes, and preventive primary care.[7] Inputs include the number of doctors, nurses, and support staff providing care, the equipment and clinical supplies used, and the hospitals and other premises where care is provided.

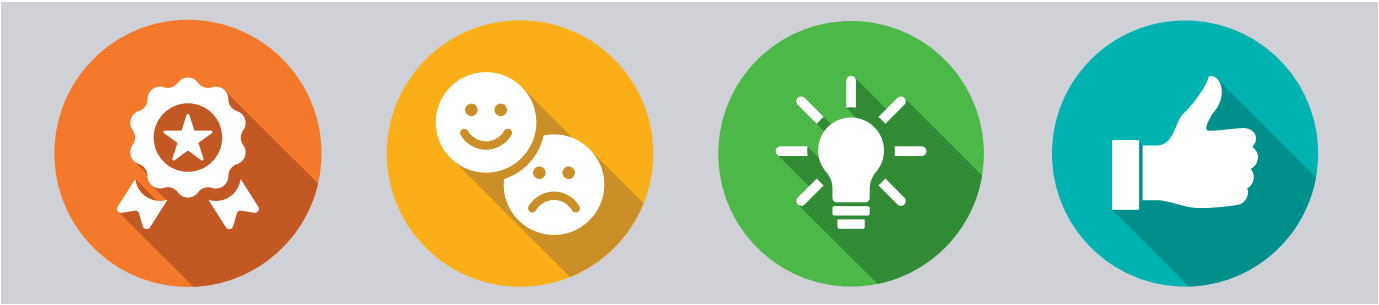
Until 2008, productivity growth in the NHS (with adjustment for quality) more or less tracked that in the wider economy. But since 2009, it has averaged 1.4%, easily outperforming that in the wider economy of 0.2%.[8] However, recent productivity gains have occurred mainly because of restrictions in staffing levels[9] rather than a purposeful strategy. This clearly is not sustainable in the long term. What should the NHS now do?

What can help to increase productivity?

Welfare and morale

Studies across several sectors report that the health and welfare of staff influences their productivity.[10] The NHS has one of the largest workforces of any organisation in the world, and about 70% of the costs in the NHS are from employing staff. Work is often physically, emotionally, and psychologically demanding as the service runs 24 hours a day, 365 days a year.

The NHS staff survey is a barometer of morale, engagement, and stress levels across England and results vary widely by trust. In 2017, 38% of the



487 727 staff who responded reported feeling unwell because of stress in the past 12 months.[11] The annual findings could feature much more highly in the assessment of performance by trust boards and regulators (Care Quality Commission and NHS Improvement) and be linked to scrutiny of management practice and leadership style of the organisation. It is no coincidence that trusts rated by the CQC as high performing, such as Salford, Northumbria, East London Foundation Trust, and Frimley/Wexham Park, score highly on the staff survey. GPs don't participate in the staff survey, but a 2015 survey conducted by the Commonwealth Fund of GPs from 10 countries found that 59% of those from the UK said their job was extremely or very stressful, a higher proportion than elsewhere.[12]

The sickness absence rate for all those working in the health sector amounts to 3.5%, considerably higher than the rate of 2.9% for the public sector as a whole and 1.7% for private sector workers.[13] Public Health England estimates that the cost of sickness absence by NHS staff is £2.4bn a year: reducing absences by one day per person a year would save around £150m (roughly the cost of 6000 full time staff).[14]

The NHS is already investing in initiatives to improve physical and mental health and wellbeing in the workplace.[15] These include promoting healthy food choices in the workplace, the cycle to work scheme, uptake of flu vaccination, mindfulness, and other prevention and self-management support, as well as targeted support such as counselling and physiotherapy. These types of interventions are effective,[16] yet implementation is highly variable across the NHS.

Productivity is a subject guaranteed to kill the attention of clinicians and patients. Clinicians associate it with working harder—and patients with cutting costs

Training in service improvement

The productivity of staff could be boosted considerably if every one of the 1.3 million workers, particularly clinical staff, is supported through training to improve their everyday work. Most trusts rated by the CQC as outstanding have some kind of structured programme to build this capacity in staff.[17] One example is the flow coaching programme, part funded by the Health Foundation and delivered by Sheffield Teaching Hospitals NHS Foundation Trust.[18] This has trained hundreds of NHS staff in team coaching and improvement science skills and is based on coaching programmes that have proved successful in the US.[19] Clinical and non-clinical coaches receive face-to-face training to run weekly "big room" meetings, which bring together a range of staff and patients involved in a clinical pathway to discuss, plan, and review improvements.

