comment

“The NHS doesn’t exist to provide commercial opportunities” **DAVID OLIVER**
“A multi-professional model risks creating a nightmare scenario” **HELEN SALISBURY**
PLUS GPs playing *Game of Thrones*; consultant turned patient's relative

TAKING STOCK Rammya Mathew

GPs are attempting to do too much

GPs in the UK are well known for providing a comprehensive service. But the demands just keep growing. Much of the additional work making its way into general practice is in the guise of “new models of care,” driven by an ambition to provide “care closer to home.” But, if we consider the current landscape in general practice—workforce shortages and high rates of burnout—policy makers might be accused of a little wishful thinking.

An example is clinical commissioning groups incentivising practices to provide electrocardiogram (ECG) services for patients. Saving patients the hassle of travelling to their local hospital is a noble aspiration. But it’s not such a good idea when GPs are offered no cardiology input to interpret the ECGs and when their funding for providing the service is paltry next to the amount offered to local trusts.

I’m not ashamed to admit that my ECG interpreting skills aren’t on a par with those of a cardiologist. And, when I’m already working 10-12 hour days, it’s not a good use of my time to find a cardiologist to look at the ECGs I can’t interpret.

Another concern is the explosion of new drugs on the market and the growing pressure to prescribe more of these in primary care. Gone are the days when metformin and gliclazide were the only drugs GPs were armed with to treat type 2 diabetes. And, in many areas, GPs are now routinely expected to initiate high risk drugs such as the newer oral anticoagulants. Is it worth compromising patient safety for the sake of efficiency—or even for patient convenience?

Many GPs argue that the profession thrives on variety and that we can gain much job satisfaction from resolving patients’ problems rather than referring them on and inadvertently providing a more fragmented service. But the idea of being a GP is not to be a specialist in everything but to be a specialist in people: helping them to make sense of their health, supporting them in decision making, and advocating for them in a healthcare system that can be daunting and difficult to navigate.

Azeem Majeed, professor of primary care at Imperial College London, has repeatedly warned that “GPs in the UK are trying to do too much—both in terms of the number of patient contacts they have each day and the range of clinical work they undertake.” I agree, and I’d argue that policy makers need to exercise caution when looking to pack more into an already overloaded job description.

GPs enjoy variety, autonomy, and being specialists in their own right. But, when we’re already on our knees, it isn’t going to take much more for an indispensable profession to keel over.

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The idea of being a GP is not to be a specialist in everything but to be a specialist in people

PERSONAL VIEW
Tom Nolan

PCNs are coming and the Night’s Watch can’t protect us

The primary care networks deadline looms for GP practices, but even *Game of Throne*’s style solutions cannot answer all the questions

If there was an award for innovative ways of sending GP partners over the edge, primary care networks (PCNs) would win—and not because there’s a lack of competition. Other entries this year include Capita, the NHS e-referrals service, Babylon, and people who sit in meetings referring to how many different professional hats they wear.

PCNs are what everyone in primary care is talking about. GP practices have until mid-May to form networks of practices, which cover a population of between 30 000 and 50 000 patients. Over five years, money will be poured into these new organisations, funding an army of social prescribers, pharmacists, physiotherapists, physician associates, and any other non-GP role that NHS England can think of.

PCNs will also, from next year, be asked to sign contracts with other organisations to deliver care together. This is what PCNs are really about, we’re told. Yet nobody can tell me who these partner organisations will be and what work we’ll be doing. “Social care, community services, voluntary sector,” I hear people with clinical commissioning hats on say, as they mentally flick through their favourite working-at-scale PowerPoint slide deck.

We’re frantically forming alliances, breaking them, forming new alliances, and stabbing each other in the back

Despite not really understanding what this means, forward we go, considering whether to run our PCNs through federations or set up as a limited company or through a nominated practice. “You need to have a company,” say those in federation hats, “because of the liabilities.” What liabilities?

“For all the staff,” they say. Your head spins: don’t we employ staff already?” And what about VAT?” You look around to see if anyone else is confused, or to check if someone’s filming you—maybe it’s a practical joke.

BMJ OPINION Matt Morgan

Hello from the other side

It’s that strangely timed phone call while you are at work. Too early in the day to be a simple hello, too late to be telling you that you’ve forgotten your lunch. You answer expecting something to be wrong, and you’re right. Your partner’s voice is shaking and upset. They need your help.

I’ve been on the other side of the doctor-patient relationship a few times in my professional life. My mum having cancer, my dad having emergency surgery, as well as the unfortunate incident during my stag do that is not for these pages. This time was different. This time my wife told me that her brother was critically ill, being cared for in a hospital I know well, by people I know well, by a specialty that I am a part of.

During the short drive to the hospital, I mentally rehearsed how I should behave. I was there as a supportive husband, a brother in law, a friend. I would act as the bridge between the medical speak of the team and my family’s worries. I wasn’t there as an intensive care consultant. All I wanted for him was the best care that the NHS should be providing to all of its patients, not special care.

As I walked onto the familiar intensive care unit, it felt different. I felt different. It was as if I left Dr Matt Morgan to one side and stepped forward in the shoes of the other me. I wasn’t fully a relative, yet neither was I fully a doctor. This surprised me. I expected to care most about the facts of medicine. Was he easy to intubate? Is he on the correct ventilator settings? Does he have broad spectrum antibiotics prescribed? What is the diagnosis? Yet these were not the things at the front of my mind.

Instead, I cared about the greeting that the receptionist gave, how clean the toilets

Eight kings

The next stage, once you've understood that you need to be careful about VAT and liabilities, is to group together. To reach the 30 000 patient mark, for an average sized practice of 9000 patients like ours, means finding at least three other practices to work with. It's like a cross between *Game of Thrones* and *Doctors*.

In our version of Westeros, we have eight kings. Over the past few weeks, we've been frantically forming alliances, breaking them, forming new alliances, and stabbing each other in the back. I won't say it isn't fun, but we're only in season one. Before too long I know I'll either be burnt at the stake or, more likely, turned into a white walker (sessional GP).

In the meantime, the clock is ticking, and sign our network agreement we must. We're in the position where the practices we really want to work with are too far away, and the practices we're happy to work with don't want to work with each other. As for the practices we have our differences with but with whom we ought to join for the greater good—over my dead body (that is, the series three finale).

