comment

> Face to face consulting, the essential work of a GP, is devalued monetarily next to the corporate activities of the mega-manager

NO HOLDS BARRED Margaret McCartney

We need more openness on GPs' pay

Boris Johnson has done it. So has Jeremy Corbyn. Jacob Rees-Mogg said that he didn't want to be the last. In Norway, which lacks British shyness, everyone's is public. In some political circles tax returns have gone full frontal—what you earn and from whom, published with offshore profits and share dividends for all to see.

General practice would benefit from similar openness. English general practices are now required to publish the average earnings of GPs in the practice. But this is presented as average income without the hours worked or the role performed.

General practice used to be mainly a profession of partners. The building may or may not have been co-owned, but the contract to provide NHS services was shared, as were on-call duties and management of the building, staff, and services. There were always some people not working as partners—salaried assistants, for example—but the landscape has changed.

As the general practice model has changed from corner shop (local, limited goods, personal knowledge of patrons, continuous care) to supermarket (open more hours, big digital data gathering substituted for personal care, less continuity), the risk of exploiting workers on the shop floor looms larger.

A few practices have mushroomed and taken over smaller, peripheral services. Critically, however, the trend has been for a few GPs to assume the role of owner-managers and to employ salaried doctors to work the sessions required. This would not have been possible before the emergence of out-of-hours cooperatives to cover evening and weekend work. It has led to inequality in earnings. Neither England's publication of earnings nor the figures published by the Health and Social Care Information Centre distinguished part time from full time GPs, but partnered GPs appear to earn about twice as much as salaried GPs.

About 550 GPs earn more than £200 000 a year (690 earn less than £30 000).[1] This may be a small number of doctors, but the effects are disproportionately large: a small number of GPs now act as chief executives—seeing few patients but managing many other doctors. This means that face to face consulting, the essential work of a GP, is devalued monetarily next to the corporate activities of the mega-manager.

GPs, at best, have worked in egalitarian, cooperative groups. They may have been independent contractors but felt bound to the NHS in their values and dedication. Groups of newer and more experienced GPs working together are a time honoured method of transferring skills between generations.

We need more openness about pay at the top end of the scale: huge differentials in power are not a good basis for building the future of general practice.

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READ MORE ARTICLES ONLINE ABOUT FUTURE HEALTHCARE (see p 445)

- Do we still need hospitals (and hospital beds)? (bmj.co/beds)
- Matisse, decoupage, and digital health (bmj.co/matisse)
- Doctors should champion digital technology, says government minister (bmj.co/freeman)

PERSONAL VIEW Deborah Gold

Stop stalling and make PrEP for HIV available now

Further delay to pre-exposure prophylaxis risks the NHS appearing discriminatory of populations at risk

Compelling evidence of the effectiveness of pre-exposure prophylaxis (PrEP) for HIV has been available for over five years. But we are still waiting for the NHS to embrace this potentially revolutionary intervention.

Truvada, a combination of emtricitabine and tenofovir usually used to treat HIV, can also prevent HIV infection. PrEP could at last mean real headway in reducing the transmission of HIV, with the number of newly diagnosed people unchanged in the UK for the past decade.[1]

In November 2010, the iPrEX (pre-exposure prophylaxis initiative) trial found efficacy of 92% among those who took PrEP as prescribed.[2] Subsequent studies have confirmed its efficacy and its effectiveness. One of the most recent is the UK's PROUD (pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection) study, which looked at the real world effect among men who have sex with men.[3] The reduction in incidence among men in the PrEP arm was 86%.

Does it make sense for the prevention of infectious disease to be delegated to 150 local bodies, without any national strategic direction?

Additionally, those who did get HIV while participating in the study were not likely to be taking PrEP when infected.

The US Food and Drug Administration licensed Truvada for use as PrEP in 2012, and in 2014 the Centers for Disease Control and Prevention recommended PrEP for those at high risk of acquiring HIV. Other countries such as France are now following suit. In England, however, progress is painfully slow.