Flow coaching academies have now been set up in seven trusts across the UK to drive improvements in patient experience and patient flow through pathways of care and reduce unwarranted variations in processes and outcomes, working cultures, and behaviours. "Why has it taken me 20 years to be introduced to these skills," remarked one consultant recently, on learning how to improve the flow of patients through her department. "How could I do my job properly without them?" The royal colleges of general practitioners, surgeons, and physicians are among those taking the initiative by encouraging their members to train in quality improvement. But these efforts are still the exception and not yet the rule.

Good management

Good management is critical, and its large effect on productivity in many different types of organisations has been quantified convincingly over the past decade.[20] Highly productive organisations work at it for years, management working with frontline workers to design improvements with constant monitoring, investment, and incentives. The lessons include that small everyday changes, built up over years, add up to highly reliable and constantly improving operating processes.

To achieve this healthcare needs effective and stable management and an engaged workforce. The benefits are reliable, safe, and less wasteful care for patients—that is, important productivity gains. Although the NHS has recognised the need to improve the quality of leadership practised by clinical and non-clinical leaders,[21] the focus on boosting good operations management has been much weaker. This needs to change.

Workforce planning

One way to increase productivity is to substitute costly with less costly staff where appropriate.[22 23] But since 2010, the number of expensive hospital consultants has increased by 22% while the number of nurses has increased by just 1%.[24] Shortages have resulted from too few staff being trained, or attracted from other countries, to meet present and future demands.[25] If demand outstrips the supply of labour, staff command higher wages, irrespective of their productivity. Clearly the NHS needs to improve workforce planning.

Technology

Staff also need the right equipment and technology to do their jobs. One of the reasons why labour productivity is lower in European countries than in the US is that US companies have invested more heavily in capital and technology,[26] a process termed capital deepening.[27] The prime minster and the secretary of state have recently emphasised the promise of artificial intelligence, data analytics, and robotics.[28] And in a recent book on the future of the professions, Richard and Daniel Susskind describe these and other new and assistive technologies that are likely to substitute for some tasks currently carried out by doctors and make work processes more reliable and cheaper.[29]

But the NHS has been experiencing capital shallowing rather than deepening as capital funds have been raided to fund hospital deficits, leading to a backlog in maintenance and limited investment in technology.[30] And although the government's recent industrial strategy includes investment in the life sciences, the objective is less about technology to improve the productivity of the UK's largest industry (the NHS) and more on developing businesses to boost the wider economy in the UK. Without further attention, opportunities to boost productivity in the NHS will be missed. The answer includes protecting capital funding from raids and better scanning, experimentation, and evaluation of technology for their effect on productivity in the NHS than is the case today.

Reduce variation

Another way to improve productivity is to reduce variation in clinical care, as this may indicate wasteful activity.[31] Several important initiatives already exist. For example, in England,

Small everyday changes, built up over years, add up to highly reliable and constantly improving operating processes

Getting it Right First Time (GIRFT) is a clinically led, data driven programme to improve value in hospital care[32] and Rightcare supports clinical commissioning groups to improve cost effective care and reduce variation.[33] Clinical audits also seek to encourage better clinical outcomes partly by identifying variation against established guidelines. All of these are useful and rely on data to highlight the need for change.

But once variation is identified, the support to help clinicians make change is inadequate. We have already discussed efforts by trusts and some royal colleges to build staff capability in quality improvement. The NHS could also learn from clinical networks such as the ImproveCareNow initiative in the US, where networks of clinicians and patients work together to set priorities for improvement and use quality improvement techniques combined with data to make effective changes.[34]

Reduce perverse incentives

Increasing productivity does not just mean doing more of the same with the same or fewer resources, but also adding more quality for the inputs. More quality must include producing better health—for example, such that costly hospital admission is avoided when appropriate. Each year more patients are treated in hospital, and paradoxically this has boosted productivity: the more patients treated, the higher NHS output. This kind of higher output may represent poor quality care, and productivity measures need to be developed that better account for this.

If the NHS is failing to deliver the right sort of care in the right places, something may be wrong with the incentives for organisations and individuals. The national tariff payment system incentivises hospital treatment because the more patients that hospitals treat, the more they are paid. Transformation funds have been used to subsidise hospitals in deficit[35] in some parts of the country, frustrating plans to shift care out of hospital. Inadequate primary, community, and social care support are resulting in avoidable hospital treatment: the biggest increase in hospital admissions over the past 10 years is for same-day treatment for older people.[36] These areas need urgent attention.