I know I'm not the only GP partner tearing my hair out right now. I'm not the only one lying in bed at night, running through the options in my head, over and over again, each time coming to the same, inevitable, conclusion: networks are coming. And for that, PCNs deserve an award.

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were, whether the doctors pronounced his name correctly. And when I was asked what advice I had for my in-laws, my response also surprised me. I didn't advise on what tests should be done next, or what procedures he needed to have. Instead, I simply said, "Make sure you bring in a photo of him with his son and put it on the end of his bed."

I wanted to short circuit the disease identity mentality that we are all guilty of in the intensive care unit. I wanted to bring back humanity to counteract the bright digital physiology of critical illness.

When you say hello from the other side, it is often the things that you think about the least during a busy clinical shift that you really care about. And so, I think, do patients.

Matt Morgan is honorary senior research fellow at Cardiff University, a consultant in intensive care medicine, head of research and development at University Hospital of Wales, and an editor of BMJ OnExamination

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ACUTE PERSPECTIVE David Oliver

The TaxPayers' Alliance, Hancock, and health technology

On 24 April the TaxPayers' Alliance published a report on the potential benefits of automation for the NHS and social care. It included an enthusiastic foreword by the health secretary, Matt Hancock.

The report states, "There are barriers to entry into the NHS for companies offering innovative healthcare solutions. Many are being addressed and in the long term it's crucial the NHS remains open to new ideas and innovation." These "barriers" prevent entry to a tax funded service used by taxpayers.

But the NHS doesn't exist to provide commercial opportunities. The NHS should define the challenges technology could meet, rather than technology being forced on it—and should insist on rigorous evaluation and evidence.

Hancock has made adopting technology in the NHS a key mission. He's called for a "tech revolution" in the NHS and social care, insisting on a common set of mandatory open standards for IT providers. Those who can't meet these will be "phased out." He insisted on opening the NHS market to providers of "off the shelf" technologies rather than having it develop its own solutions.

What he did not insist on was rigorous evaluation or independent appraisal. It's not clear whether private sector providers will continue to hide from freedom of information requests because of commercial sensitivity. It seems that health technology will be held to different standards of evidence than other service innovations or treatments, focusing on rapid adoption and faster access to the market.

The TaxPayers' Alliance report—*Automate the State*—is labelled on its website as "research." It says that the "potential value of time released for NHS staff through improved productivity from increased automation is estimated to be £12.5bn a year." It provides a few examples of innovation in practice, but it isn't "research" as I understand it. No methods, workings, or peer review are in evidence, making it hard to scrutinise the claims or to look for biases.

Meanwhile, the alliance itself is a concern. Its name suggests a mandate to represent taxpayers, but its agenda is one of a small state and greater marketisation of public services. Yet many taxpayers support strong public services, including a free-at-point NHS, and want less marketisation. The alliance has also been criticised over transparency about its funding sources, their provenance, and its methods.

I'm a taxpayer. I work for the NHS. And I think Hancock should be far more careful about which organisations he endorses or promotes if he doesn't want to alienate staff and service users alike.

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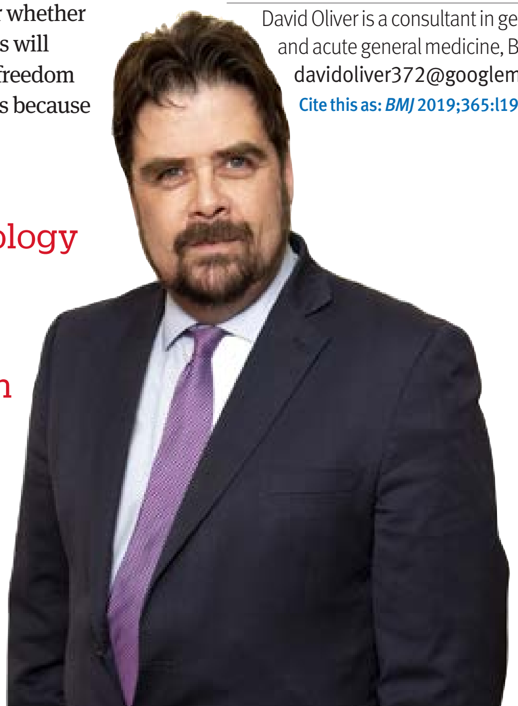
It seems that health technology will be held to different standards of evidence than other service innovations



PRIMARY COLOUR Helen Salisbury

Alone in a darkened room

In some general practices, patients seeking help or advice may be seen by a doctor but could equally be given an appointment with a nurse, paramedic, physician's associate, or pharmacist. This may look a sensible—and cost effective—solution to the current GP workforce crisis.

However, all patients still need a registered GP who ultimately bears responsibility for their care. In this new, multi-professional model, most evident in some more commercial practice chains, individual GPs can end up with list sizes of more than 4000 patients.

When my last patient leaves the surgery at the end of the day, I usually have two or three hours' more work to do. I'll be looking at lab results, signing off prescriptions, reading clinical correspondence, and writing referral letters and medical reports. I admit that I could be more efficient—hours 10, 11, and 12 of my working day tend to be a bit slow—and our systems could be improved, too.

Even with streamlined processes, however, many decisions have to be made, and GPs bear responsibility for any that can't easily be put into a protocol and delegated. Does this marginally low haemoglobin need investigating? That will depend on multiple features of the patient and the history, which may be clear if you know the patient and requested the test but will require more digging if this arose from someone else's consultation. Is it OK for this patient to continue taking his antidepressants even though he hasn't responded to several requests for a review? This is much easier if you made the original diagnosis.

Taking decisions is tiring. We spend our lives making judgments about what's safe, what's reasonable, and what risks are acceptable. It's even more exhausting when the information we need to make those decisions isn't at our fingertips, in the shape of a patient we already know. In these situations we're likely to become more risk averse, calling patients back for further investigations or appointments, or referring more to secondary care, with a consequent drop in efficient use of resources. There's also a serious risk of burnout in ourselves.

We risk creating a nightmare scenario in which GPs spend most of their time alone in a darkened room, staring at a computer screen. We'd no longer do much of the job we chose and trained to do: consulting with patients we know, diagnosing, treating, caring, supporting.

