comment

"I'm not sure career managers are less committed to quality than clinicians" **DAVID OLIVER**
"It's worrying an NHS trust is explicitly offering a two tier service" **HELEN SALISBURY**
PLUS Reforming the social care system; tackling air pollution

WOUNDED HEALER Clare Gerada

Tips to thrive in medicine

I recently interviewed two retired doctors, Michael and Bernadette Modell, both in their 80s, who taught me when I was a medical student.

I remember their lectures vividly, as well as my attachment at Kentish Town Health Centre, where Michael was a partner. They were giants of their respective specialties: Michael was professor of general practice, and Bernadette forged a career creating the specialty that we now know as clinical genetics. They inspired not just me but a generation of students and young doctors who trained at University College Hospital.

I asked them both about their experiences in medicine, which were—as they would be today—full of challenges. Bernadette talked about how hard it had been to get grants as a woman in academia. Michael recalled how difficult it had been to persuade the university to expand the half day general practice training, which was squeezed between a trip to the public baths and the delousing centre. They both talked about their sacrifices, particularly in terms of financial security and family life. But they also looked back fondly on their wonderful, privileged, and fulfilling careers and lives.

In the same week as meeting the Modells I gave a talk to a group of newly appointed consultants who were attending a "thrive and survive" course. Some of the doctors in the room were looking with some trepidation at the thought of 30 more years working in medicine, wondering how they would cope with the pressures, stresses, and life events that would inevitably come their way.

They asked me for tips for surviving a lifetime in medicine. I thought about this from my own perspective. Luck has played a large part. For example, having healthy children (or at least unwell only at weekends), being in a sustaining relationship, and living close to where I work. But there's more to career fulfilment than luck, and much of it is in our control.

Surrounding yourself with likeminded enthusiasts creates a sense of "can do." Forming a peer support group, where you can share your trials and tribulations and gain perspective on difficulties, is important. Using spare money to buy time to work (especially in the early days, when we spent most of our disposable income on cleaners, childcare, and takeaway meals), and accepting that guilt is ever present as one tries to juggle family with a professional career, has helped me. I've learnt that variety really is the spice of life and that I should always look to the new opportunities that medicine provides.

The Modells thrived despite the many pressures they faced. Given today's difficulties, I wonder whether the new consultants I recently met will look back fondly in 2049 and say that they truly had the best job in the world? I hope so.

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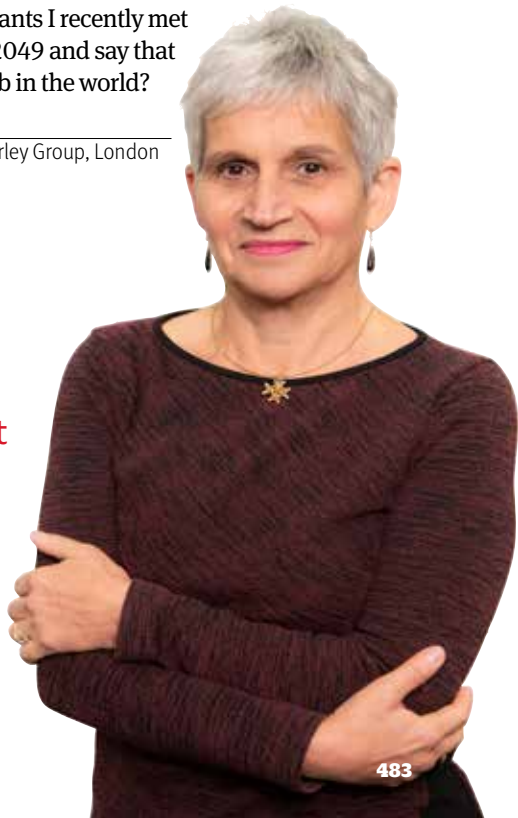
Cite this as: *BMJ* 2019;365:l4354

There's more to career fulfilment than luck, and much of it is in our control



PERSONAL VIEW Anita Charlesworth

How can we make social care, like the NHS, a source of pride?

The system is close to breaking point and reform is long overdue

History casts a long shadow and often it's the choices that seem less important in the moment that have the biggest long term impact. In 1948, older and disabled people were divided into the "sick," who were placed in hospitals, and those needing "care and attention," who were placed in residential homes.

Hospitals were integrated into the new NHS while those providing "care and attention" formed the social care system run by local authorities. Whereas NHS services were free at the point of use, local authorities could levy means tested charges for residential and community social services. The die was cast.

Fast forward more than 70 years and this divide has had profound implications. For all its faults, the NHS has grown and prospered. Since it was established, UK spending on the NHS has risen 12-fold in real terms. In recent years, social care has become the poor relation; while NHS funding in England was protected from austerity, social care funding fell by 4.9% from 2010-11 to 2017-18.

The end of the second world war not only led to the foundation of the NHS, but also sparked a baby boom. The next decade will see that generation reach the age at which many will need care: the number of people aged over 65 is projected to grow by 24% through the 2020s. Alongside a rapidly ageing population, one of the huge successes of the post-war era is increased longevity for people with disabilities; in the early 1980s, the average lifespan for someone with Down's syndrome was 25 years—today it's 60 years.

Cost and complexity

The social care system is close to breaking point and reform is long overdue. For more than 30 years, successive governments have recognised the need for reform, but each has prevaricated in the face of the task's cost and the complexity. Decades of neglect now make the task harder, but it is possible.

Other countries—notably Germany and Japan—have grasped the nettle. Their systems are not perfect, and are not an off-the-shelf map for England, but they show that with political will, fundamental reform is possible.

We don't have to look abroad to see that different choices can be made. Scotland and Wales both spend much more on social care than England, and the gap has been widening. In 2010-11, adult social care spending in England was £345 per person, a third lower than in Scotland. In 2016-17, the amount fell to £310 per person and the gap with Scotland has widened to 43%. Part

Other countries—notably Germany and Japan—show that with political will, fundamental reform is possible

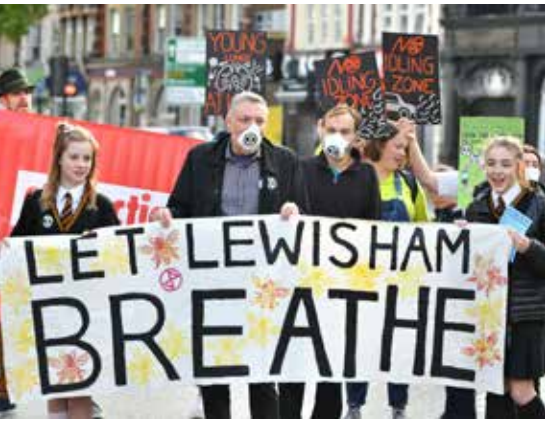
of the reason for the different spending is different entitlement regimes; in Scotland, people are entitled to free personal care.