Strong equalities argument

Men who have sex with men and people from black African communities are at highest risk of HIV infection.[1] So there is a strong equalities argument for PrEP to be made available now. And, conversely, any further delay may appear to reflect a lack of value placed on the health of these most affected communities. The stigma that still surrounds HIV and its sexual route of transmission cannot be allowed to trump evidence.

We know that PrEP works and that it is cost effective when provided to people at high risk of HIV infection. Yet NHS England's vacillating has thrown into stark relief a health system that is not designed to come to timely and confident decisions about nationally important preventive interventions, for all the talk we hear of prevention being the new health priority.

PrEP highlights the lack of system-wide accountability. Even if the drugs were commissioned by NHS England, the sexual health clinic service to prescribe and monitor PrEP would have to be separately commissioned by each local authority. So even if we eventually get a positive decision from NHS England on the drugs, that won't be the end of the story. Does it make sense for the prevention of infectious disease to be delegated to 150 local bodies, without any national strategic direction?

In September 2014 NHS England began the process to decide whether to commission the drugs used in PrEP. In March 2016, after 18 months of work and just before its final decision was due, NHS England announced that this specialised commissioning process

ACUTE PERSPECTIVE David Oliver

Delirium matters

Being admitted unexpectedly to hospital is depersonalising and distressing. This is compounded for the one inpatient in eight who has delirium.[1] Delirium affects 20-30% of over 65s during acute admission.[2] We should do more to prevent delirium, ensure that we don't miss it, reverse it, explain it, and minimise its impact. Clinical staff need support to do this.

Risk increases if you're older and frailer. Add existing sensory or cognitive impairment, transit through busy, noisy wards, and contact with numerous unfamiliar staff.

Delirium carries high mortality and morbidity and is a red flag for potentially serious illness. It's characterised by acute onset over 1-2 days, a fluctuating course, and disturbances of cognition, perception, or consciousness.[3] The symptoms of hyperactive delirium can be terrifying—disorientation, restless distractibility, hallucinations, and paranoid misperceptions. Relatives visiting may be similarly distressed at witnessing this (a patient's story: http://bit.ly/deliriumpatient).[4]

Meanwhile, hypoactive delirium—leaving patients stuporous and withdrawn, yet still distressed—is less dramatic and is more easily missed or misattributed to old age or dementia.

Don't lazily label patients as having "acopia," and be especially wary of blaming a urinary tract infection. This can be the cause of delirium

If a patient is not already delirious on admission, precipitants include infection, dehydration, metabolic disturbance, pain, constipation, urinary retention, surgery and anaesthetic,[5] side effects from many drugs, and withdrawal from others.[6]

Awareness of this problem is growing despite failure to teach medical students enough about the frailty related syndromes they're increasingly likely to encounter.[7] For such a common, serious problem, which can often be prevented using systematic approaches,[8] delirium still has to gain parity with falls, thrombosis, and infection, which attract mandatory incident reporting as preventable harms.

PRIDE CENTER FLORIDA

was inappropriate because PrEP is a preventive intervention.

Despite a legal argument by the National AIDS Trust (NAT), NHS England reconfirmed this decision in late May 2016. Faced with this impasse, NAT has no choice but to take the matter before a court for judicial review. The public interest in resolving this is too great to ignore it.

Fractured decision making

This is a health system failing to look at the bigger picture, with decision making dangerously fractured and with no one providing clear direction and leadership. The provision of PrEP for those at high risk, who need it and want it, could reduce the human and financial costs of this preventable condition. While we delay, 17 people a day are being diagnosed with HIV.[1]

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The National Institute for Health and Care Excellence has produced excellent guidelines and quality standards.[2 9] Health Improvement Scotland has a national programme of quality improvement for older people in acute care,[10] including the "Think delirium" resource and several exemplar websites.[11] The Royal College of Psychiatrists has excellent information leaflets for families.[12] Once delirium has been diagnosed we can do much through medical and nursing interventions to identify and reverse the underlying cause, modify its course, and minimise its impact.[2 3]

Some pleas, however: explain delirium sensitively and reassuringly in understandable language. Have systems to screen for people at highest risk and to target prevention. Use simple, validated tools such as 4AT to identify most cases.[13] Don't cause avoidable delirium complacently through poor quality care or treatment. Although delirium and dementia often coexist, don't label delirium as new or progressive dementia. And don't make premature decisions on future care while patients are still delirious.