I'm appreciative of the skills of other primary care staff, and I look forward to working with an extended team: we may at last be recruiting a pharmacist at my practice who we hope will improve the quality of our prescribing. But, no matter who does the consultations, GPs will still bear overall responsibility for their patients, and this is an increasingly heavy burden as fewer doctors take a share of that load.

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Taking decisions is particularly exhausting when the information we need isn't at our fingertips, in the shape of a patient we already know

LATEST PODCASTS

Could open access have unintended consequences?

Our latest Head to Head article asked "Should I publish in an open access journal?" and in this podcast we're joined by some of the authors to debate their position.

David Sanders argues that "equity is crucial for healthcare and that's a global issue. We've had such profound digital changes over the past two or three decades and to allow everybody to have equity of access to me seems like an entirely reasonable principle."

James Ashton worries that while the principle behind having open access is sound, "the current system is inherently unfair towards those who don't have the ability to pay." He points out that it risks introducing a bias towards "those researchers and those within industry, who have the finances to be able to publish their results."

Patient Dave deBronkart underlines what is at stake in this debate, observing that "nobody can achieve the best possible results if they don't have access to all the available information."

Gypsy and traveller health

In the UK, Gypsy and Traveller communities are often overlooked by society and formal healthcare services. In this podcast we're joined by Michelle Gavin and Samson Rattigan, who work in East Sussex to bridge the gap between the healthcare system and those who identify as Gypsies or Travellers.

Michelle explains how past research has shown that "Gypsy and Roma traveller people have significantly worse health outcomes and lower life expectancy." As Samson cites, "30% of Irish travellers don't live beyond 60." They explain how access to health and education contributes to this and offer some simple ways in which GPs and hospitals can support this neglected group.

Catch up on all of *The BMJ*'s latest podcasts at bmj.com/podcasts

Edited by Kelly Brendel, deputy digital content editor, *The BMJ*

How organisations can contribute to improving the quality of healthcare

Naomi Fulop and **Angus Ramsay** argue that we should focus more on how successful institutions and their leaders create the culture and infrastructure that facilitate better care

Improving the quality of healthcare is complex.[1,2] Frontline staff are often seen as the key to improving quality—for instance, by identifying where it can be improved and developing creative solutions.[3,4] However, research and reviews of major healthcare scandals acknowledge the contributions of other stakeholders in improving quality, including regulators, policy makers, service users, and organisations providing healthcare.[5,6]

The lessons have potential relevance to all settings

KEY MESSAGES

- The contribution of healthcare organisations to improving quality is not fully understood or considered sufficiently
- Organisations can facilitate improvement by developing and implementing an organisation-wide strategy for improving quality
- Organisational leaders need to support system-wide staff engagement in improvement activity and, where necessary, challenge professional interests and resistance
- Leaders need to be outward facing, to learn from others, and to manage external influences. Strong clinical representation and challenge from independent voices are key components of effective leadership for improving quality
- Regulators can facilitate healthcare organisations' contribution by minimising regulatory overload and contradictory demands

Policies on the role of organisations in improving quality have tended to focus on how they might be better structured or regulated. However, greater consideration is required of how organisations and their leaders can contribute to improving quality: organisations vary in both how they act to support improvement[7,8] and the degree to which they provide high quality healthcare.[9]

Some earlier studies suggest that high performing organisations share several features reflecting organisational commitment to improving quality. These include creating a supportive culture, building an appropriate infrastructure, and embedding systems for education and training.[10,11] Subsequent reviews of quality inspections[12] and reviews of evidence on factors influencing quality improvement,[9] and board contributions[13] indicate that organisational leadership is crucial in delivering high quality care.

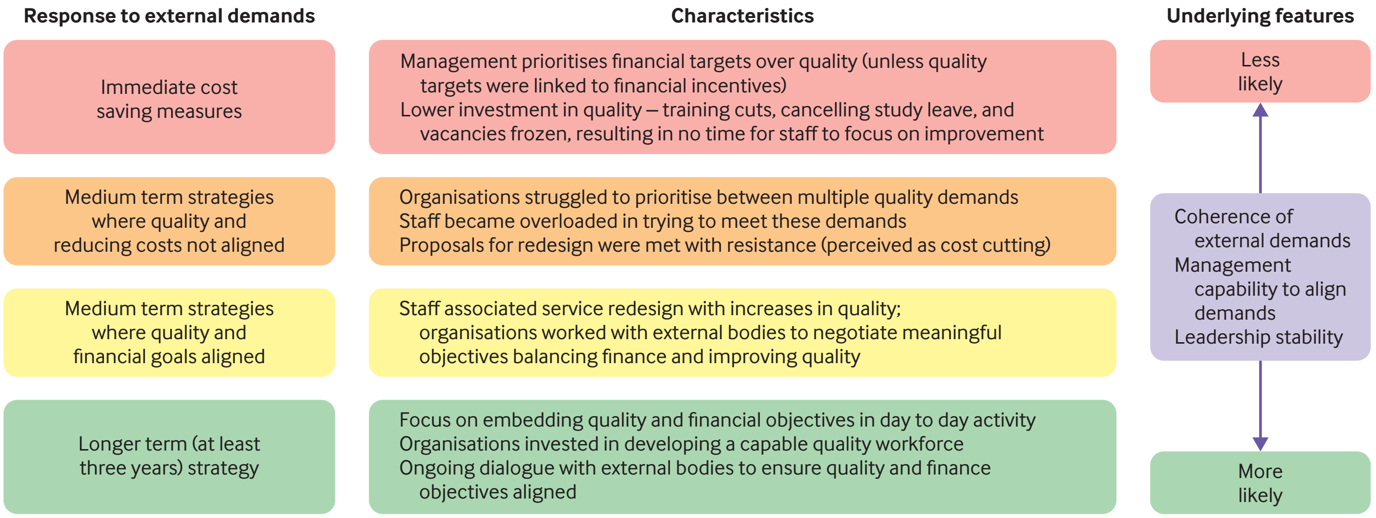
We discuss how organisational processes such as development of a strategy and use of data can be used to drive improvement, the characteristics of organisations that are good at improvement, and what to consider when thinking about how organisations can help improve quality of healthcare and patient outcomes.

We present evidence on the role of organisations in improvement drawn from acute hospital settings in the UK and other countries. Although contexts may vary—for example, in whether health policy is made at regional or national level, or in the form and function of healthcare organisations—the lessons have potential relevance to all settings.