Local council budgets have fallen by a fifth since 2009-10 as government grants have been cut. As a result, councils struggle to match demand. Over the next five years, council income from local taxes is projected to grow by 1.4% a year but caring for an ageing population and people with disabilities will rise by at least 3.6%.

This is before considering the quality of care, in which staffing is a key determinant. The workforce is under enormous strain; pay rates are much lower than equivalent NHS roles, one in five staff are on a zero hours contract, and turnover is high and rising. It is estimated a third of social care nurses have left their role in the past year. Keeping up with need and ensuring better terms and conditions for staff would require government to find an extra £4.4bn in 2023-24.

BMJ OPINION Alex Armitage

We must act now to prevent air pollution deaths



Recently the Lewisham Extinction Rebellion group used the tactic of "swarming"—stopping traffic for short periods of time at major junctions—to cause disruption and draw attention to illegal levels of air pollution in the borough, which is transected by the A2 and the South Circular, two of the capital's busiest roads. A study by researchers at Goldsmiths in 2017 found $PM_{2.5}$ levels in the area were six times higher than WHO guidelines.

I am a paediatric registrar and I have worked at the Lewisham and Greenwich NHS Trust for two and a half years. News of the demonstration gave me hope. Far from feeling threatened by travel delays, I remembered the countless young children brought to the emergency department with life threatening asthma. Memories of children being wheeled in to the emergency department on their parent's lap in severe respiratory distress do not fade fast. Memories of scrutinising blood gases with raised lactate levels showing that the child's beta-adrenoreceptors are saturated, meaning the option of giving more salbutamol, the principal drug for treating acute asthma, has been exhausted.

Memories of the practised speed of nursing colleagues drawing up intravenous boluses of magnesium and infusions of aminophylline—administering IV therapy for asthma is an unwelcome familiarity for paediatric emergency staff in south east London. Memories of making anxious calls to the local paediatric intensive care unit. Memories of waiting for what seemed like hours to monitor a young child, in severe respiratory distress and on full IV therapy, to see if they will need intubation and retrieval.

Then there is the matter of the balance between the individual and the state, the major fault line entrenched by decisions taken in 1948. Beveridge's vision for the welfare state started from the premise that "social security must be achieved by co-operation between the state and the individual." In social care, the state has pulled back and too many people have been left to cope alone.

Introducing a cap

Andrew Dilnot mapped out a plan to cap care costs for older people. Parliament legislated in 2014, but implementation was postponed indefinitely. Introducing a cap would add a further £2.8bn to social care costs in 2023-24, much less than the cost to introduce free care as in Scotland.

Reform is not easy, but the time has come to ensure the last pillar of the welfare state lives up to Beveridge's vision by providing a social care system that is as much a source of national pride as the NHS.

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Cite this as: *BMJ* 2019;365:l4349

For doctors on the front line like me, who witness the health effects of social and ecological destruction on a regular basis, the need to take political action has become clear.

When our political system fails to deliver, in the face of clear evidence that we must act now, the time has come to accept that standard methods of political engagement—such as letter writing, petitions, and emails—bring, at best, insufficient progress. These are insufficient to avert the tens of thousands of annual air pollution deaths in the UK.

Evidence from history suggests that peaceful civil disobedience is the most effective way to bring about change. The time has come for us to act.

Alex Armitage, specialty trainee year 6 paediatric emergency medicine, Queen Alexandra Hospital, Portsmouth

ACUTE PERSPECTIVE David Oliver

Medical *v* career executives

My recent column on the paucity of doctors as NHS hospital chief executives brought an interesting postbag, sparking more reflection on my part.

Clinically active doctors can often assume management, educational, and leadership roles that stop short of full time organisational executive. Perhaps the lack of doctor chief execs isn't a big deal if we're influential in other ways.

One of my Twitter respondents, Jill Aylott, argued that medical leadership is indivisible from practice because delivering continuous quality improvement for patients was what counted. The implication was that a focus on clinical quality and safety requires more doctors and other clinicians in charge and fewer career managers. I'm not sure career managers are less committed to quality than clinicians, but I understand that deep training and experience in the core business of patient care counts.

I'm reminded of an essay by Richard Bohmer, a doctor and improvement expert, on "The Hard Work of Health Care Transformation." He argues that most meaningful improvement in patient care and sustained change sit at a local level in small and medium sized, multidisciplinary clinical teams. The wider organisation exists to ensure the right culture, incentives, investment in managerial and educational support, and data for quality improvement.

Another Twitter correspondent, Dominic Harrison, wrote to me of "prophets" and "kings." Doctors who want to campaign and criticise (prophets) feel constrained in executive (king) roles that don't readily enable them to speak truth to power, but come with regulatory accountabilities. Such doctors, he argued, must embrace "radical pragmatism"—accepting the constraints and accountabilities rather than lobbying to change the context.

Many doctors would, I suspect, be uncomfortable embracing radical corporate pragmatism, focusing solely on how much the organisation is doing to simply maintain performance, and ignoring bad news or challenging the realpolitik. So, what's the solution for doctors who want to deliver change?

I don't believe the NHS's only business is continuous quality improvement. I'd suggest we also need to focus on morale, skills, and retention. But much of senior public sector management is about struggling to maintain performance levels in the context of funding shortfalls, crumbling estates, staffing gaps, and complex regulatory and political accountabilities.

In such roles, the real experts who have the right skill set may not be doctors but career managers all along.

Perhaps the best we can do is encourage, develop, and support doctors who want to tackle these jobs, accepting that medical leadership comes in many guises and not just in the office of chief executive or medical director.