Making change happen

There is clear scope for the NHS to boost productivity. Some of the ingredients to do so are already in place, but others clearly are not. Disruptive technologies that will enhance productivity may be on the horizon, but their effect is uncertain and they will require investment and staff support to be realised. In the meantime productivity gains can continually be made at the front line of care, with patients and clinicians having a large part to play supported by technology, and at the intersection between healthcare and other services. Incremental improvements on these multiple fronts could add up to make all the difference. This won't happen by chance: an overt coordinated strategy for productivity is now needed and must be included in the forthcoming 10 year NHS plan.

Jennifer Dixon, chief executive, Health Foundation, London
jennifer.dixon@health.org.uk

Andrew Street, professor of health economics, Department of Health Policy, London School of Economics and Political Science, London

Dominique Allwood, assistant director of improvement, Health Foundation, London, UK

Cite this as: *BMJ* 2018;363:k4301

MAKING DOCTORS BETTER

Doctors' wellbeing—is anybody listening?

Everything that Gerada et al say about doctors' wellbeing is correct (Editorial, 6 October). But despite reading similar observations in articles, editorials, and letters, not just in *The BMJ* but in other medical and non-medical publications and other media over the past year, nothing has changed. Are those who can bring about change, making doctors better and keeping their patients safer, actually listening?

The proposals for a cure (and prevention is always better, as we know) are going to take time and proper investment. Should we not also, as a matter of urgency, be calling for the provision of high quality occupational health services and support, not just for doctors but for all healthcare professionals experiencing organisational stress or burnout? And let's stop using the term "resilience," which implies that the problem, even fault, lies with the individual who is affected.

Dil Sen, clinical senior lecturer, Manchester

Cite this as: *BMJ* 2018;363:k4652

Self care support for GPs

A relative of mine is a therapist. He had a year of psychotherapy as part of his training and has ongoing supervision for his wellbeing. Annual appraisal for GPs feels like an exercise in checking that we are safe and up to date and cannot be described as supporting our wellbeing.

We need more support to say "enough is enough." In general practice there is no protection from incoming workload—with a shrinking GP workforce and growing consultation rate, finding time to set aside for self care is difficult. Practices can help create a supportive workplace, but only if those in leadership are coping. Paradoxically, many GPs are opting for locum work to protect themselves from stress, but I have found great support in the patients I have developed relationships with by being a list holding partner and having continuity of care.

Negligence manslaughter cases may have set things back, but I am hopeful that we can re-focus attempts to create a no blame culture and foster better institutional compassion for healthcare workers. At present, however, "the system" still feels institutionally hostile.

Mark Sage, GP, Edenbridge

Cite this as: *BMJ* 2018;363:k4655

LETTER OF THE WEEK

Accreditation lacks its own verification

The King's Fund found that Care Quality Commission audits had little impact on quality of care (News Analysis, 6 October). Oxebridge Quality Resources put this in the wider context, saying that placing confidence in related systems from the ISO does not prevent loss of life.

Compliance with such standards is equated with "quality." But these standards lack anything more than anecdotal evidence of their efficacy, effectiveness, or value.

Narrative papers from single centres report positive outcomes from ISO laboratory accreditation. But the data assessing accreditation of multiple hospital or laboratory sites remain negligible and unpersuasive.

The non-clinicians who devised ISO systems were unaware of the problems of screening, and most clinicians didn't know of the standard's controversial history.

Professional oversight could deliver genuine quality more economically than unprovable compliance systems. In pathology, an optimal balance of quality and cost may need no more than attention to qualifications and training; technical and medical oversight of internal quality control; external technical and interpretive proficiency testing; and external oversight.

Modifying these principles for different care settings would enable streamlined systems that assure quality for patients without diminishing the lives of staff. Then we could publish strong evidence on how well they work. They may be superior.

Ian G Wilson, consultant clinical microbiologist, Belfast

Cite this as: *BMJ* 2018;363:k4647

Dysfunctional view of illness

The article on doctors' wellbeing raises some salient points. Systemic solutions are important, but the article ignores a major concern—the behaviour of doctors when they are ill.

Doctors often ignore illness or seek different pathways of advice and treatment because medical culture can encourage, consciously or unconsciously, the hiding of illness.

The availability of a "special doctors only service," such as the Practitioner Health Programme, may reinforce the belief that illness is something to be embarrassed about, especially if the service undertakes a "protective" role.