Placing healthcare organisations in context

Health systems operate at three interrelated levels: macro, meso, and micro (box 1). Research suggests that an organisation—through its leadership and processes—can bridge these levels to influence the quality of care delivered at the front line.[14-16]

A key macro influence on organisations performing their role in improving quality is the way the healthcare system is



Response to external demands	Characteristics
Immediate cost saving measures	Management prioritises financial targets over quality (unless quality targets were linked to financial incentives) Lower investment in quality – training cuts, cancelling study leave, and vacancies frozen, resulting in no time for staff to focus on improvement
Medium term strategies where quality and reducing costs not aligned	Organisations struggled to prioritise between multiple quality demands Staff became overloaded in trying to meet these demands Proposals for redesign were met with resistance (perceived as cost cutting)
Medium term strategies where quality and financial goals aligned	Staff associated service redesign with increases in quality; organisations worked with external bodies to negotiate meaningful objectives balancing finance and improving quality
Longer term (at least three years) strategy	Focus on embedding quality and financial objectives in day to day activity Organisations invested in developing a capable quality workforce Ongoing dialogue with external bodies to ensure quality and finance objectives aligned

Fig 1 | Leading and implementing system-wide change across organisations: centralising acute stroke services in London and Greater Manchester[25-28] governed and regulated. Regulation provides accountability to the wider system and therefore has a potentially strong influence on how healthcare organisations approach improvement. For example, multiple regulators in healthcare systems, as is the case in England, can lead to “regulatory overload,”[17] making it hard for organisations to focus on quality improvement rather than quality assurance[18] because of the need to respond to different (and potentially conflicting) regulatory approaches, priorities, incentives, and sanctions.[17-20]

How can organisations contribute to improving quality?

Organisations can use various levers and processes to translate external inputs (such as policy and regulatory incentives) and internal inputs (such as local assurance systems providing data on performance and capacity) to support quality improvement.[7-21] Organisations can facilitate improvement by developing and implementing an organisation-wide quality improvement strategy[9-23] that includes the following actions:

- Using appropriate data to measure and monitor performance[20-22]
- Linking incentives (both carrot and stick) with performance on quality[16,22]
- Recruiting, developing, maintaining, and supporting a quality proficient workforce[21]
- Ensuring sufficient technical resources and building a culture that supports improvement.[9,16]

Many of the key organisational activities important to improving quality, such as setting strategy and agreeing performance measures, are defined at organisational level by the board.[13] Bottom-up, clinician led improvement is often seen as the answer to the quality challenge, and it is an important part of successful quality improvement.[3,24] However, relying solely on frontline staff to lead improvement is risky because professional self interest can shape or limit the focus of improvement activity.[22-26] Furthermore, lack of system-wide or organisation-wide agreement on objectives might result in variations at system level, reflecting localised priorities rather than what is likely to provide the best care for patients. As well as empowering staff and supporting system-wide staff engagement in activity around improving quality[4,20] organisational leaders must challenge localised professional interests, tribalism, and resistance to change.[18,22]

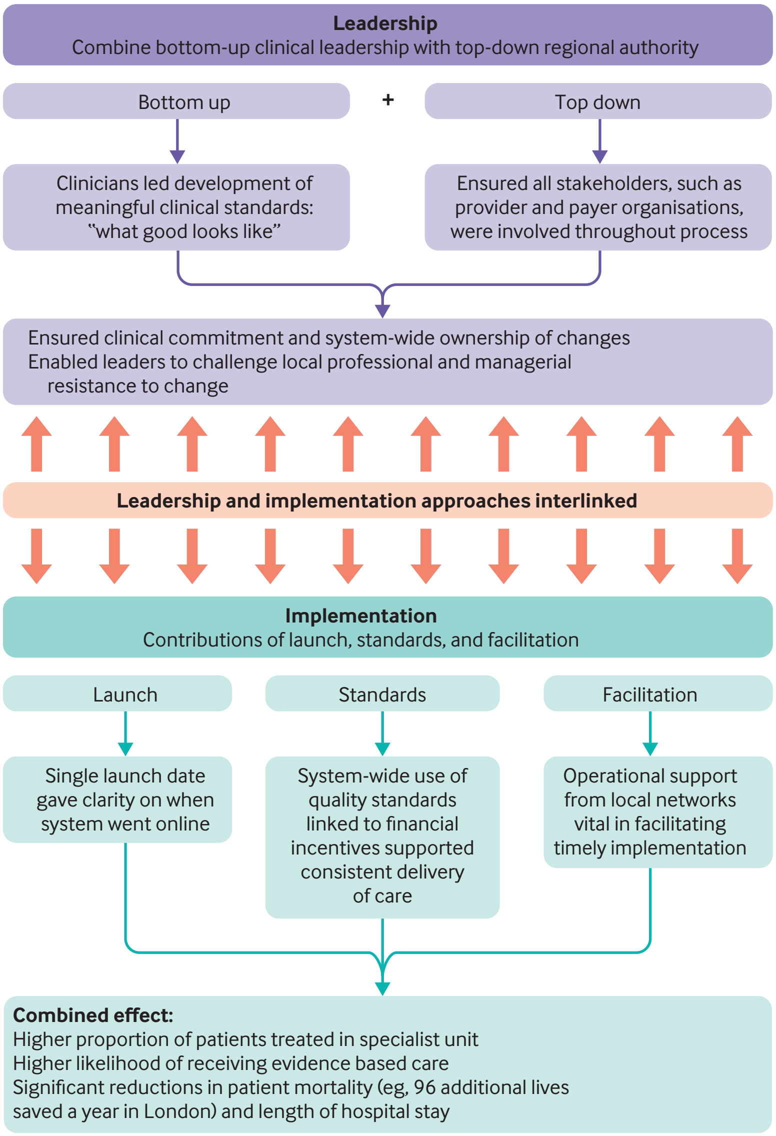
The reorganisation of acute stroke services in the UK (fig 1) shows how leadership can play a pivotal role in managing professional and organisational resistance to changes that aim to improve quality of care. Importantly in this case, leaders cited external organisations’ priorities and public consultation responses when holding the line against local resistance to change.[25]

The culture of organisations is commonly considered important in improving quality, as discussed elsewhere in this series.[20-30] Although the relation between culture and quality is complex, organisations can use formal and informal processes to influence culture and thus improve quality of care.[30]

What helps organisations contribute to quality?