Finally, don't lazily label patients as having "acopia,"[14] and be especially wary of blaming a urinary tract infection: UTI, or "acute trimethoprim deficiency," can be the cause of delirium—but often it's not.

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Delerium and agitation at the end of life, p 450

THEBMJ.COM BLOGS

Céline Miani and Eleanor Winpenny

Can hospital services work in primary care settings?

It's widely acknowledged that general practice is facing substantial challenges. Recent proposals put forward by NHS England to address this have been positively received, with a series of funding commitments and reforms geared towards galvanising primary care.

However, at the same time the NHS *Five Year Forward View* envisages significant amounts of care traditionally provided in hospital settings moving into the community. In light of this, a review we helped to carry out—exploring how and where hospital services can be moved into primary care settings—is particularly relevant.

Some of the most effective new approaches highlighted in the study supported improved communication between GPs and specialists—for example, by facilitating requests for specialist advice by phone or email. Other approaches, which could reduce patients' use of hospital services, include: carrying out minor surgery in primary care, having GPs with a specialist interest provide additional services to patients, and allowing GPs to have direct access to a wider range of diagnostic tests and investigations.

With these new approaches there is a risk of increasing GP workload and potentially also increasing the demand for specialist care; however, the report cites examples of improvements to patient satisfaction. For patients, the increased flexibility of being able to visit their local practice rather than their hospital may improve their experience of care. There is also the potential of shorter waiting times resulting from additional services being delivered in community settings.

The one consistent problem highlighted in the study is the cost effectiveness of moving care into the community, which remains unclear in many cases. Many of the services described provide benefits, but the key question remains: are these benefits enough to justify additional costs?

Despite the need for further economic considerations, the study did show that high quality care in the community can be provided and is popular with patients. Ultimately, shifting healthcare from hospitals to the community will only be justified if patient satisfaction and convenience are valued above costs to the NHS, or if this shift reduces healthcare costs in the long term.

Céline Miani is a senior analyst at RAND Europe. Eleanor Winpenny is a career development fellow at MRC Epidemiology Unit

Read this blog in full at bmj.com/blogs

Anthony David Barnes

Former consultant surgeon Queen Elizabeth Hospital Birmingham (b 1934; q Birmingham 1958; BSc, FRCS, ChM), died from a primary malignant brain tumour on 30 April 2016.

Anthony David Barnes ("Tony") was in the vanguard of renal transplantation in the UK and made major contributions to the establishment of the specialty. In addition to renal transplantation, Tony was accomplished in all aspects of general surgery, and his experience with patients with renal failure helped him establish the principles of parathyroid surgery. He led the appeal for funding of a purpose built postgraduate centre for the Queen Elizabeth Hospital and managed the British team to success at the first International Transplant Games in 1980. In his retirement he moved to Pembrokeshire, where he planted a 6 acre arboretum and had a national collection of ilex (holly). Other interests included fishing and opera. He leaves his wife, Pat, and three children.

John Buckels, Malcolm Simms

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Alan Wilfrid Gough Goolden

Former consultant radiotherapist and oncologist Hammersmith Hospital, London (b 1919; q St Bartholomew's Hospital Medical School 1953; MRCS, DMRT, FRCR, FRCP), died from septicaemia on 8 July 2015.

Alan Wilfrid Gough Goolden served for two years as a surgeon lieutenant in the Royal Naval Volunteer Reserve and subsequently worked in the radiotherapy department at the Royal South Hants Hospital. He then moved to the Hammersmith Hospital, where he spent the rest of his career. Clinically, his first love was the thyroid and the investigation and management of thyroid diseases. Later he developed an interest in what would now be termed haemato-oncology. He separated from his first wife, Lorema, in 1980. His companion thereafter, until her death in 2005, was Anne Zanetti. Alan's final years were marred by spinal stenosis and a series of small strokes. Nevertheless he continued to live in his own home, supported by his carer, Maria Tunjic. He leaves two sons.