If we don't tackle the fundamental matters of changing doctors' beliefs and recognising the importance of collaboration and coordination with employers and educational support services, the measures outlined in the editorial may make only temporary improvements. And doctors will continue to have dysfunctional health related behaviour that may affect patient care and future illness.

Ian Aston, consultant occupational physician, Nottingham; Harj Kaul, consultant occupational physician, Leicester

Cite this as: *BMJ* 2018;363:k4657

WORKFORCE

NHS Resolution provides performance assessment

Sooltan calls for a national body to assess the performance of doctors (Letter of the week, 1 September). We draw attention to the NHS Resolution's Practitioner Performance Advice service.

We are an independent, advisory body with a remit to resolve concerns about the performance of doctors, dentists, and pharmacists. One of the key ways we do this is through assessments of individual practitioners, which provide a comprehensive, impartial, and evidence based view of clinical performance. This is a detailed, workplace based assessment, which includes direct observations of practice and a review of clinical records, carried out by appropriately qualified clinicians from the same specialty as the practitioner.

Patient safety is at the heart of what we do, and our assessments support both healthcare organisations and practitioners to resolve performance concerns in a safe, fair, and timely way.

Sanjay Sekhri, acting director, Karen Wadman, acting director, Practitioner Performance Advice, NHS Resolution

Cite this as: *BMJ* 2018;363:k4522

Philippa Howlett

Cardiology registrar (b 1980; q Edinburgh 2005; MRCP), died from cancer on 27 November 2017

Philippa Howlett ("Phil") moved to London after her foundation training, and decided on a career in cardiology. While working towards a training number, she used her time as a registrar at the Royal Surrey Hospital, where she is remembered for her exceptional dedication to patient care, as well as her impeccable fashion sense and ability to perform all tasks in high heels. Phil's interests within medicine were broad and she undertook her doctorate research into mechanisms and prevalence of atrial fibrillation. She was diagnosed with cancer at the age of 34, shortly after being awarded a training number in cardiology, which she was never able to take up. During her illness, Phil's energies were occupied with her beloved Cocker Spaniel, Rufus, and her little narrowboat, *Sloe*.

Simon Pearse, Kate Pearse, Rosemary Howlett, Ian Howlett

Cite this as: *BMJ* 2018;363:k4317

Michael Robert William King

Consultant radiologist (b 1972; q King's College London 1999), died from glioblastoma on 26 April 2018

Michael Robert William King ("Mike") studied natural sciences and undertook an MSc in engineering and physical science in medicine at Imperial College, London, before completing his medical degree. At Queen Alexandra Hospital, Portsmouth, he became director of breast screening in 2012. He later also became joint clinical director. Always passionate about medicine and working for the NHS, he held himself and others to a high standard. He possessed a brilliant mind and intellect, but he will mostly be remembered for his humour and kindness. Mike appreciated good food and wine, enjoyed electric guitar lessons, and loved sport. For someone who claimed to be "socially awkward," Mike had an enormous number of friends, and he is so deeply missed. He leaves his wife, Zephy, and two daughters.

Angelique Beling, Pete Osborn, Manish Patel

Cite this as: *BMJ* 2018;363:k4316

Jeremy Oliver Neil Lawson

Consultant paediatric surgeon, London (b 1927; q St Mary's Hospital Medical School 1952; FRCS Eng, FRCPCH), died from a stroke on 17 July 2018

Jeremy Oliver Neil Lawson was appointed consultant paediatric surgeon to St Thomas' Hospital and Westminster Children's Hospital in 1971. He also visited Queen Mary's hospitals in Roehampton and Carshalton. His particular interest was in paediatric urology and Hirschsprung's disease and the anatomy of the rectum and anus. He published several papers, contributed chapters, and taught medical students. After retiring from the NHS in 1990, he continued in private practice for five more years. In his spare time, he showed a keen interest in archaeology and history. He was working towards publishing an anatomy paper in his 80s. Predeceased by his wife in 2015, he was diagnosed with Alzheimer's disease in 2017. He leaves three children and five grandchildren.