As set out in box 1, the relation between a healthcare organisation and its external environment (especially regulators) is important in that organisation’s contribution to quality.[18,23] A qualitative study of hospitals and their external environments in five European countries showed how some were better able to align multiple financial and quality demands.[7] Figure 2 shows contrasting organisational responses

Fig 2 | How hospitals respond to external finance and quality demands[7]



Leadership
Combine bottom-up clinical leadership with top-down regional authority

Bottom up + Top down

Clinicians led development of meaningful clinical standards: “what good looks like”

Ensured all stakeholders, such as provider and payer organisations, were involved throughout process

Ensured clinical commitment and system-wide ownership of changes
Enabled leaders to challenge local professional and managerial resistance to change

Leadership and implementation approaches interlinked

Implementation
Contributions of launch, standards, and facilitation

Launch: Single launch date gave clarity on when system went online

Standards: System-wide use of quality standards linked to financial incentives supported consistent delivery of care

Facilitation: Operational support from local networks vital in facilitating timely implementation

Combined effect:
Higher proportion of patients treated in specialist unit
Higher likelihood of receiving evidence based care
Significant reductions in patient mortality (eg, 96 additional lives saved a year in London) and length of hospital stay

Box 1 | **Macro, meso, and micro contributions to the quality of healthcare[14]**

Macro (national health systems)

- Regulatory system
- Finance
- National priorities and policies
- Accreditation

Meso (hospitals)

- Strategies
- Systems
- Processes
- Cultures
- Practices
- Structures

Micro (departments, teams)

- Relational issues
- Communication
- Professional work
- Competence

to external demands and the features of both the external demands and the organisations that contributed to these different responses.

Organisations can also contribute to improving quality through participation in (or leading) major system change, working beyond their own catchment areas across their local system—for example, integrating health and social care services[31] or centralising specialist acute services across multiple hospitals in a given area.[32 33] Evidence suggests that how such changes are led and implemented influences the impact of the changes, including on patient outcomes (fig 1).

Box 2 | What helps organisations contribute to quality?

Organisational process
- An organisation-wide quality strategy to shift from external assurance to prioritising improvement
- Combine hard and soft data to drive quality
- Engage and communicate with stakeholders, including patients and carers, staff, and external partners
- Build culture of trust, supporting innovation and problem solving

Organisational leadership
- Support system-wide staff engagement in improving quality
- Be outward facing, to learn from and manage external context
- Challenge local professional interests where necessary
- Feature a strong clinical voice and independent challenge, especially on the board

Underlying features
- Space to think about improving quality
- Resources to implement improvements
- Coherent external requirements: avoid regulatory overload and contradictory demands
- Stability of leadership

What do organisations that do well in improving quality look like?

Research suggests that organisations that deliver high quality care show high commitment to improving quality, reflected for instance in how organisations are led (eg, senior management involvement) and managed (eg, use of data and standards). As an illustration, fig 3 (see bmj.com) contrasts the approaches taken by US organisations with high patient mortality from acute myocardial infarction with those that have low mortality.

Some recent research has developed the concept of maturity in relation to how boards of organisations govern for quality improvement and what organisational processes accomplish and sustain it.[18]

More mature boards tend to use data to drive improvements in quality rather than merely for external assurance,[18 20] and they combine hard quantitative data on performance with soft data on personal experiences to make the case for improvement.[22] They also engage with relevant stakeholders (including patients[18] and the public), translate this into strategic priorities,[9-11] and have processes for managing and communicating information with stakeholders.[8-18] They value learning and development[4-34]—for example, drawing on external examples of good practice to achieve initial improvement then focusing on local, creative problem solving for continued improvement.[34] Finally, these organisations are outward facing, engaging with and managing their wider environment, including payers and other provider organisations.[7-34]

By contrast, organisations with lower levels of such capabilities (such as lack of coherent mission, high turnover of leadership, and poor external relations) appear to slow or limit improvement.[18-36] Some interventions have been identified to help organisations struggling to improve quality.[35] Furthermore, research on organisational turnaround provides evidence of organisational leaders harnessing crises, such as major safety issues or financial difficulties, to drive radical change and improvement.[36 37]

Key changes to turn round organisations have included refocused accountability systems (eg, making quality a key performance indicator, devolving accountability to clinical teams[11 38]), introducing processes to facilitate improvement (eg, dedicated improvement roles,[36 38] increased training opportunities, and sharing data on quality and cost with clinical teams[11-38]), supporting culture change (eg, increasing collaboration between clinicians and management[11-38] with clinicians leading on quality and management supporting them), and learning from the experience of other organisations.[11-38] However, for such interventions to have a chance of success, organisations need both sufficient space to think and the people to make change happen.[23]

Organisations need both sufficient space to think and the people to make change happen

The composition of senior leadership seems to influence how well organisations deliver on quality. Having clinicians on the board has been associated with better organisational performance,[23 39] through enhanced decision making, increased credibility with local clinicians (facilitating frontline uptake of policy), and making organisations more likely to attract talented clinicians.[39] Active discussion of strategy is enhanced by independent challenge by non-executives who are well versed in quality issues; this is likely to enhance focus on quality at board level, ensuring it is at the heart of an organisation's vision and strategy.[13] As noted elsewhere, focus is growing on service users guiding improvement.[40] However, it has been challenging to involve service users meaningfully at senior leadership level.[41]

What can we conclude?

Although organisations are central to improving quality, there is much variation in how they contribute, both locally and at system level. We have described ways in which organisations can contribute to improvement in terms of their processes (such as how they develop strategy and use data to drive improvements in quality), their leadership (such as how leaders engage with and manage both their external context and local professional interests), and underlying features (including coherence of external demands and leadership stability). Box 2 summarises these themes. However, the balance of priorities among these is unclear: organisations will want to analyse how they can maximise their contribution to improving quality, taking account of their particular context.

Regulators and policy makers also need to consider how they can better facilitate healthcare organisations' role in improving quality. Organisations are more likely to deliver quality improvement effectively if externally set objectives are clear and manageable, and there is time and resources with which to meet these. Regulators should seek to avoid generating regulatory overload and contradictory demands; and they should strengthen organisational leadership's hand by giving them headspace to look beyond compliance and prioritise improving quality.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Raising awareness of the health effects of environmental exposures

von Ehrenstein et al's research on prenatal and infant exposure to ambient pesticides and autism spectrum disorder in children is welcome and timely (Research, 23 March).