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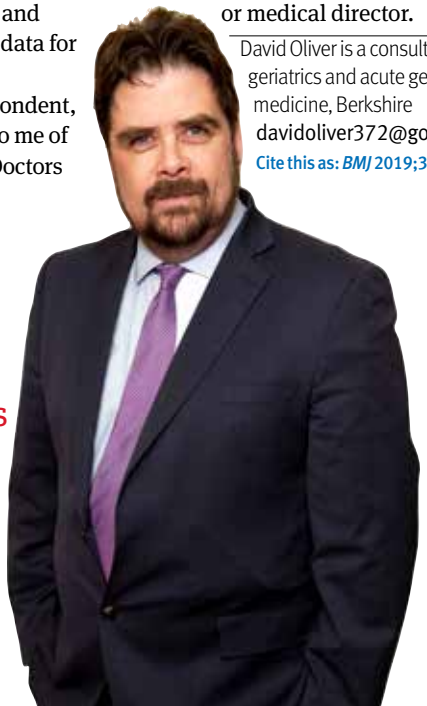
Cite this as: *BMJ* 2019;365:l4339

The real experts who have the right skill set may not be doctors but career managers



PRIMARY COLOUR Helen Salisbury

Endgame for the NHS?

Since its foundation, the NHS has been committed to providing treatment according to clinical need. The distinction between want and need is important—there may be treatments that patients want but don't need, such as cosmetic surgery. In these cases, they have to go to the private sector and pay up front or through insurance.

This is set out in the first two points of the NHS constitution, which state that it provides a comprehensive service, available to all, and that access is based on clinical need, not ability to pay.

This week Warrington and Halton Hospitals NHS Trust was in the news for its list of charges for 71 procedures. This is not entirely new: starting with varicose vein surgery in 2013, the scheme was relaunched in September 2018 with a hugely expanded list of procedures and has only now hit the headlines.

The list appeared under the banner "My Choice—by the NHS, for the NHS," next to the NHS logo. This would leave many people asking, "Is this an NHS service or not?" The list included prices for cataract surgery (from £2251), knee replacement (from £7179), and hip replacement (from £7060), all of which are beyond the means ofmost people served by these hospitals, given Warrington's high deprivation.

The trust's justification is that these procedures have been limited by NHS commissioners. Operations on this nationally generated list were initially referred to as "procedures of limited clinical value" and are now "criteria based clinical treatments." If patients don't meet the criteria but still want the surgery, they will have to pay.

This makes a mockery of the NHS constitution: either patients have a clinical need, in which case they should receive timely NHS care, or they don't, in which case it's not in their interests to have the procedure, and it shouldn't be done by the NHS.

What this programme reveals is that access to procedures with a proved track record of safety and efficacy, which patients need to see clearly or move comfortably, is being denied.

The "criteria" are increasingly stringent: the Royal College of Surgeons raised the alarm in 2017 about restricting hip and knee surgery on the basis of arbitrary pain and disability thresholds rather than clinical assessment. And cataract guidelines from NICE explicitly state that commissioners should not restrict access to surgery on the basis of visual acuity, yet that's what happens to patients covered by over a third of clinical commissioning groups.

These decisions are not about optimising outcomes for patients but are a reaction to inadequate funding.

Even more worrying is that an NHS trust is explicitly offering a two tier service. We should resist this transformation from a single, comprehensive system, where all are treated equally, to one where rich patients have rapid access and poor patients struggle to be referred and then languish on waiting lists. Bevan must be turning in his grave.

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Cite this as: *BMJ* 2019;365:l4375

This is not about optimising patient outcomes but a reaction to inadequate funding

LATEST PODCAST

Reducing cigarette use

Where are we with global cigarette consumption? The authors of two recent studies discuss what their research found, with author Steven Hoffman setting the scene:

"I think there are probably four things that everyone should know about tobacco. The first is that it is the number one preventable cause of death that we have. If there's one risk factor that every country should be thinking of tackling it's tobacco consumption.

"The second is that this century, if things go as they are now, the World Health Organization estimates that one billion people will die from tobacco consumption.

"The third is actually good news. On a per capita basis, at least, there have been declines in tobacco consumption since about 1985.

"The worrying news, however, is that there's great regional variation. In some countries, we're seeing those declines in tobacco consumption, but in other countries there's actually greater consumption."

Working as a team in space

More than 200 people have lived and worked on the International Space Station, including Nicole Stott. In a recent podcast she talked about why team dynamics are so crucial in a high pressure job. Here she shares how astronauts' training prepares them for working in teams:

"If you think about astronauts, there's a type A personality thing going on there. In that personality type is this tendency to think that you can do everything really well, even when you can't. One of the things the training—going underwater or hiking in a canyon—does is make you acutely aware of all the things that you are not good at. So you have to accept that others are going to be able to make up that difference."

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

ANALYSIS

Healthcare can help to heal communities … and the planet

Health gains are undermined by the health sector's impact on social inequity and the environment, but that can change, argue **Damon Francis and colleagues**

Over the past few decades, the world has made substantial progress on health outcomes, with large improvements in life expectancy and childhood mortality and many breakthroughs in treatments. Although progress has not been evenly distributed, some of the biggest improvements have been in countries with the most difficult health challenges.[1]

At the same time, however, the healthcare sector is contributing to poor health by exacerbating social inequity and environmental damage, both of which are major factors in the growing burden of non-communicable diseases such as cardiovascular disease, chronic respiratory diseases, and diabetes.[2-4]

The 17 sustainable development goals (SDGs) adopted by world leaders in September 2015 recognise that human wellbeing depends on reducing social inequity and protecting the environment. A recent study showed that the global healthcare sector is critical to achieving the SDGs and the comprehensive vision of health behind them.[5] It concluded that healthcare is the most important sector for achieving six of the 17 goals, including those related to poverty, education, and employment. Healthcare is also in the top three for another seven goals and is cited more often than any other sector.[5]

We consider how healthcare is harming social inequity and causing environmental damage and present examples of healthcare organisations that are working to achieve healthy people living in equitable and resilient communities on a sustainable planet.