Alastair J Munro

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Bhasker Kamath

Retired consultant anaesthetist Hull and East Yorkshire Hospitals NHS Trust (b 1950; q St John's Medical School, Bangalore, India, 1974; FRCA), died from cancer on 17 August 2015.

Bhasker Kamath came to the UK in 1974 and trained in anaesthesia in London, Nottingham, and East Midlands. He was appointed as a consultant in Hull in 1988, working tirelessly for the trust until his retirement in 2014. He enjoyed his work, had a passion for knowledge and teaching, and always demonstrated an excellent work ethic. Bhasker had many friends within the trust and always had a smile on his face. On a personal note, he was a devoted family man, an avid food connoisseur, and an exceptionally seasoned traveller. In his retirement he was planning to be, in his own words, "a full time leisure practitioner." He leaves his wife, Sunithi, and two sons.

Ahmed Saleh

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John Cockrill

Former general practitioner Rainham, Kent (b 1925; q Trinity College, Dublin, 1950), d 24 March 2016.

John Cockrill entered general practice in Rainham in 1963 but found that he could not agree with the future direction of NHS general practice and resigned in 1967. He was an independent GP in Rainham for the rest of his career. He chaired the Medway and Gravesend branch of the BMA in 1972 and was its treasurer in 1975-83. He was also a member of the Maidstone local medical committee. In 1972 he established the Gerald Townsley Trust, in memory of a well known Medway surgeon, which provides money for an annual lecture by a medical celebrity, and a surgical fellowship for young Medway surgeons to experience training overseas. He spent the last five years of practice at the BUPA Alexandra Hospital in Walderslade and retired in 1996. John leaves his wife, Anne; three children; and six grandchildren.

Peter Webb

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Gregory Anthony Hugh Cookson

Former general practitioner (b 1928; q Trinity College Dublin 1952; DPH), died after a cardiac event on 11 December 2015.

Gregory Anthony Hugh Cookson joined the Clarkson Surgery in Wisbech, Cambridgeshire, in 1964. He retired as a partner in 1990 and continued to work as a locum until 1998. He also spent time as a GP trainer and course organiser at the King's Lynn vocational training scheme. He was involved in the inception of MAGPAS (the Mid Anglia General practitioner accident scheme). This meant the boot of his small hatchback was permanently full to overflowing with spinal boards, flashing lights, and all the other emergency kit of the day. He enjoyed tennis, gardening, and the *Times* cryptic crossword. He spent many happy years as a rainfall observer for Anglia Water. His later life was blighted by dementia. He leaves Jemima, his wife of 52 years; four children; and nine grandchildren.

Toby Cookson

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Ramakant Maganlal Rash

Retired consultant geriatrician (b 1937; q Manchester 1962; FRCP), died from bronchopneumonia on 26 March 2016.

Ramakant Maganlal Rash arrived from Uganda in 1956 and studied medicine at Manchester University. After qualifying he worked at Crumpsall, Withington, and Wythenshawe hospitals. Inspired by his mentor, John Brocklehurst, he chose a career in geriatric medicine. In 1975 he was appointed consultant at Wythenshawe as the first and sole geriatrician, with responsibility for six wards and 132 patients, until a colleague was appointed in 1982. He retired in 1997, having given everything in his desire to deliver a personal service to the highest standard for the older people of south Manchester. He loved clinical work, was adored by his patients, and was respected and revered by staff. Only his family were more important than his work. He leaves his wife, a son, and two grandchildren, as well as a Manchester City FC season ticket of 37 years.

Amar Rash

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Terry-Nan Tannenbaum

Prolific Canadian public health doctor whose own diagnosis led her to campaign for an end to the stigma surrounding lung cancer

Terry-Nan Tannenbaum (b 1952; q University of Calgary 1978), d 17 March 2016.

Terry Tannenbaum was a public health doctor who advocated for reducing health inequalities, for elderly people, immunisation, pandemic planning, and infectious disease control. She led campaigns against SARS, HIV, H1N1, measles, meningitis, and infections acquired in the community or hospitals. She worked to improve tuberculosis (TB) control locally and internationally and was a teacher, researcher, and writer.