Exponential growth in the number of environmental hazards is unmatched by research on their effects on health. Doctors are increasingly called to deal with the health effects of industrialisation (including cancers and reproductive effects) but are often ill equipped to understand their causation and to effectively manage them.

The challenges in establishing environmental causation of disease should not be underestimated. These include practical issues in conducting experimental and non-experimental research; multifactorial causation of many diseases, including interaction of genetic and environmental factors; limited knowledge of the biological pathways through which environmental influences exert their causal effects; and difficulties in testing causal inferences. These factors are often compounded by the lay interpretation of the findings of environmental health research and the public's perception of risk.

Environmental medicine deserves a more prominent place in medical curriculums. Environmental health research should be actively promoted despite the practical, financial, and societal barriers. Tackling the root cause of disease through elimination or substitution of hazardous agents should rank higher than implementing cancer screening or biological monitoring.

Raising awareness of the health effects of environmental exposures will empower doctors to counsel their patients and influence public health policy more effectively.

Anna Trakoli, consultant in occupational medicine, Bradford

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DIGITAL HEALTH

Health apps don't comply with good practice

Despite continuing concerns over Babylon Health's GP at Hand (News Analysis, 23 March), the company has been distributing a leaflet to residential addresses in London with the strapline: "Get well now."

As well as implying instant relief of symptoms after a telephone consultation, the flyer also states: "Prescriptions delivered to the pharmacy of your choice within an hour." Prescribing without examining a patient is extremely poor medical practice and is fraught with risk for both professional and patient. It doesn't fit with GMC guidance on good practice.

GMC guidance also advises doctors to "check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving." But the NHS app—designed to be a digital "front door" for all NHS patients—is unable to connect with any providers of online GP consultations.

My complaint about the leaflet to the Advertising Standards Authority was rejected; the promise about prescribing was justified on the dubious grounds that "both the patient and the consultant GP are aware that a physical examination will not be possible through a virtual appointment such as this."

We urgently need guidelines on robust evaluation of computerised diagnostic decision support directed at patients for safety, efficacy, effectiveness, and cost.

John Puntis, consultant paediatrician, Leeds

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ANTIBIOTIC USE

Don't blame doctors for trying to manage patient expectations

Glover et al claim that there is little evidence to show that patients are unreasonably pressuring GPs for antibiotics (Personal View, 23 March). Similarly, there is little evidence that doctors are always "blaming" patients for antibiotic resistance.

Some patients do expect to receive antibiotics. UK doctors are taught to manage patient expectations using the ICE (idea, concern, expectation) model, which has been shown to reduce unnecessary prescribing (though not specifically of antibiotics).

We should continue to harmonise patients' expectations and doctors' clinical judgment

If financial incentive was the main reason for overprescribing antibiotics, wouldn't fee-for-service doctors decline antibiotic prescribing so they can claim for a follow-up?

We should continue to harmonise patients' expectations and doctors' clinical judgment in a professionally appropriate way. Rxfiles, which provides drug information to Canadian doctors, has designed "prescription pads" for non-prescription of antibiotics for upper respiratory tract viral infection, available in multiple languages.

We must acknowledge that antibiotic overuse is multifactorial, rather than blame solely doctors or patients for the problem.

Eugene Y H Yeung, physician, Lancaster

Cite this as: *BMJ* 2019;365:l1895

DIETING AND BODY SHAMING

Political correctness has trumped common sense

I'm not sure what Kar is trying to say about body shaming (Partha Kar, 23 March). He implies that some people cannot lose weight, and he conflates food choice (or lack of) with weight gain. Political correctness risks creating intellectual paralysis; we seem to have lost sight of common sense.

Inequality shouldn't stop us from doing our job or patients from losing weight. If a patient only eats beans on toast, eating less will make them lose weight. Advising them that they cannot lose weight unless they eat tofu and kale is nonsense.

Many of my patients are healthcare assistants, porters, and cleaners who can't afford more than basic foods. If they don't lose weight, they risk losing their jobs. They want to know how. We talk about exactly what they eat for each meal and discuss how they can cut down portion size and what they can eliminate or substitute. Those that succeed all tell me the same thing: "I ate less." They need good, common sense advice, not politically correct silence.

Anthony N Williams, consultant occupational physician, Temple Ewell

Cite this as: *BMJ* 2019;365:l1902

FORMULA MILK ADVERTS

Why do mothers choose formula in the first place?

Godlee and colleagues aptly point out that the reasons for falling rates of breastfeeding are multifactorial, including social circumstances and, perhaps, advertisements for formula (Editorial, 23 March).

Banning formula adverts may shift focus from the root cause of its use in the first place. Formula being used more often is not evidence enough that it is being used just because it is available—some mothers have had to make this choice with heavy hearts. Before formula was available, we had "wet nurses," a much superior alternative to formula for women who could not breastfeed for whatever reason.

Banning adverts but keeping products on shelves is not a solution: we need to ask why mothers are pushed to make this decision. Would making human breastmilk more readily available make a difference?

For now, as a GP I am interested in knowing what formulas are available and what my patients are using as an alternative or in addition to breastmilk.

Bushra Wahid, GP, Mount Maunganui, New Zealand

Cite this as: *BMJ* 2019;365:l1893

NITROUS OXIDE

Monitoring nitrous oxide in hospitals

Acharya and colleagues say that recreational use of nitrous oxide is an emerging public health problem (Editorial, 24 November).

In hospital, nitrous oxide is generally used as an analgesic for short periods, but repeated admissions to the emergency department for acute pain can lead to large volumes being consumed regularly. An extended stay on the labour ward could lead to unrestricted access for several days.

Because administration of nitrous oxide is controlled by the patient and the dose is variable, records of use are often limited or non-existent. Doctors, nurses, and midwives may be unfamiliar with the risks of prolonged use of nitrous oxide, possibly allowing problems to occur. This is accentuated by the general lack of protocols defining safe practice and limits for use.

Perhaps we should be keeping more accurate records of usage in hospitals and making protocols more widespread, particularly for patients at high risk.