Sustainable energy and production

Climate change has rapidly become a critical driver of global morbidity and mortality. The World Bank estimates that climate change could exacerbate existing health inequities by putting more than 100 million people back into extreme poverty by 2030.[6] Another recent study conservatively estimates that climate change will increase mortality by 35/100 000 or 3.9 million lives a year by 2099, with a much heavier toll on low income regions.[7]

Although many countries have not done an extensive assessment of their health sectors' contributions to climate change, the NHS estimates that the health sector represents 39% of all public sector greenhouse gas emissions in England.[3] In the US, healthcare contributes 9% of overall greenhouse gas emissions.[2]

Pollution and toxic waste rank alongside climate change as major threats to health and sustainability, particularly for low income communities. The World Bank estimates that 23% of child deaths among residents of India could be attributed to pollution, which means that about 350 000 children aged under 5 years die every year as a result of bad air, contaminated water, or similar problems.[8]

Unfortunately, healthcare is an important contributor to morbidity and mortality from pollution. One study estimated that the indirect health burdens caused by emissions from the healthcare sector are commensurate with the health burden caused by preventable medical errors.[9]

Increasingly, healthcare organisations of all sizes are implementing strategies to limit their harmful environmental effects (box 1). By switching to renewable energy and reducing healthcare waste, healthcare organisations can reduce greenhouse gas emissions and pollution, contribute to growth in renewable energy employment, and realise large financial savings.[10]

Resilient food systems

Agriculture and food production can damage the environment through extensive pesticide use and expose farmworkers to toxic chemicals that are linked to cancer, birth defects, and neurological damage.

Unhealthy processed food has contributed to a large rise in obesity and non-communicable diseases around the world. Industrial meat production is an important contributor to antibiotic resistance, which in Europe causes morbidity and mortality at a similar scale to influenza, tuberculosis, and HIV combined, and is projected to substantially increase healthcare costs over the next decade. Many hospitals contribute to these problems, serving food that causes the same diseases they are treating through its low nutritional quality and unsustainable production methods.[14-16]

Some healthcare organisations are beginning to improve the food they serve to their patients and the systems that produce that food. These organisations are treating "food as medicine"— providing prescriptions for fruits and vegetables, teaching cooking classes, and integrating other creative approaches to healthy eating with clinical care. They are also leveraging their purchasing power to support local and sustainable

KEY MESSAGES

- Social inequity and environmental damage cost many lives and cause substantial ill health
- The healthcare sector contributes to these harms, undermining its efforts to improve health
- To reverse these harmful effects, healthcare practitioners and organisations must adopt a broader aim of healthy people, living in equitable and resilient communities, on a sustainable planet
- Examples show the power of the healthcare sector to achieve results on all three levels

Box 1 | REDUCING GREENHOUSE GAS EMISSIONS

Gundersen Health System[11]

This non-profit healthcare organisation based in Wisconsin, US, was 100% dependent on coal for electricity and 100% dependent on natural gas to heat its facilities in 2006. It recognised that reliance on fossil fuels added to local respiratory health problems and had a negative effect on the local economy as well as increasing the cost of delivering care.

Gundersen set a goal to become the first health system in the US to be heated, cooled, and powered by renewable energy it owned.

Over the next few years, it co-invested in a variety of community based clean energy projects. Guided by audits conducted by a local air conditioning company, Gundersen invested $2m (£1.6m) in efforts to reduce energy use and saved $1.2m every year thereafter. Regional partners co-investing in two wind sites included a large private construction company and an organic farm cooperative.

As a collaborating partner, the local county government contributed gas from the local landfill, which Gundersen used to heat, power, and cool an outpatient campus with 1200 staff. It purchased previously unused hardwood chips from several lumber mills to fuel a high tech biomass boiler providing heat, power, and sterilisation capability.

Gundersen decreased its particulate and greenhouse gas emissions by more than 90%, saved money, and boosted the local economy. Each year the system has many days of energy independence and also provides a backstop for extreme weather events when the grid may fail.

These efforts also more deeply connected Gundersen with its community partners in the shared purpose of improving health and economic wellbeing, and serve as a model in healthcare for addressing climate change.

Region Stockholm[12]

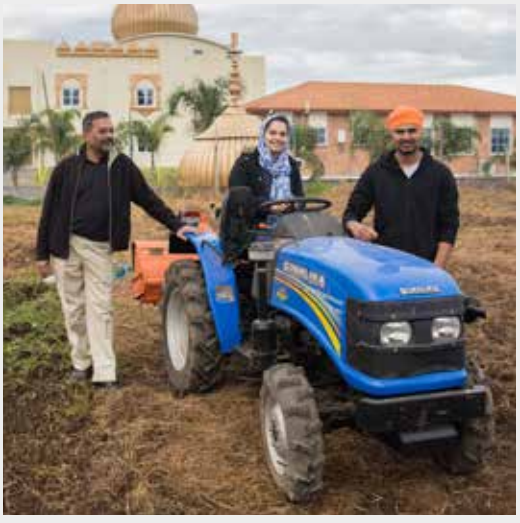
A local health authority that is also one of Europe's largest healthcare providers, Region Stockholm has led several initiatives to tackle climate change and harmful healthcare waste.

In 2004 it installed a pilot facility at Karolinska University Hospital that splits nitrous oxide—a commonly used gas in medicine that has 300 times the global warming impact of carbon dioxide and contributes to ozone depletion—into harmless nitrogen and oxygen. The facility was the first of its kind in the world, and the programme has since been extended to all the region's hospitals.

The region also works to reduce the emissions of active substances from the production of pharmaceuticals by requiring its suppliers to implement procedures to monitor and control harmful discharge and emissions. Additionally, the council has incorporated data on the environmental effect of pharmaceuticals into the development of a drug formulary known as the Wise List, which has had the added benefit of reducing healthcare costs.

The Wise List is mainly used by primary care providers in the Stockholm region, and adherence to the drug formulary is high.[12]

Healthy Families New Zealand[13]



Healthy Families was established by the New Zealand Ministry of Health to prevent chronic disease through a comprehensive and coordinated approach rooted in leadership of community residents.

In Auckland, an urban area with about 1.6 million people, a collaborative initiative with the Sikh community to use waste land for food production and to create a food forest found that it is customary in the Sikh community to dispose of fabric used in religious rituals in incinerators, creating air pollution and greenhouse gas emissions.

In partnership with Healthy Families and others, they developed a programme to share the fabric with communities who could reuse it. Since December 2017, women from Samoan, Tongan, Maori, and Cook Islands communities, together with other community based organisations in Auckland, have been creating upcycled products that provide additional income and the associated health benefits to hundreds of families.

