# comment

> Jeremy Hunt's biggest success as health secretary has been to unite the medical profession—against him

**NO HOLDS BARRED** Margaret McCartney

# A profession united for the NHS

In the ballot on strike action, junior doctors voted almost unanimously in favour (98% of 28 305; response rate 76%).[1] Consultants are offering their full support. GPs have been marching alongside.

Jeremy Hunt's biggest success as health secretary has been to unite the medical profession—against him. What's next? I wish that the Department of Health would sit down with ACAS (the Advisory, Conciliation and Arbitration Service) and the BMA.

Not all of the vast media coverage on this row has been accurate. The BMA, despite wanting the threat of imposition of contract removed, has told me that it is not insisting on the removal of the other preconditions as a prelude to talks (that is, the 22 recommendations of the Review Body on Doctors' and Dentists' Remuneration[2]).

And, clearly, Hunt has presented statistics to tell the story he wants to tell, whether it's about weekend care[3] or consultant cover.[4] Policy based on biased numbers cannot benefit patients.

But we shouldn't see this row in isolation. The US commentator Noam Chomsky described a "standard technique of privatisation: defund, make sure things don't work, people get angry, you hand it over to private capital . . . If it can be privatised it's a huge bonanza for investors . . . And as usual when the system crashes, going back to the taxpayer to bail them out."[5]

Remember Hinchingbrooke Hospital. It was run by the stock market listed company Circle until it left its contract early, citing funding and social care cuts and increases in emergency attendances,[6] and requesting a £10m (€14.3m; $15.3m) bailout from taxpayers as it went.[7]

Chomsky was correct, and the dispute with juniors has got the vultures circling. The Department of Health has framed its row with juniors on erroneous statistics but has told the public that it's all about obtaining a "truly seven day" NHS. We already have one, of course, but one based on need rather than want.

In the political—and truly unevidenced—NHS, the Department of Health continues to flush money away on things that simply don't work. It has failed to show cost effectiveness for private finance initiative contracts, Choose and Book, health checks, telehealth, dementia screening, and so on.

The NHS lolls from one financial crisis to another, but these were not caused by junior doctors. Juniors are essentially being offered a contract with more unsocial hours for less money and with no effective restrictions.[8] Junior doctors should not have to take a hit because the Department of Health doesn't understand evidence based medicine—or why health needs should come above wants.

Juniors will vote with their feet. The NHS will become more unsafe. It will be said to have failed. This dispute may represent a turning point: what do we want to spend money on in the NHS? And whose evidence will we choose to believe?

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Review, p 24

**We fear . . . that doctors who work the longest and most antisocial hours will suffer the biggest pay cuts**

want to strike, but for the good of our patients, colleagues, and the NHS we may have to.

We believe that it is our duty to oppose the imposition of a contract that, in its current form, would threaten patient safety and stretch junior doctors to breaking point. We cannot allow the scrapping of safeguards that limit working hours. Long working hours put patients at risk. What possible motivation could there be to remove these safeguards?

We fear that the contract would mean that doctors who work the longest and most antisocial hours will suffer the biggest pay cuts—this amid understaffing, with up to half of emergency department and general practice training posts unfilled. A deterioration in working conditions would undermine recruitment and retention of juniors. Doctors will leave the NHS, and this will further affect patient safety.

We are also concerned that the proposed contract changes will penalise part time workers and those who choose to start families, and that it will deter doctors from undertaking vital lifesaving research.

I am sure there are many more points of contention, but most of my colleagues agree that these are the key points. This is our narrative, and we have a responsibility to the public to ensure that it is heard.

Is this a winter of discontent for junior doctors? Or is it spring for grassroots junior doctors? I hope it will be the second. It's time to outline a positive narrative. I hope the health secretary, Jeremy Hunt, will want to own it with us, to work towards a safe and fair future for both patients and doctors.

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of diabetes or obesity. Combined with exercise, this regime meant that Pratiksha and Sandeep lost much weight, and Sandeep improved his $HbA_{1c}$ despite a reduction in his drugs. But how sustainable will the changes be?