Christopher Ward, core trainee year 2 anaesthetics, London

Cite this as: *BMJ* 2019;365:l1906

GP SUICIDES

Lack of support for female doctors

The NHS and its subcontractors do not seem capable of preventing either staff suicides or the demoralising effect on the service. Iacobucci mentions the vulnerability of female GPs (LMC Conference, 30 March).

Across other occupations, women live longer than men, but medical women have earlier deaths than their male peers. Referrals to specialist counselling services are a good idea, but recent changes across the profession mean that universal, non-clinical support from medical peers and mentors might be weakening. Accounts from over 400 trainees show that a serious "lack of care for young medics" is undermining their health.

More than 20 years ago the president of the Medical Women's Federation, Beulah Bewley, realised that systems of support failed to grow with the rising numbers of women qualifying. Newly qualified women were showing more depression and anxiety than their male peers. Today, stress in primary care services is at unprecedented levels.

Woody Caan, editor, *Journal of Public Mental Health*

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RECRUITMENT INCENTIVES

Consultants may value working conditions over money

Trouble recruiting is partly caused by NHS workforce planning, rather than the perceived attractiveness of a specialty (David Oliver, 30 March).

In clinical neurophysiology we turn good candidates away at ST3 selection because Health Education England will not fund more training posts. This is particularly frustrating as there are insufficient numbers of qualifying neurophysiologists to fill consultant posts, only 40% of which have an applicant.

I suspect that most consultants would prefer employers to attract them by creating more pleasant working conditions, opportunities for career development, properly staffed and resourced departments, and a sense of being appreciated rather than being handed a pot of gold.

Gareth Payne, consultant clinical neurophysiologist, Bangor

Cite this as: *BMJ* 2019;365:l1914

DATA FOR IMPROVEMENT

Getting the patient's perspective with qualitative data

Shah makes a good point—if we are to find ways of improving (the quality of) patient care, we need to consider more than one perspective (Quality Improvement Series, 23 February). Quality of care is complex. We can't agree on an objective definition of what it is and how we can use available data to measure it. We must also keep the focus on quality improvement, not on performance targets and accountability.

The Donabedian model and its dimensions of care (structure, process, and outcome) remain as insightful as when it was first proposed over 50 years ago. But getting the patient's perspective on improving the quality of their care needs in-depth analysis based on qualitative data. Interest in these data has been growing since Pope et al published their paper on qualitative methods in 2002.

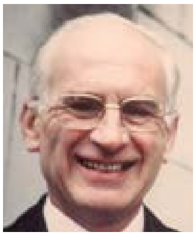
We must include those with experience of qualitative health services research in cross disciplinary studies. Finally, findings must be acted on, and measuring quality improvement must become standard in the training of healthcare professionals and in the running of healthcare organisations. Otherwise, we risk measuring for measuring's sake.

Antonio Sanchez Vazquez, research fellow, Cambridge

Cite this as: *BMJ* 2019;365:l1886

OBITUARIES

Peter John van den Brul



Consultant anaesthetist West Suffolk Hospital (b 1924; q St Thomas' Hospital Medical School 1952; DA, FFARCS) died from the effects of old age on 14 September 2018

Peter John van den Brul spent the early years of his life in the Netherlands. After qualifying he applied for a post in the Colonial Medical Service in order to be near his fiancée, Marjorie (Madge) Masson. From 1954 to 1957 he served as district medical officer in former British Honduras (Belize). Having decided on a career in anaesthetics, he undertook training posts in Bath and, from 1961 to 1964, at the University Hospital of the West Indies in Jamaica. He settled in Suffolk, where he held a consultant post until his retirement in 1985. In his final years, he pursued a passion for gardening, with a special interest in alpine plants. He leaves Madge, three children, and eight grandchildren.

Karen van den Brul, Lucy van den Brul, Nick van den Brul

Cite this as: *BMJ* 2019;365:l1497

Douglas John Pearce

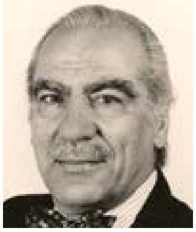
Consultant anaesthetist (b 1926; q 1950 Westminster Hospital Medical School; FFARCS), died after a fall on 21 November 2018

Douglas John Pearce was diagnosed with tuberculosis in his final year of training and had to take a year off for treatment. He was appointed as a consultant anaesthetist in Southampton and worked at three hospitals. Apart from his work in cardiac surgery, intensive care, and pain relief, he was in administrative charge and then chairman of the department from 1964 to 1974. He held many posts in societies and official bodies and introduced a rotation of anaesthetists from the region into the specialist units in Southampton. Douglas retired in 1990 and enjoyed sailing and playing golf. Illness struck again when he had to have a coronary bypass, but he made an excellent recovery, partly thanks to his wife, Margaret, a former nurse. He leaves Margaret, a son, and a daughter.

Malcolm Yorston

Cite this as: *BMJ* 2019;365:l1498

Stephan Elias Tchamouroff



Consultant in genitourinary medicine and HIV/AIDS specialist Brighton and Sussex University Hospitals NHS Trust (b 1933; q St Bartholomew's Hospital, London, 1960; FRCOG), died from complications arising from intestinal pseudo-obstruction on 23 February 2019

During his time as a medical student, Stephan Elias Tchamouroff also trained for a period as a singer but eventually pursued his first love, medicine. Stephan took a consultant post in genitourinary medicine in Brighton in 1979. In the 1980s, his research trials had a crucial role in the global effort to tackle HIV/AIDS. In later years Stephan chaired the BMA's south east coast committee and was president of the Brighton and Sussex Medico-Chirurgical Society. He was a member of the New York Academy of Sciences, an adviser to the British Board of Film Classification, and a member of the British Association of Medical Managers. He leaves his wife, Paula, and a daughter.

Tanya Tier

Cite this as: *BMJ* 2019;365:l1571

J Roger Owen

Consultant clinical oncologist Gloucestershire Hospitals NHS Foundation Trust (b 1948; q Royal London Hospital, London, 1971; FRCP, FCRC), died suddenly from type 1 ruptured aortic aneurysm on 14 December 2018

J Roger Owen started work in Gloucestershire's oncology centre in 1981. He modernised treatment techniques across all modalities and forged clinical and research links that ultimately led to the Three Counties Cancer Centre. In the early 1980s, he joined forces with colleagues at the Institute of Cancer Research and the Royal Marsden Hospital, London, to conduct the Standardisation of Radiotherapy Trial (START-pilot). Roger was lead author on the manuscript reporting results in *Lancet Oncology*. This trial informed the subsequent UK-wide START-A and START-B trials including over 4000 patients. These studies established a new NICE approved standard of care for the UK in 2008 and, subsequently, a new international standard of care. Roger leaves his wife, Marie Owen, also a doctor; three children; and grandchildren.