Family role model

Terry Tannenbaum was born on 13 April 1952 in Montreal, to Ada and Isaac Tannenbaum. Her father was a family doctor and one of the leaders in the developing specialty of family medicine in Canada. He was the first general practitioner to hold an academic position as an associate professor at McGill University in Montreal. Isaac was a tremendous role model for his children, often taking them to visit patients on his house calls. Like their father, Terry became an associate professor in the department of family medicine and the department of epidemiology, biostatistics, and occupational health at McGill, and her brother David became an associate professor in the department of family and community medicine at the University of Toronto.

After studying liberal arts (psychology) at Brown University in the US, Tannenbaum qualified in medicine from the University of Calgary. She undertook her family medicine residency at the Jewish General Hospital in Montreal in 1980. She also gained a master's in public health at the University of Massachusetts medical school (1986), and an MBA and master's of management at McGill University (2008).

When she was diagnosed with lung cancer in January 2014, Tannenbaum had a clear understanding of the likely outcome. She was determined, however, to live the rest of her life as best she could, for as long as she could. She managed to return to work part time and, using her own experiences, she became an advocate for more action and funding for lung cancer prevention, diagnosis, treatment, and research. She wrote six instalments of a blog for the Canadian Lung Association, where she detailed her thoughts and experiences, and called for compassion for those with a lung cancer diagnosis.

"When people learn of my diagnosis, inevitably they ask if I smoked (which I did, more than 35 years ago)," she said. "We don't blame people for other diseases, but lung cancer is still all about blame. It's not about smoking. Let's forget the stigma. This is about a terrible disease—and it doesn't get the compassion and support and funding that other diseases do."

When she died, Tannenbaum was a deputy director of the department of public health at the Montreal Health and Social Services Agency. Before assuming this role she had been head of the health protection division, consultant physician to the planning division, and chief of infectious diseases.

Tuberculosis initiatives

From 1999 to 2006, Tannenbaum was also the medical director of a cooperative project to develop a TB control programme in Ecuador. During this period, Ecuador went from having the worst TB control in the Americas to having a world class programme that was available to 70% of its population.

Tannenbaum was president of the North American Region of the International Union against Tuberculosis and Lung Disease in 2004-05, and received their outstanding service award in 2015. She also worked on a five member team developing minimum core competencies for medical officers of health, served for many years on the Canadian Tuberculosis Committee, was a consultant for the Pan American Health Organisation, and a founder member of StopTB Canada. She received a Queen Elizabeth II Golden Jubilee medal in 2002 in recognition of her work to improve lung health.

Tannenbaum called for compassion for those with a lung cancer diagnosis

"Terry was the consummate public health professional," said her friend and colleague John Carsley, medical health officer at the Vancouver Coastal Health Authority. "She was a great medical detective, and had excellent judgment and a clear ethical framework."

Sheila Kussner, founder of Hope and Cope, a non-profit organisation affiliated with the Jewish General Hospital in Montreal said, "She was a woman of strength, of character, of integrity—a truly special lady in every respect."

Tannenbaum loved her family, her job, her pets (including those she rescued), climbing mountains, and keeping fit. "She exercised avidly every day until two months before her death," said her brother David.

Terry-Nan Tannenbaum leaves her husband, Andre Dascal, and two children.

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β BLOCKERS FOR HEART FAILURE

Research into "real world" older patients is needed

This meta-analysis (Research, 23 April) shows that β blockers benefit patients aged 40-85 with heart failure and reduced ejection fraction who can tolerate them; but it doesn't tell us how older people in clinical practice tolerate them. All trials were conducted 10-20 years ago, had exclusion criteria to avoid harm, and had titration periods designed to increase doses safely.

β blockers are associated with increased orthostatic hypotension in older patients with hypertension and may be associated with falls in very elderly patients. In my clinical practice of treating older fallers, β blockers are often poorly tolerated and have to be stopped.

A more accurate conclusion might be that older patients with heart failure and reduced ejection fraction can be trialled on β blockers, taking care with patient selection and titration period, and that a minority might not be able to tolerate these drugs.

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Adverse effects and tolerability of β blockers

Kotecha et al state: "Although β blockers are often associated with side effects, data from randomised trials consistently show . . . little or no increase in lethargy with modern generation β blockers."