Richard Lawson

Cite this as: *BMJ* 2018;363:k4314

Ronald Matthew Pollock

Regional medical officer; director, MPA Health Strategy and Planning (b 1928; q Cambridge/ Middlesex Hospital 1957; FFPH), died from old age on 12 September 2018

Ronald Matthew Pollock held posts in medicine, surgery, trauma services, and radiotherapy at the Middlesex Hospital in London before becoming a general surgeon in Scotland. In 1967 he joined the Oxford regional health authority and became chairman of the planning team responsible for the development of the John Radcliffe Hospital. He subsequently served as deputy regional medical officer before becoming regional medical officer in 1987. After retiring from the NHS in 1992 he established a consulting firm with his colleague, Howard Goodman. He had extensive experience in strategic planning and was involved in introducing the methodology more widely into the NHS. He leaves four daughters and five grandchildren.

Emma Parkin

Cite this as: *BMJ* 2018;363:k4260

Stephen Charles Wyndham Rowlands

General practitioner Trowbridge, Wiltshire (b 1953; q St Mary's Hospital Medical School, London, 1976), died from cutaneous T cell lymphoma (mycosis fungoides) on 17 November 2017

Stephen Charles Wyndham Rowlands ("Steve") started a career in anaesthetics, but changed to general practice in 1980. In his first training post at Northwick Park Hospital, he met his future wife, Chris. After working abroad for four years, Chris and Steve returned to the UK and settled in Trowbridge, Wiltshire, where Steve completed his GP training before taking up a partnership at Bradford Road Medical Centre. He stayed in this practice for 27 years and retired from clinical practice on his 60th birthday in 2013. He became unwell in early 2017 when his longstanding mycosis fungoides sadly became aggressive. He leaves Chris, three children (one a doctor), and a grandchild.

Megan Rowlands

Cite this as: *BMJ* 2018;363:k4256

Anthony J Winterton

General practitioner Chippenham, Wiltshire (b 1929; q St Mary's Hospital Medical School, London, 1954), died from cardiorenal failure on 8 September 2018

Anthony J Winterton ("Tony") read medicine at St Mary's Hospital Medical School in London, where he played a great deal of rugby. In 1956 he joined the New Road practice in Chippenham, Wiltshire, where he became a partner a year later and remained for more than 35 years. Tony met Elizabeth ("Beth") at school, and they married in 1956. In Chippenham, he worked hard to maintain the existence of the four local hospitals and served for 10 years on the Wiltshire area health authority and local medical committee. He worked until the age of 80, when he was annoyed that the General Medical Council brought in a ruling stopping doctors working beyond 80. Tony leaves Beth, three sons (one a doctor), and seven grandchildren (one a doctor).

N Whyatt

Cite this as: *BMJ* 2018;363:k4255

Peter Fisher

Homeopathic physician to the Queen

Peter Antony Goodwin Fisher (b 1950; q Cambridge 1976; FFHom, FRCP), died in a bicycle crash in Holborn, London, on 15 August 2018

Peter Fisher was probably the nearest anyone will ever get to being homeopathic royalty: homeopathic physician to the Queen, president of the Faculty of Homeopathy, and chair of the World Health Organization's working group on homeopathy. But what made him remarkable was his singleminded determination to promote homeopathy despite the unrelenting flood of criticism and scientific evidence against it. His career was a masterclass for politicians on how to stay on message. Vowing that he would "debate anyone, anytime," he was an accomplished writer and speaker.

Perfect timing

Fisher could not have chosen a better time to start specialising in homeopathy. He graduated from Cambridge in 1976 during the evolution of the new "pick 'n' mix" medical culture and amid a growing realisation that care professionals could never provide the personal engagement many patients wanted. The thalidomide scandal had shaken public faith in modern medicines, and homeopathy and other forms of complementary medicine were coming in from the cold—with a helping hand from Prince Charles and an unquestioning media that gave more prominence to royal patronage than to evidence based medicine.

But Fisher's conversion to unorthodox medicine and homeopathy was far removed from the turmoil in the NHS. A self confessed communist revolutionary during his student days, he was one of the first Westerners to go to China after US President Richard Nixon's historic visit in 1972, which had ended 25 years of no communication or diplomatic ties between the two countries.

In what was a life changing trip, Fisher saw a woman on an operating table in a provincial hospital, her entire abdomen open, having half her stomach resected. Her anaesthesia consisted of three needles in her left ear. This was, he thought, not something that he "had been taught in Cambridge." For a while he considered studying traditional Chinese medicine.

He first used homeopathy himself after developing an unspecified complaint. After "various distinguished physicians" claimed that nothing could be done for him a US friend recommended "the magic of the minimum dose." In 2012 he was interviewed for the World of Homeopathy website and recalled: "The first thing [after taking the remedy], I had a terrible aggravation. It made me realise at least it did something. And then it helped, and that sort of started the ball rolling."