Will these families get better at identifying and managing harmful behaviours? Will they consult differently? Will they be healthier? Will viewers change their behaviour?

**Will these families get better at identifying and managing harmful behaviours?**

Many people know that their diet and exercise levels are unhealthy. But, by focusing on individuals, did the BBC miss a bigger picture? How do we create a society where work, shopping, eating, and home environments make healthy choices the easy ones? And how do we stop doctors and our healthcare system overinvestigating and overmedicalising people, when it is our broader society that seems in greater need of our medical attention?

There are plenty of ideas out there.

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**ACUTE PERSPECTIVE** David Oliver

# Who is to blame for older people's readmission?

I'm dismayed whenever the wishes of mentally competent older inpatients go unheard or ignored, whether by practitioners or families. As experienced adults with very individual life stories, needs, and wishes, they have the right to take risks, to be partners in decisions, and not to be bypassed or patronised. Even when autonomy is impaired, their individual humanity should be respected.

But population ageing has changed the inpatient demographic.[1] Dementia, delirium, sensory and communication impairment, frailty, and disability all complicate acute illness,[2 3] compounded by a depersonalising institutional environment.[4 5]

Many patients depend on carers if they are to stay at home or to return there. Many carers are themselves older, in worsening health, and poorly supported.[6] Hospital admission can be as unsettling for families as for patients. Involving carers early and often is crucial. We learn more from them than they can from us. And they provide continuity in an often fragmented system.[7]

John's Campaign, started by the writer Nicci Gerrard, has added momentum to a movement to welcome carers on to the

**Involving carers early and often is crucial. We learn more from them than they can from us. And they provide continuity in an often fragmented system**

ward as partners in care. Since 2014 around 100 UK hospitals have signed up to it,[8] scrapping visiting restrictions or issuing "carers' passports."[9] We've done this on my home ward, and we wouldn't turn the clock back.

Gerrard told me, "Carers of people with dementia or frailty worry, with a frantic tenderness and a sense of letting them down, that they will feel abandoned, scared, bewildered . . . Other people who don't know them won't understand their idiosyncrasies and practical and emotional needs . . . they'll be alone in a world they can't navigate.

"Carers can interpret and advocate; stay with the patient in a way nursing staff simply can't; and reassure them in ways that no one else would be able to. They can liberate the hospital staff to do their job."

The benefits can outweigh perceived risks. These have been described at other hospitals such as Heart of England[10] and Nottingham University Hospitals,[11] among others. Time spent communicating during rounds is time saved later. Complaints about poor communication diminish. And additional demands on hard pressed staff can be mitigated: for instance, "visitors' charters" set out limits and expectations.[12]

We need to encourage this kind of approach to make our hospitals fit for the older people who are now their main users.

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# Gordon Thomas Dickinson

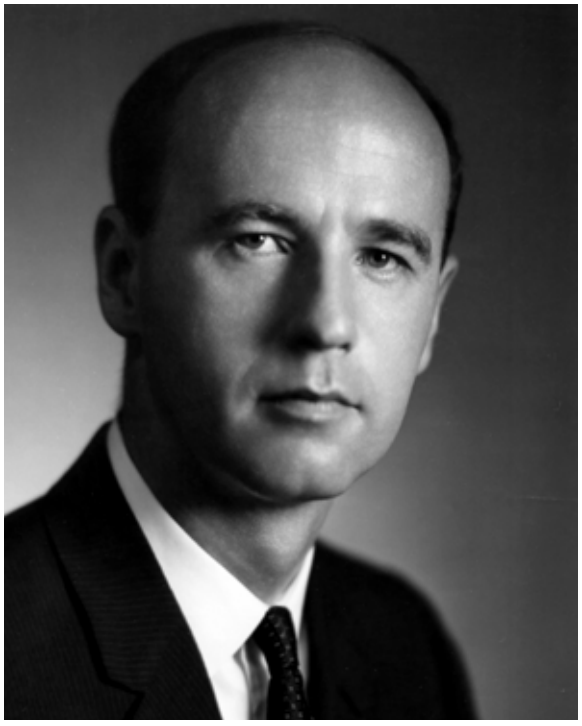
Canadian psychiatrist and medical editor