In addition to the community economic benefit, avoiding incineration or disposal in landfill prevents the equivalent of 3.6 tonnes of CO_2 emissions a year—the equivalent of taking 2.5 cars off the road in Auckland.[13]

agriculture in the communities they serve, modelling healthy food environments, and contributing to healthier food systems and guaranteed markets for sustainable growers (box 2).[17]

Healthy homes and neighbourhoods

Where people live is perhaps the single most important determinant of their health. Stark disparities in health outcomes between neighbourhoods that are within walking distance of one another have been documented in high and low income countries because of inequitable distributions of power, money, and resources.[18]

Health hazards that originate within the home are a major cause of health problems. The hazards include injury; exposure to chemical substances, mould and damp, pests and infestations; poor access to water and sanitation; proximity to pollution sources; and inadequate protection from extreme weather.[19]

Despite this, and the fact that focusing healthcare resources on neighbourhood based primary care can achieve remarkable results, much of the healthcare sector continues to concentrate its activities in hospitals and specialty care far removed from these places and issues.[20] Global initiatives to increase investment in the community conditions that drive health outcomes have often been opposed by powerful interests, including some health insurers and health professional organisations.[4]

As healthcare organisations recognise that health is driven by home and neighbourhood contexts, they are applying new strategies that are centred outside clinics and hospitals and focus on root causes of disease, in some cases achieving short term financial benefits as well. These approaches are often led by patient organisations and community leaders and include local primary care as well as purchasing, hiring, and investment strategies that support improved health outcomes for disadvantaged communities (box 3).[21 22]

Box 3 | HEALTHY HOMES AND NEIGHBOURHOODS

Chagas Ecohealth[23]

Chagas Ecohealth is a collaboration of community residents, health ministries, researchers, and others working to develop strategies to stop the spread of Chagas disease in central America using an approach rooted in local ecology and community driven problem solving.

Worldwide, around 40 000 new cases of Chagas disease occur each year, and in Guatemala alone, over four million people are at risk of transmission of the disease by triatomine insects ("kissing bugs").

Traditional approaches to preventing transmission relied on annual insecticide spraying of homes, which is expensive, damaging to the environment, and has short lived effects. One collaborative intervention in Guatemala showed that targeted home improvements using local labour and materials greatly reduced levels of triatomine infestation in homes, and improvements were sustained over time. The intervention also contributed to other health benefits, to local economic activity, and to a reduction in the use of substances that harm the environment.[23]

Nationwide Children's Hospital[24]

In partnership with Community Development for All People (CD4AP) and other groups in Columbus, the US state of Ohio developed an intervention to improve housing conditions in a neighbourhood that had been historically disadvantaged through systematic racial segregation and economic exclusion. Nationwide Children's Hospital provided over a quarter of the $22.6m investment from community partners, and CD4AP brought strong representation from residents, many of whom were patients of Nationwide, to develop the intervention.

Together, the partnership renovated buildings, developed new housing, and created programmes to ensure affordability for renters.

Early outcomes include a reduction in vacancy rate (the chief concern of residents) from over 25% to 6%, and associated increases in rates of graduation and decreases in homicides, with additional improvements in health expected over the long term.[24]

Box 2 | BETTER FOOD PRODUCTION

Vienna Hospital Association

The group of 11 hospitals, nine geriatric centres, and six long term care homes cares for 400 000 inpatients and 3.5 million outpatients a year and serves 30 000 patient meals a day.

As part of Vienna's green procurement policy, more than 30% of all the ingredients served across the group are organic, and most of this is sourced from local suppliers. It serves less meat and also provides tap water rather than bottled water.

The healthcare sector's food purchasing strategy is embedded in the city's climate action plan, which requires a 50% reduction in greenhouse gas emissions by 2020 for products procured. Through this integrated approach, the hospital system is taking better care of its patients, modelling healthy food environments, supporting sustainable agriculture, and reducing its climate footprint.[17]

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Gary Cohen, president and cofounder, Health Care Without Harm, Boston, Massachussetts

Jay Bhatt, president, Health Research and Educational Trust, Chicago, Illinois

Charlotta Brask, sustainability director, Region Stockholm, Sweden

Mahesh Devnani, assistant professor, Department of Hospital Administration, Post Graduate Institute of Medical Education and Research, Chandigarh, India

Gael Surgenor, director of community and social innovation, Southern Initiative, Auckland

Conclusion

In his 1981 essay, "Solving for Pattern,"[25] the writer and social and environmental activist Wendell Berry discussed a remarkably similar challenge to the one we currently face in healthcare. He noted that although industrial methods had solved some of the problems of food production, they had produced "side effects" so damaging that they threatened the survival of farming. He proposed that farmers and others focus on a solution that was biological and not industrial—a solution that recognised the planet as an interdependent whole.

Organisations have a responsibility to society and the environment that goes beyond their primary purpose, and the healthcare sector is no different. Given the different ways that healthcare organisations affect health, we should pursue a triple aim of healthy people, living in equitable and resilient communities, on a sustainable planet. The examples presented here show that it is possible.

Cite this as: *BMJ* 2019;365:l2398

LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Medical associates are here to stay

The BMA junior doctors' vote against professional equivalency for medical associate professionals is counterintuitive and shortsighted (This Week, 25 May).

In cardiothoracic surgery, surgical care practitioners have performed surgical tasks such as conduit harvest (pictured) since the early 1990s. Senior house officers and junior registrars initially protested, but soon it became clear that well trained (by doctors) surgical care practitioners provide efficient service as well as excellent training of very junior doctors. The practice spread to other surgical specialties.

Medical associate professionals do not take away opportunities from the medical profession—they create new ones. This has been the case in the US since the introduction of physician assistants in the 1960s.

Development of professional regulation and oversight of their training and assessment has been messy. Medical associate professionals are expected to complete university masters courses, many of which are substandard and provide poor value. Professional oversight of their training and the need for good quality assessment of knowledge is essential to maintain safe practice.

The decision to provide an independent regulator for physician associates (anaesthesia) and for medical associates was taken by the government earlier this year, although Brexit seems to have ensured progress in this area is painfully slow. For various reasons, much to the regret of many, surgical care practitioners have been denied an independent regulator, and their training and assessment remains messy and rudderless.

Medical associate practitioners are here to stay. They help to provide efficient and timely treatment for NHS patients. Their training, assessment, and oversight provide exciting opportunities for the whole of the medical profession.

BMA junior doctors, pick your battles wisely and think again.