Formerly an honorary consultant rheumatologist at King's College Hospital, Fisher was at the time of his death director of research at the Royal London Hospital for Integrated Medicine (formerly the Royal London Homeopathic Hospital), Europe's largest centre for integrative medicine. For more than 25 years he was also editor in chief of *Homeopathy*, the only Medline indexed homeopathic journal (a status he was extremely proud of). His elevation as a fellow of the Royal College of Physicians enraged many other doctors.

He became homeopathic physician to the Queen in 2001 and claimed to have treated her entire family. Prince Charles was a particular ally who, Fisher noted, was "very friendly and not afraid to stick his neck out."

Challenges

But his role as a homeopathy champion became increasingly challenging. In 1993 Edzard Ernst gave up a prestigious chair in Vienna to become the world's first professor of complementary medicine at the University of Exeter. Complementary medicine specialists initially saw Ernst's appointment as a golden public relations opportunity, but he quickly built an international reputation for successfully applying science to test the value of alternative therapies.

Peter Fisher's career was a masterclass for politicians on how to stay on message

In a Head to Head debate with Ernst in *The BMJ* in 2015 (Should doctors recommend homeopathy?), Fisher urged doctors to put aside any bias based on the alleged implausibility of homeopathy, arguing that, when integrated with standard care, it was safe and popular with patients and that it improved clinical outcomes without increasing costs.

But Ernst argued that the £3m-£5m that the NHS spent on homeopathy would be better used elsewhere and that, although patient choice was important, it should be evidence based.

June's High Court ruling upholding NHS England's decision to stop funding homeopathic remedies did nothing to dampen his ambition or campaigning zeal. He had turned a speculative eye on polypharmacy in elderly patients, arguing that little attention had been given to alternatives.

Fisher married Nina Oxenham in 1999. They were divorced in 2017. He leaves two daughters.

John Illman, London
john@jicmedia.org

Cite this as: *BMJ* 2018;363:k3611

FROM THE ARCHIVE

A reunited Germany

Twenty nine years ago today, people were chipping away at the Berlin Wall with hammers and chisels as Germans crossed the border between east and west Germany. Less than a year later, Germany became a single state. How did unification affect health? In November 2000, Ellen Nolte and Martin McKee wrote in *The BMJ* (*BMJ* 2000;321:1094) that "it is beginning to be possible to assess what this impact has been."

Nolte and McKee looked at mortality rates and found that "the immediate post-unification period was characterised by an increase in deaths in the east, with life expectancy falling by almost a year among men, although by only 0.1 year among women. This was owing primarily to a rise in deaths from injuries and violence, reflecting the sudden availability of western cars but also to an increase in homicides. This worsening mortality pattern has resolved, although deaths from injuries have only now returned to their pre-transition levels.

"The rapid transition did, however, usher in a period of sustained improvement in health that exceeded even the most optimistic predictions. Between 1992 and 1997, life expectancy at birth increased by 2.3 years in males and by 2.4 years in females." What specific factors account for these changes, ask Nolte and McKee. "The most likely explanation is a rapid change in diet, reflecting greater availability of fruit and vegetable oils." While "a second factor seems to be an improvement in the quality of medical care. Finally, a general improvement in living standards among elderly people seems to have contributed to the fall in deaths at older ages."

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"Knowledge of what an intensive care admission means is highly variable. There are some physicians who have a very good grasp of what intensive care means and there'll be others that don't. It doesn't necessarily mean that they're bad doctors, it just means they haven't necessarily had the experience or been exposed to intensive care. So this is where I think we need to promote ourselves as a specialty and work collaboratively with our colleagues in other specialties; it's all about giving the patient the right information at the right time to allow them to have an input into the care that they would want."

Jamie Gross, a consultant in intensive care medicine, discusses how patients or their families often don't understand fully the implication of an ICU admission and how this can be improved.

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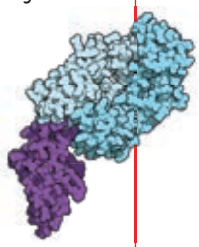

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A special collection on the future of primary healthcare

The Alma Ata declaration of 1978, which stated that primary healthcare would be essential to obtaining the goal of "Health for All" by the year 2000, was a pivotal moment in public health. While this vision proved to be beyond reach, 40 years later the approach championed by the declaration remains a blueprint for countries striving to achieve health for all.

In support of these principles and to further debate, *The BMJ* has produced a special collection that brings together content on the progress and future of primary healthcare.

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