**Gordon Thomas Dickinson, psychiatrist and *CMAJ* editor (b 1932; q McGill University, Canada, 1958), died suddenly at home on 4 August 2015.**

From general practitioner to journalist to stockbroker to psychiatrist to psychoanalyst: such was the curiously meandering career of Gordon Dickinson, sometime editor of the *Canadian Medical Association Journal* (*CMAJ*). These abrupt changes of direction inevitably had an impact on his family. "Over the time I was married to him," his former wife, Mary Lou, reflects, "I felt like I'd been married to five different people." She accepts the suggestion that her husband seems to have spent much of his working life finding out what he wanted to do. "But also making a contribution on the way," she insists.

Dickinson began his higher education by doing an arts degree. Only afterwards did he study medicine. He did an internship and then spent a year in general practice, both in the US.

In 1960 he noticed an advertisement placed by the Canadian Medical Association for an associate editor to work on its journal. "He'd always wanted to write, though not about medicine in particular," says Mary Lou Dickinson. "But he was interested in a wide range of topics." He applied and was hired by the then editor, Stanley Gilder. Dickinson's introduction to journalism was demanding. Almost immediately the journal switched to weekly publication, and Gilder resigned a month later—he was not replaced for five months. In 1965, when still only 33, Dickinson took over as editor—but only for four years. His employers were sorry to see him go.



His former wife said, "I felt like I'd been married to five different people"

Precisely why Dickinson left is something of a mystery, and even his former wife is at a loss to pin his resignation down to a single factor. He spent the next two years working as a stockbroker for Merrill Lynch. Then came a residency in psychiatry at the University of Toronto. In 1976 he completed his training in psychoanalysis and established a private practice. He retired in 1984 after a heart attack.

In 1962, while working for *CMAJ*, he completed a part time MA in philosophy through the University of Toronto. His leaving gift from the journal was an eight volume encyclopaedia of philosophy.

Gordon Dickinson leaves both his wives and three children.

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# Ivanka Zdenka Matylda Anna Richarda Myskova

Psychiatrist who left her native Czechoslovakia months before the end of the "Prague spring"

Iva's qualifications were initially not recognised, and it took until 1979 for her to gain full registration

**Former associate specialist psychiatrist Queen Elizabeth Psychiatric Hospital, Birmingham (b 1936; q Charles University, Prague, Czechoslovakia, 1960), died from pneumonia after a stroke on 26 October 2014.**

Ivanka Zdenka Matylda Anna Richarda Myskova (née Schneider; "Iva") arrived in Birmingham from her native Czechoslovakia in May 1968. Her qualifications were initially not recognised, and it took until 1979 for her to gain full registration. She worked in locum posts in paediatrics and held a research fellowship in genetics. In 1975 she transferred into psychiatry, and in 1992 she moved to the new Queen Elizabeth Psychiatric Hospital, where she remained until she retired at the age of 68. In the 1980s, after paying restitution to the Czech authorities for her education, Iva received a presidential pardon and was able to return to her family. She was on a holiday visit there in 2014 when she had a severe stroke. She leaves two daughters.

**Roslyn Jamieson**

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## Thomas Aquinas Marinus Crusz

**Consultant haematologist National Blood Service (b 1944; q University of Colombo, Sri Lanka, 1971; MSc, MRCPath), d 22 September 2014.**
Thomas Aquinas Marinus Crusz ("Tom") moved to England in 1978, where he undertook additional postgraduate qualifications. Appointed as a consultant haematologist for the National Blood Service, he helped develop and implement national reporting and monitoring systems. After retiring in 2009 Tom continued his many interests, including playing the cello, singing, and writing. He leaves his wife, three daughters, and two grandchildren.
**Shanthini Crusz**
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## Vincent James Marmion