Norman Briffa, consultant cardiac surgeon, Sheffield

Cite this as: *BMJ* 2019;365:l4265

EQUIVALENCY OF MEDICAL ASSOCIATE PROFESSIONALS

Opposing medical associates is a disgrace

The idea that upskilling medical associate professionals is harmful to the integrity of the medical profession is ridiculous (This Week, 25 May). To "actively oppose" recognising their contribution, skill, and training by not allowing them to prepare for and sit postgraduate exams is a disgrace.

The Royal College of Emergency Medicine is leading the way in the formal credentialing of advanced clinical practitioners. One of the drivers for this is the mismatch between the number of suitably qualified senior decision makers in the specialty and the numbers needed in the face of ever increasing demand. The process is rigorous, and not everyone is able to complete it.

At 3 am on the floor of a busy emergency department, particularly during junior doctor changeover periods, I am extremely grateful for the presence of a sage and wise hand that does not need constant supervision.

Brendan Fletcher, ST6 emergency medicine/paediatric emergency medicine, Norwich

Cite this as: *BMJ* 2019;365:l4255

> The standards allow only excellent candidates to get through and practise

Only the best in our NHS

Medical associate professionals are not replacements for junior doctors but facilitators to allow junior doctors to work efficiently.

The issue of studying for two years to be a physician associate, compared with five years for medicine, has been the subject of much debate. Physician associate courses in the UK are intense two year programmes with a carefully planned curriculum mapped out, maintained, and revised by the Faculty of Physician Associates at the Royal College of Physicians. All students go through a series of assessments before being granted the masters degree. After this they must go through national level exams conducted by the faculty. Each university has strict criteria for choosing their students.

The standards in place allow only excellent candidates to get through this process and practise in our NHS. Regulation by the GMC will allow physician associates to help our patients and us as professionals.

Bilal Haider Malik, senior lecturer, Uxbridge

Cite this as: *BMJ* 2019;365:l4246

SURGICAL CHECKLISTS

Success in Scotland

I agree with McLachlan that the World Health Organization's surgical safety checklist can only improve outcomes for surgical patients when used systematically (Patient Safety, 25 May). So I was surprised that the article didn't cite Ramsay et al's recent paper.

They found a 36.6% reduction in postoperative mortality between 2008 and 2014, after the checklist was implemented Scotland-wide in 2011 as part of the Scottish Patient Safety Programme.

Improving patient safety during surgery was the first workstream of the programme, but it has been rolled out across many specialties and into primary care, delivering reductions in overall hospital deaths and stillbirths as well as in complications such as sepsis and pressure sores.

The extensive involvement of frontline staff in development of the programme is key to its ongoing success, creating patient safety champions throughout NHS Scotland.

Philippa Whitford, breast surgeon and MP, Ayrshire

Cite this as: *BMJ* 2019;365:l4288

SOCIAL MEDIA ADDICTION

Technological déjà vu

Zendle and Bowden-Jones point out the methodological shortcomings of research on the effects of social media (Editorial, 25 May). These observations apply to research on technology use more generally. Studies typically ask people to consider their personal experience with technology, reflecting a general shift away from behavioural measurement in psychology. We found that popular assessment inventories did not align with the most basic measures of objective behaviour, including those associated with compulsive use.

Narratives around the mass adoption of new technologies are almost always negative. Researchers might want to start asking why or how the use of social communication technology would cause harm and to develop more suitable measures accordingly. Moral panics about new technology (the printing press, the telephone, the internet) are, historically speaking, either overblown or demonstrably false.

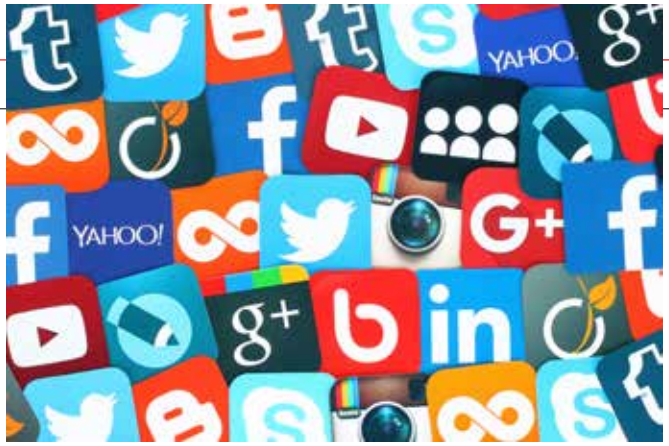
Understanding the effects of technology remains crucial, but researchers might want to consider what drives "technophobia" in the first place.

Brittany I Davidson, doctoral researcher in information systems, Bath; David A Ellis, lecturer in computational social science, Lancaster

Cite this as: *BMJ* 2019;365:l4277

Data from the social media industry are unreliable

Further research is needed to better understand the association between social media use and addiction, but several considerations should be made before science jumps into bed with industry.



Narratives around the mass adoption of new technologies are almost always negative

First, the reliability of data from social media platforms must be questioned. A recent study found that three in four children aged 10-12 years had their own social media account, despite the minimum age being 13, indicating that industry data have similar limitations to the self reported Bergen questionnaire.

Second, the popularity of different platforms is constantly changing, so industry data may not be useful for longitudinal studies.

Finally, industry data will not distinguish addiction from excessive use as social media platforms cannot record the emotional and behavioural effects of use and inability to use social media. In this era of digital relationships, we may need to disconnect from the social media industry to reconnect with our patients.

Isobel Baxter; Amy Craig; Ellena Cotton; Thomas Liney, fourth year medical students, Manchester

Cite this as: *BMJ* 2019;365:l4281

LONELINESS

Architecture, agencies, and activities

Make no mistake: loneliness is a killer (Minerva, 1 June). Our work at several Sure Start sites uncovered a younger, hidden population of lone parents with preschool children who seemed to have serious, unmet health needs. On a friendless estate, loneliness and low self esteem combined with depression and drink could even make some young mothers vulnerable to violent men.

Better architecture, town planning, and transport are all needed to combat loneliness. Good Neighbours and other locally accessible voluntary and community agencies are even more important. Some activities, from cycling groups to youth football, dancing or choral singing, seem to bring people together, although there is no one-size-fits-all solution.

The Department of Health has finally realised that gardening can be good for us. Let a thousand flowers bloom—but remember that family and ethnic history shape the meaning of gardens.