Sean Elyan, John Yarnold

Cite this as: *BMJ* 2019;364:l1211

James Dodman

Consultant in anaesthesia and intensive care medicine Pinderfields General Hospital, Wakefield (b 1972; q Newcastle 1996; FRCA, FFICM), died from oesophageal cancer on 26 December 2018

James Dodman ("Jim") was appointed a consultant in 2007. His career as an educator flourished because of his superb accessibility, excellent people skills and wisdom, and his highly regarded clinical skill. He rose through appointments as college tutor and training programme director for the Yorkshire School of Anaesthesia, and eventually he also became an adviser on the General Medical Council's fitness to practise panel. Jim was highly regarded by many trainees and colleagues for his fairness; common sense; and engaging, friendly personality. He still contributed to the training side of the career almost to the end. Jim leaves his wife and children, his parents, and his two brothers.

Robert Cruickshank

Cite this as: *BMJ* 2019;365:l1655

David Ivor Keith Evans

Consultant paediatric haematologist (b 1930; q St Thomas' Hospital, 1957; MA (Cantab), DCH, MRCP, FRCP), died from glioblastoma multiforme on 13 June 2018

David Ivor Keith Evans dedicated his career to setting up and running services for children in the north west. He helped develop the leukaemia service at the Royal Manchester Children's Hospital into one of the UK's major centres for childhood cancer. He was co-investigator on a research project to examine the extent of problems raised by sickle cell disorders in Greater Manchester and led a public appeal to raise money to establish a new bone marrow transplant unit. David remained at the Royal Manchester and Booth Hall children's hospitals until his retirement in 1992 and moved south to Oxfordshire in 1999. He pursued his many and varied interests until shortly before his terminal diagnosis in March 2018. He leaves his wife, Brenda; three children; and three grandchildren.

Alison Howarth

Cite this as: *BMJ* 2019;365:l1572

Martin Gore

Early champion of immunotherapy for cancer

Martin Eric Gore (b 1951; q Barts 1974; PhD, FRCP, CBE), died from organ failure on 10 January 2019

Around 15 years ago, Martin Gore, who has died from organ failure after a yellow fever vaccination, emerged from a long clinic for patients with advanced melanoma cancer and voiced his frustrations to a junior colleague. After 20 years of such clinics, he was disheartened to be largely prescribing the same drugs as when he was a registrar.

Within a few years, clinical trials led by his unit at the Royal Marsden NHS Foundation and its partner, the Institute of Cancer Research (where he was professor of cancer medicine), had confirmed the efficacy and safety of new immunotherapy treatments that were extending survival times and even curing some patients.

In 2016, when he received a CBE, he spoke of cancer medicine being “on the cusp of a new era of ever more effective therapies.” He admitted then to “some dark days when improvements in treatment for some appeared unobtainable.”

Unusually, Gore was regarded as an international authority on the treatment of three cancers—melanoma, ovarian, and kidney cancers—each of which had relatively few treatment options until the past decade.

Route to prominence

Gore’s route to prominence and leadership in oncology was an unusual one; having initially worked as a GP in Deptford, south London, after qualifying from St Bartholomew’s Hospital Medical College in 1974. One colleague recalls that Gore felt he was a mediocre medical student who found his true home in oncology.

In 1981 he joined the Ludwig Institute of Cancer Research as a clinical scientist and was awarded a PhD for his work on breast cancer. The early 1980s also saw a stint as a general medicine registrar at University College Hospital London as he completed consultant training.

Gore often used humour to support colleagues working in a specialty characterised by pain and death

Gore was an early and rare enthusiast for the possibilities that immunotherapy offered. He was a coauthor of *Immunotherapy in Cancer* in 1996, and continued to champion its potential after the first tranche of treatments yielded disappointing results and challenging side effects. As one colleague put it, he knew the idea was right but the science wasn’t there yet.

As a senior house officer at the Royal Marsden in 1979, Gore collaborated with Eve Wilshaw in the development of platinum based treatments for ovarian cancer. A decade later, when he returned to the Marsden’s Chelsea site, it was to take up Wilshaw’s post as consultant cancer physician.

This followed several years as senior lecturer at the Institute of Cancer Research, based at the hospital’s south London site, where he also conducted clinics. He was appointed professor of cancer medicine at the institute in 2002. With a key role in training junior doctors, his enthusiasm and support for those on rotation at the Royal Marsden is credited with persuading many to work in what had been a relatively unattractive specialty.

Immunotherapy

As the hospital’s medical director for a decade from 2006, Gore maintained a relatively heavy clinical workload, driven by his wish to link the laboratory to the clinic in the search for new treatments. Working with research institutions, Gore and his clinical team were involved in the development of novel therapeutics in ovarian cancer, melanoma, and renal cell carcinoma, particularly in the area of immunotherapy.

During this period, he began his long working days at 6.30 or 7 am, with 1960s music streaming through his open office door. He was energetic and ebullient, and former colleagues remember him buoying up staff during bleak times—particularly after the major fire at the hospital in 2008.

An extrovert with a naturally cheerful disposition (he took part in student theatrical productions while at Barts), he often used humour to support colleagues working in a specialty characterised by pain and death. They were character traits apparently inherited from his parents, who had fled Poland after the Nazi invasion in 1939. Gore suspected that his father went on to work for British intelligence during the war.

His national roles included chairing the Department of Health’s Gene Therapy Advisory Committee for six years from 2006. The report of an independent review into failings in the breast screening programme, which he co-chaired, was published by the Department of Health and Social Care just weeks before he died. Gore was also a member of the commission on human medicines at the Medicines and Healthcare Products Regulatory Agency and advised the European Medicines Agency on oncology treatments.

He published more than 500 scientific papers and was a coauthor or editor of several textbooks.

The Duke of Cambridge presented him with a lifetime achievement award in 2015, and he was made a CBE a year later.

He leaves his wife, Pauline, whom he met when she was working as a nurse at Barts; and their four children.

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