**Consultant ophthalmologist (b 1928; q Queen's University Belfast 1950; FRCPE, FRCS Ed), died from cardiac failure and end stage renal failure on 24 April 2015.**
Vincent James Marmion moved from Belfast to England in 1960 to pursue ophthalmology as his specialism. In 1964 he was appointed consultant ophthalmologist and worked for 29 years at the Bristol Eye Hospital and at Western General Hospital. He leaves his wife, Peggy; eight children; and 21 grandchildren.
**Emma Prower**
Cite this as: *BMJ* 2015;351:h5104

## Malcolm McKay

**Retired general practitioner (b 1935; q Durham University 1958), d 19 June 2015.**
In 1962 Malcolm McKay entered general practice in Brandon, County Durham, and helped to create an extended group practice. He later joined a family practice in Low Fell, Gateshead, where he remained until he retired. Malcolm's hobbies involved his great interest in all fauna and flora, but his greatest love was salmon fishing. He leaves his wife, Lise; two daughters; and three grandchildren.
**Peter Moran**
Cite this as: *BMJ* 2015;351:h5026

## Sheila Mary Pickworth

**Former general practitioner (b 1933; q Royal Free Hospital, London, 1956; MRCS), died from multiple system atrophy on 27 August 2015.**
Sheila Mary Pickworth (née Brodie) and her husband, John, moved from Stoke on Trent to Barnt Green, where Sheila was appointed clinical assistant in general medicine at Bromsgrove General Hospital. After 18 years she joined her husband in general practice. She was diagnosed as having multiple system atrophy in 2005 and became increasingly disabled. She leaves John, four sons, and nine grandchildren.
**John Pickworth**
Cite this as: *BMJ* 2015;351:h5098

## Malcolm Peter Young Scott

**General practitioner and medical adviser (b 1930; q Middlesex Hospital, London, 1956; MRCS Eng, MFOM RCP), d 30 July 2015.**
After a stint as a GP in Hampstead, Malcolm Peter Scott ("Peter") moved to Southend in 1966 to take up his first partnership. Later he specialised in occupational health, working in London and Bristol. He was well travelled and enjoyed classical music and reading modern history. He leaves his wife, Audrey, and their three sons.
**Chris Scott**
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## Umesh Chandra Sharma

**Consultant orthopaedic surgeon (b 1931; q 1953; FRCS), d 10 December 2014.**
Umesh Chandra Sharma came to the UK in 1961 and was appointed as a consultant in orthopaedics at Stonehouse Hospital, Lanarkshire, in 1977 and later at Hairmyres Hospital. He retired in 1995 and did locum work afterwards. He was on the hospital staff committee, held office in the Overseas Doctors Association in Glasgow, and sat on the committee of the Glasgow Hindu Temple Committee. He leaves his wife, Sushma; three children; and two grandchildren.
**Devesh Sharma**
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## Leonard Williams

**General practitioner Croydon, Surrey (b 1924; q St Thomas' Hospital, London; 1952; MRCGP), died from congestive heart failure on 1 January 2015.**
Leonard Williams was severely wounded in 1944 while fighting on the Gothic line in Italy. He was evacuated back to England and, after spending nearly a year in hospital, decided on a career in medicine. Despite his injuries he became captain of St Thomas' Medical School's football team. He leaves his wife, Jean; three sons; and eight grandchildren.
**Nick Williams**
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## Kenneth Wray

**General practitioner, independent lecturer, health and retirement (b 1919; q Cambridge 1945; MRCS Eng, MRCP Lon), d 10 September 2015.**
Kenneth Wray joined the Western Elms Surgery in Reading at the inception of the NHS. He retired in 1984 but continued to be active, as a medical assessor for the NHS, a referee for Reading crematorium, and a clinical assistant at the Royal Berkshire Hospital. Wray leaves Marjorie, his wife of 68 years; three daughters; seven grandchildren; and 11 great grandchildren.
**Elizabeth Holland**
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PSYCHIATRIC HOSPITALS

## Reasons not to ban smoking in psychiatric hospitals

Despite the harms of smoking (Head to head, 7 November), a complete ban is problematic. In 2008, after a total smoking ban, fires in psychiatric units increased sharply. In October 2008 a fire at the secure unit Camlet Lodge caused £60m in damage and relocation of 60 patients. In my hospital, patients forbidden to smoke in the grounds lined up beside the main road instead. The hospital was forced to permit smoking in purpose built shelters.