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

Cite this as: *BMJ* 2019;365:l4348

DOCTORS' REST FACILITIES

Doctors' messes are missed

In the 1960s and 1970s hospitals had messes for junior doctors (This Week, 25 May). They also provided accommodation. Both disappeared under cost pressures and a ridiculous belief that, because they were not core NHS activities, they were dispensable.

When withdrawal began, I said that it was a mistake. Not only did the mess provide a rest space, but it was a place to meet colleagues and chew over a difficult case. On-site accommodation meant that no one died driving home. Segregated dining facilities enabled doctors to discuss work without being overheard by patients or relatives.

I know that medicine is more complex now and that many trainees have their own homes, but I have an overwhelming sense of "I told you so." How long before we abandon the dangerous shift system, I wonder?

Andrew N Bamji, retired consultant rheumatologist, Rye

Cite this as: *BMJ* 2019;365:l4295

JUNIOR DOCTORS' MORALE

Good job, junior

I and many of my foundation year 1 colleagues share a frustration. It is not being overworked, underpaid, or exhausted, but rather the lack of positive feedback received from seniors after a job well done (Careers, July 2016). If a mistake is made, you can be certain that you'll hear about it. But performing a task above the level expected, or simply doing a good job, will often go unnoticed.

Morale is hugely important for junior doctors; a simple "well done" from my consultant is highly motivating. We all have a challenging job that can leave us feeling tired and, at times, undervalued. Positive feedback substantially increases enthusiasm, engagement, and enjoyment in our individual jobs and the medical profession as a whole. So, seniors, next time you notice a junior do a good job, please remember to give them a pat on the back.

Matthew A Barton, foundation year 1 doctor, Prescot

Cite this as: *BMJ* 2019;365:l4344

Dowling Munro

Dermatologist who specialised in research into topical steroids

Dowling Donald Munro (b 1931, q Royal Free Hospital 1954; DObst RCOG, FRCP, MD Lond), died suddenly from a cerebral haemorrhage on 10 February 2019

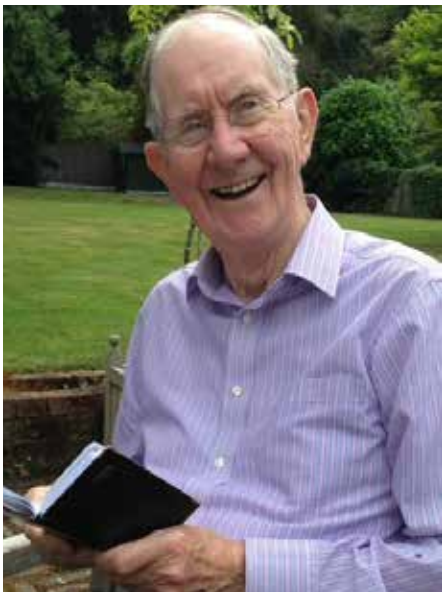
Dowling Munro was a consultant dermatologist who did pioneering research into topical steroids. His analysis of the complications of steroid treatment was "in the forefront of dermatology at that time," says Anthony du Vivier, who worked with Munro at St Bartholomew's Hospital in London.

Du Vivier, who is a consultant dermatologist at King's College Hospital, London, says, "Topical steroids completely transformed dermatology because, before them, treating disorders such as eczema was a nightmare. But these drugs have potential side effects. One of the areas Munro worked in was the absorption of these steroids through the skin, demonstrating that they could result in adrenal suppression.

"This was to become of particular importance when clobetasol propionate (Dermovate) was launched in 1974, when patients particularly those with psoriasis began to use it to excess, resulting in iatrogenic Cushing's syndrome."

Malcolm Rustin, another former mentee of Munro and subsequently professor of dermatology at London's Royal Free Hospital, says his "important" work combined investigation of the skin with endocrinological analysis at Barts, which had one of England's foremost endocrinology departments. "They worked out that steroids were being absorbed, could cause atrophy of the skin, and could affect and suppress the hypothalamic-pituitary-adrenal axis and cause low cortisol levels. Munro's collaborative work elucidated some of the modes of action of topical steroids and their side effects," says Rustin.

Munro gained his MD thesis on the effect of percutaneously absorbed steroids on hypothalamic-pituitary-adrenal function. He was also a key figure in investigating the hormonal basis of acne, hair disorders, and the treatment of psoriasis with cytotoxic drugs. He showed



Munro was keen on bee keeping, and his enthusiasm for snowdrops was widely admired among fellow galanthophiles

the increased incidence of alopecia areata in Down's syndrome and its association with autoimmune disease. He and his colleagues were the first to show the efficacy of azathioprine in the treatment of psoriasis. He also investigated the link between liver fibrosis and methotrexate in the treatment of psoriasis.

Early life and career

Born in Glasgow, Munro trained at the Royal Free Hospital. He did his national service with the Royal Army Medical Corps (RAMC) in Cyprus, during a period of violent unrest in the mid-1950s. Afterwards, he became senior registrar in the skin department at St Mary's Hospital, London, working with consultant dermatologist Michael Feiwel, who stimulated his interest in topical steroids.

He spent a year in the US as a public health research fellow, working with renowned dermatologist Dick Stoughton in Cleveland, Ohio. Stoughton had discovered a test that showed a vasoconstrictor response or blanching of the skin because of vasoconstriction when a powerful steroid was placed on the forearm. He showed that the greater the degree of vasoconstriction, the more potent the topical steroid was likely to be.

Munro returned to the UK and became a consultant dermatologist at Barts, working alongside physician Peter Borrie, the department's "charismatic" head. Together, they inspired young physicians to train as dermatologists and develop their careers, with Munro becoming a valued mentor and friend to many.

Munro held numerous posts including president of the St John's Dermatological Society and of the section of dermatology at the Royal Society of Medicine. He became president of the Dowling Club, which was established in the 1947 by Geoffrey Dowling (no relation) to advance the education of young RAMC doctors.

Retirement

After he retired, in his early 60s, he passed more exams to work in the St John Ambulance service and for a decade or so led medical support teams at "raves" and other events dealing with emergencies such as drug overdoses.

He was keen on bee keeping, and his enthusiasm for snowdrops was widely admired among fellow galanthophiles. Munro became an authority on "twinscaling," a propagation technique that entails cutting a snowdrop bulb into many small pieces, including the "end plate," in order to generate identical new snowdrops. He was sharing rare specimens shortly before he suddenly and unexpectedly died from a cerebral haemorrhage.