Close scrutiny of the reference for that statement shows that the withdrawal rate of β blockers because of fatigue was more than twice as high, and for sexual dysfunction almost five times as high, as in patients receiving placebo. We calculated that for every stroke or heart attack prevented, three patients were made impotent by β blockers and eight experienced fatigue that resulted in their stopping treatment—hardly an acceptable risk-benefit ratio for an asymptomatic disease such as mild essential hypertension. Obviously the risk-benefit ratio is different in heart failure, where b blockers are essential, and hypertension, where they are optional.

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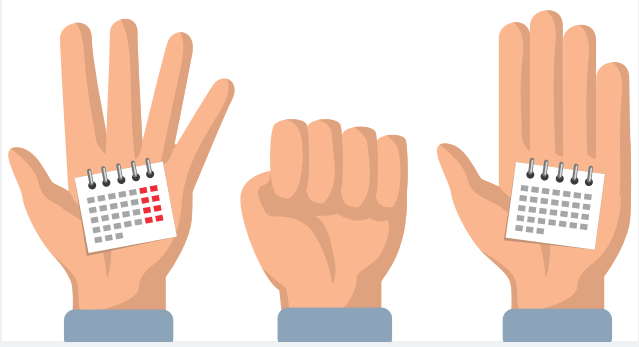

LETTER OF THE WEEK

Care varies across the week, not just at weekends

The "weekend effect" (Editorial, 21 May) is an oversimplification: weekends are not the only times when quality is compromised by the way services are organised.

Hospitals are busiest on Mondays and Tuesdays, when emergency admissions, elective admissions, and outpatients are highest, numbers of discharges are low, and an excess of admissions over discharges at the weekend has produced high bed occupancy. Pressure eases as the week progresses, as discharges begin to exceed admissions, and elective and outpatient activity drops on Fridays. Diurnal variation in emergency admissions also exists, with numbers low overnight and early in the day, but high in the afternoon until late evening.

By contrast, most hospitals provide "routine" services Monday to Friday 9 am to 5 pm, which are closing down when demand from emergency admissions is highest. With rising demand, many hospitals now operate near to full capacity, so even minor delays for a few patients have serious knock-on effects on many others.

The solutions will entail changes to routine weekday working, not just weekend working, for a range of staff, not just doctors. For example, extending routine working hours in support services into early evenings, providing additional resources on Mondays, Tuesdays, and weekday afternoons, and shifting low risk elective work and outpatients from Mondays to Fridays all might help.

None of the potential solutions is likely to occur without serious investment.

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Authors' reply

The age of trial patients does not reflect that of those in the community. This must be rectified to improve applicability of future research. In double blind trials, β blockers are effective and well tolerated, whereas observational studies show higher levels of adverse events owing to patient and physician bias. Although trials recruit a selected population, pooling trials at the individual patient level obtains a more heterogeneous cohort that better reflects the population—31% of our trial population was over 70 years and 13% over 75, allowing us to test the efficacy and tolerability of β blockers according to age using randomised controlled data.

Different risk-benefit assessments are needed according to treatment indication. However, the 20-30% relative reduction in death in patients with heart failure is clearly different from hypertension, where other agents with similar efficacy are available. Overall withdrawal in our study was similar for β blockers and placebo. We have no data on causes of withdrawal such as sexual dysfunction and fatigue, but withdrawal for these reasons would occur in 1.3% and 2.4%, respectively, at most.

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Douglas G Altman, Peter D Collins, Marcus D Flather

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DIETARY FATS

Best to judge diets by their total food content

The debate over types of fat doesn't look at the foods containing them (Research, 16 April).

It's better to judge a diet by looking at foods rather than nutrients. Good evidence shows that a healthy diet contains vegetables, fruit, pulses, whole grains, olive oil, fish, some lean meat or poultry, and dairy. And it contains only small amounts of "discretionary" foods and drinks ("junk" food).

This is the diet our guidelines recommend, but it bears little resemblance to what people eat. In Australia, 35-41% of kilojoules come from junk foods. This won't be fixed by giving the nod to saturated fat.

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