I visited a medium secure unit while the "successful" pilot for a total ban was being conducted. All patients were detained under the Mental Health Act, entry and egress were strictly controlled, and patients escorted. Staff acknowledged that the policy would be difficult to enforce in non-secure hospitals. The courts upheld a smoking ban at secure hospitals containing notorious offenders. But most psychiatric patients have committed no offence and reside in hospital voluntarily or are detained for treatment of their mental illness.

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## A complete smoking ban is ethically wrong

Because of evidence of harm to others, there is no ethical argument for allowing smoking in public indoor settings (Head to head, 7 November).

Evidence that outdoor cigarette smoke exposure is harmful, except to smokers themselves, is poor, so an outdoor ban is ethically justified only on paternalistic grounds—forcing patients to quit while in hospital. But in the outside world smoking is banned solely to reduce harm to others.

The proposed ban may help some smokers quit, but the ethical test of a policy is not just that it will "work." Societies that value freedom rarely have paternalistic policies to stop people harming themselves if they are not harming others.

Some think it sensible to remove one of prisoners' and psychiatric patients' few freedoms. These people would be horrified if this policy was extended to their neighbours. But apparently it's OK with prisoners and patients because they don't deserve to be treated like other citizens.

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DOSFOTOS/PYMCA/REX

LETTER OF THE WEEK

## New health promotion for chemsex and GHB

McCall and colleagues highlight the growing problem of chemsex in the UK and the need for a coordinated policy and health response (Editorial, 7 November). Intoxicants that reduce inhibition such as alcohol do not improve performance, but γ-hydroxybutyrate (GHB), crystallised methamphetamine, and mephedrone can increase arousal, stamina, and pleasure.

Injecting drugs within chemsex settings carries risks of HIV and other bloodborne viruses. These drugs also carry specific risks, such as temporary psychosis and overdose. GHB is associated with high rates of overdose: one in five users report passing out each year.

Although specific interventions are needed for each substance, we need to start with harm reduction campaigns within the gay community, which proved effective for HIV transmission, starting with the acceptance of these drugs' sexual function and the pleasure they bring. Fact and humour may need to be combined to engage and educate users in reducing risks of harm. Together with the Gay Men's Collective, the Global Drug Survey has launched such an initiative.

Based on feedback from over 1000 GHB users, our evidence based safer G video "There's more to G than cock" is free on YouTube. Early feedback suggests that the best way to bring about change is to treat people as adults and accept that while pleasure drives drug use, most people are keen to avoid harm.

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SNAKE BITE

## Emulating the Indian model could save many lives

Although snake bite continues to be an important medical problem in India (Editorial, 7 November), we are successfully managing it there. Antivenom is manufactured by the Serum Institute of India, Bharat Serums, and Haffkine Institute (a state owned company). One vial (10 mL) costs from Rs200 (£2) to Rs500. A national snake bite protocol on the rational use of antivenom has been in place since 2007, and antivenom is free in most Indian government hospitals. Protocol guided treatment resulted in a 66% reduction in unnecessary use of antivenom and an absolute reduction in mortality of 24%. Emulating the Indian model could save many lives lost to snake bite.

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BIASED CLINICAL TRIALS

## PulMiCC trial relaunched to get to the truth

De Vries and colleagues (Letters, 24 October) are concerned about misleading claims due to outcome reporting bias.

Such problems are not confined to pharma. CEASL, another recovered trial, found that metastatic colorectal cancer after surgery could be detected earlier with intensive monitoring. The FACS trial of intensified follow-up was set up with the primary outcome being survival. By publication this had changed to "surgery with curative intent," and a positive result was reported. Yet more deaths occurred in the intensively monitored groups despite earlier detection. The later CEAwatch trial repeatedly used the phrases "curative treatment/intent" but provided no survival data.

Neither lung nor liver metastasectomy has been shown to provide a survival benefit. Cancer Research UK has relaunched the PulMiCC trial to discover the true effect of pulmonary metastasectomy on survival in advanced colorectal cancer.

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