Munro met his first wife, Pamela, at the Royal Free Hospital when she was a haematologist and he was a medical registrar. She died from a cardiomyopathy. They had two daughters. On marrying his second wife, Ella, a geriatrician, who was a widow with two daughters, Munro became a father to all four girls. He leaves Ella, a sister, four daughters, and 15 grandchildren.

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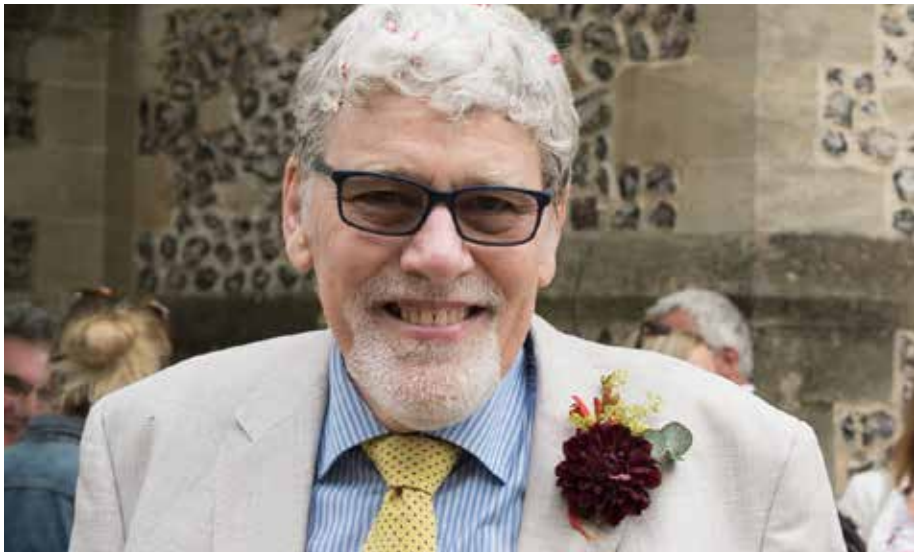
Cite this as: *BMJ* 2019;365:l1703

OBITUARIES

Michael Wilks

Campaigner who helped found the Sick Doctors Trust

David Michael Worsley Wilks (b 1949; q St Mary's Hospital Medical School, London, 1972; DObst RCOG), died from prostate cancer on 12 January 2019



Michael Wilks was a widely admired BMA campaigner who overcame his own struggles to help fellow doctors in difficulties, advance professional ethics, and promote human rights. Wilks fought alcoholism while working as a GP in London in the 1980s and finally gained sobriety in 1991. He felt there were many like him who were not being adequately supported. In 1996 he helped found the Sick Doctors Trust, which runs a 24 hour helpline, and in his role as a police surgeon, also worked to support addicts facing neglect within the criminal justice system.

He joined the BMA's Medical Ethics Committee in 1993, chaired it for nine years from 1997 to 2006, and chaired the association's representative body from 2004 until 2007. In 2010 he was elected honorary BMA vice president and he also represented the association in Europe, winning acclaim for his humility, insight, and wit.

Overcoming addiction

Educated at St John's School in Leatherhead, Wilks was a medical student at St Mary's Hospital Medical School (then part of London University) from 1967 to 1972. He undertook a three month overseas elective in Uganda but became ill, contracting malaria. After house officer posts, he went straight into general practice in London.

But he reached the point where his life "collapsed" from alcoholism, and he chose to work alone for many years. He sought help on occasions, mostly from psychiatrists, but he was diagnosed not as an alcoholic but as depressed. Wilks came to speak openly about his problems in order to help others.

He believed a genetic predisposition to alcoholism was activated and exacerbated by external factors—in his case the suicides of his father and a brother, and professional pressures.

Wilks regained sobriety with the help of Alcoholics Anonymous.

> Wilks's experiences of addiction, the lack of help available to sick doctors, and his first hand knowledge of unwell people in custody informed his career

"His experiences of addiction, the lack of help available to sick doctors, and his first hand knowledge of unwell people in custody informed his career from then on," says Andrew Finlay, a dermatology professor and a close friend since medical school.

"He chose to confront and seek solutions to these problems, which were largely ignored by the rest of the profession."

Wilks was a founder and trustee of the Sick Doctors Trust and its chairman from 2008 to 2013. He was also senior police surgeon with the Metropolitan Police from 1992 to 1997, a principal forensic medical examiner and, from 2011, a forensic physician with Thames Valley Police, providing healthcare and forensic examinations to detainees and to crime victims.

He chaired the board of trustees of the Rehabilitation of Addicted Prisoners Trust (now the Forward Trust), a charity that helps people to break cycles of addiction or crime.

Wilks served on the BMA's Forensic Medicine Committee from 1993 to 2014 and chaired it from 2010.He helped to establish the Faculty of Forensic and Legal Medicine at the Royal College of Physicians and was its registrar from 2015 to 2018. He worked to develop appropriate standards of care to ensure that detainees held in custody would receive the same level of treatment they would get in other NHS settings.

Julian Sheather, a BMA special adviser on ethics who worked with him, remembers Wilks as a "passionate" defender of human rights who helped to raise the BMA's profile in fighting abuses—for example, by criticising torture of detainees at Guantanamo Bay. "As a forensic physician, he was particularly interested in and concerned about ethics and human rights in closed institutions," says Sheather.

Overcoming addiction

During Wilks's time as ethics committee chair, the BMA argued for an overhaul of the system governing consent for organ donation, to tackle the shortage of donors and save more lives. He also helped draw up BMA guidelines for doctors authorising withdrawal of food and water by tube for patients with severe stroke and dementia, who can no longer express their wishes.

Wilks tried, unsuccessfully, to become an MP three times—twice for the Social Democratic Party in the 1983 and 1987 general elections, and he stood for the Green Party, in Winchester, in 2015. Friends say he "invigorated" the latter, attracting many new members, mostly young people who were getting involved in politics for the first time.

He developed prostate cancer, but almost two decades of dealing with the illness didn't stop his "impish sense of humour," says Peter Green, a specialist in forensic and legal medicine who knew Wilks for 30 years.

Wilks leaves his second wife, Sandy McLean Wilks; his first wife, Patricia (née Hackworth); two brothers; three children; and four grandchildren.

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Cite this as: *BMJ* 2019;364:l1329