

comment

“Let’s try simple education with dedication to empower NHS staff” **SCARLETT McNALLY**

“To function, the NHS needs more fully trained expert generalists” **HELEN SALISBURY**

PLUS Challenging the GMC’s training vision

TALKING POINT John Launer

Why we should all #sayhellotopatients

I’ve just had some imaging done at a hospital I attend. I had to wait on a trolley for about 15 minutes while other patients went in to have their procedures done. As I waited, I noticed something remarkable: 20 or so people happened to walk past me during this time and, almost without exception, smiled and said hello. This included, so far as I could tell, radiographers and doctors, porters and nurses, along with cleaners and other staff.

The experience struck me as extraordinary. I’ve often waited on trolleys in similar circumstances, and I’ve generally had the feeling I was regarded as either invisible or inanimate. It always seemed as though wearing a hospital gown and lying down demoted me from being a worthy member of the human race to an object with no entitlement to be noticed, let alone greeted.

I suspect there was something exceptional about the culture of the department where I found myself. Possibly it was the result of training, good role models, or simply having a happy environment where people were looked after and kindness had become the norm. It still made a phenomenal difference to my morale and sense of wellbeing, as well as my satisfaction as a patient.

It made me think of the famous campaign led by the young geriatrician Kate Granger, who had incurable cancer and sadly died in 2016. During one of her hospital admissions she’d noticed how many of the staff looking after her didn’t introduce themselves. Thinking it terribly wrong for such a basic step in communication to be missing, she devoted the last years of her life to campaigning on social media and more widely, for all healthcare professionals to say their name whenever meeting a patient for the first time. The hashtag #hellomynameis started to appear on name badges. Hospital managers began to inculcate the habit as part of good practice. As a result of Kate’s campaign it’s now far less common to meet staff who fail to mention their name or at least to have it clearly legible on their badge.

Drawing on this precedent, I wonder if we should begin a campaign using the hashtag #sayhellotopatients. It would take little effort for each person in the NHS to cultivate a routine of looking directly at every patient we pass and at least nodding politely to acknowledge their existence, if not actually saying hello in every case. Even when crossing a waiting room full of patients, it should be perfectly possible to make eye contact with enough people to show you recognise that they’re living, breathing equals, rather than pieces of furniture. Hotel staff are trained to do this as a routine.

My guess is that acting in this natural, human way would also be hugely beneficial to staff and team morale. The effects on patients, to judge by my own experience, would be profound. Let’s all just #sayhellotopatients.

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Acting in this natural, human way would be hugely beneficial to staff and team morale



The GMC's vision for medical training must be challenged

The regulator's document has left doctors uneasy and unhappy

On 12 March the General Medical Council (GMC) published *Our Vision for the Future of Medical Education and Training*.

This was accompanied by an explanatory blog from Colin Melville, the GMC's medical director and director of education and standards, in which he queried whether the current system of undergraduate and postgraduate medical training was "fit for purpose" and suggested that "medical training needs transforming." An enthusiastic and uncritical endorsement was published the next day by the three Royal Colleges of Physicians of London, Edinburgh, and Glasgow.

Readers might wonder why this "vision" is even worthy of comment. But, as with so many policy documents that pass by the attention of jobbing clinicians busy with patient care, both the policy statement and the blog bear further scrutiny. The GMC outlines changes in three key areas of undergraduate and postgraduate training:

- Building a bigger workforce including multidisciplinary educators,
- Changing "prequalification education," and
- Supporting career development and lifelong learning.

Superficially, this all seems completely reasonable. The teaching of doctors has always involved staff other than doctors, especially academic scientists during the undergraduate years and specialist allied health professionals and nurses in postgraduate settings. More of this would be useful. However, what's actually being suggested is that staff other than doctors should be involved in all aspects of educating, supervising, training, and mentoring doctors.

The changes proposed to undergraduate education are even more radical. Melville is explicit that, since the advent of the mobile phone, doctors no longer need a "huge repository of facts in [their] heads." This would allow medical school curriculums to be "streamlined" and quite possibly much shorter.

The GMC then responds to the problem

of younger doctors declining to enter traditional postgraduate medical training (the five to eight years needed to become a GP or consultant). Instead of career progression being contingent on formal training pathways, this will be replaced by an approach based on "outcomes rather than time spent or numbers."

Changing patient population

Readers may ask what's contentious about any of this. As Melville admits, UK medical graduates feel increasingly unprepared for work as doctors. So, perhaps a radical shake-up is exactly what the doctor ordered.

The GMC and Melville link their proposals to the changing nature of the patient population (more people living longer with multiple long term conditions, using multiple services) and the greater need for population health approaches. Both require a greater emphasis on skilled expert generalism, holistic approaches to care, and a focus on prevention.

The last attempt to improve postgraduate education, 2013's *Shape of Training*, made a considered effort to tackle these issues. But the relative lack of success of those proposals doesn't mean that narrower and shorter training, with less emphasis on knowledge, will better prepare today's doctors for caring for increasing numbers of older and more complex patients.

Plenty of doctors would support a reduction in the burden of portfolio assessments and documentation. But the rigour of multistage exams and repeated assessment, based on curriculum content developed over the past two decades, is a key plank of postgraduate medical training. This also ensures that all doctors have basic competencies to practise safely, regardless of where they train.

While other countries have shown that innovations such as modular training can provide the flexibility much desired by the younger generation, it's surprising to see royal colleges, whose international reputations are built on high standards, happy with suggestions that assessment of competence should devolve to local employers.



This is about producing doctors as quickly and cheaply as possible

A few things are striking about the GMC's new vision and its endorsements. The first is that major changes to medical education and training are usually presaged by a period of intensive evidence gathering and self-examination, with the publication of a detailed analysis of what's wrong and how this might be fixed. This is entirely absent from these proposals. The GMC already seems confident that it knows exactly what the problems are and how to fix them.

Second, there's a stated and naked urgency to this. The GMC claims that it has already been "working in the background" to get buy-in—yet this is the first that many people involved in medical education have heard of this initiative. And now the GMC seems to gallop ahead with a brief period of "listening" and then the formation of a "stakeholder group," while simultaneously working on enabling legislation.

Quickly and cheaply

None of this is reassuring to a profession already uneasy and unhappy. Much has been driven by a GMC that has emphatically not been listening to concerns about the scope of practice of physician associates and has instead been reactive and tone deaf to legitimate concerns about patient



safety. The sad conclusion is that this is really about bums on seats, producing the next generation of doctors as quickly and cheaply as possible. This comes at the cost of less education, less training, less experience, and less expertise—which in the long run can only lead to poorer and less safe care for patients.

Future doctors will also be the losers. It's very likely that other countries will no longer recognise British doctors as adequately trained and allow them registration without additional qualifiers, if at all. Moreover, the stated desire to take the the responsibility for the next generation of doctors away from doctors, devolving this to other staff and employers, strikes at the very heart of what it means to be a profession. Only doctors should be responsible for supervising, training, mentoring, and setting standards for the next generation.

The GMC's vision for the future of medical education and training risks destroying the rigour and credibility of the medical profession and the reputations of its once illustrious universities and royal colleges for years to come. Let us please wake up and push back, before it's too late.

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Retrofit simple education into the NHS

The NHS needs to retain and value the experience and intuitive competence of doctors, other senior clinicians, and managers. Educating someone for autonomous practice and the ability to deal with complexity is hard. But other types of educating can be simple.

Knowledge and skills are empowering for staff and patients. In an NHS with minimal money, time, and staff it's hard to retrofit education, but we can start with patients. Social media and advertising have changed how people absorb information, how cultures evolve, and what our "norms" are.

No Smoking Day and International Women's Day can help us to learn how to inform and educate. This is more than just raising awareness: health related education should be bite size and available everywhere. At the Centre for Perioperative Care we've launched resources on the practicalities of smoking cessation for healthcare staff, including that each craving lasts only 90 seconds, nicotine withdrawal symptoms start reducing within two weeks, and cessation cuts complications of surgery by around half.

Getting NHS teams to co-create patient resources is a great way of defining shared pathways and getting teams to bond. This process encourages other non-medical staff to expand knowledge of their service.

International Women's Day reminds us there are still gender pay and pension gaps and a motherhood penalty, with mothers earning on average £4.44 an hour less than fathers. Instead of just providing mentoring, resilience training, and unrealistic role models,

we should offer skill development. I tell students they don't need to be a man to chair meetings, but I also offer training on how to chair and how to avoid accidental bullying.

But we mainly need to fix the system that limits opportunities for education and advancement. For critical, career defining years, women tend to spend more time on caring and household responsibilities, which can negatively affect their advancement. The unconscious bias and expectations of patients and other staff also mean work takes longer for women, and the time expectations of early roles contribute to a "leaky pipeline" or "talent gap" as women leave.

It's possible to request less than full time training in any specialty, but not everyone is aware of this. We could get more women into clinical leadership quite cheaply by advertising all essential "middle management" positions as role shares—with clear role definition and administrative, and senior support. This would help encourage all genders and people from non-traditional backgrounds to take on such roles.

So, let's try simple education with dedication. This means being clear about basic knowledge and skills and defining our healthcare pathways so they are truly patient centred and value every team member. We should nurture a diverse talent pool in clinical leadership. You can start by rewriting a leaflet with your team, welcoming a student, or changing your next middle management ad.

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We mainly need to fix the system that limits opportunities for education and advancement



Practising at the top of your licence

Doctors in every branch of practice grumble about time wasted trying to fix malfunctioning printers or scouring the workplace for the right blood bottle or pathology form. A well organised health service would have staff on hand to help with such tasks, as it makes no sense to use your most highly trained staff on work that could safely be carried out by someone with less training.

The idea of working at the top of one's licence means just that—spending most of your time doing things requiring your expertise. Not surprisingly, it's an idea beloved of economists: why pay a doctor when a specialist nurse could do the job; why pay a nurse when the task could be undertaken by a healthcare assistant; and so on, right down to offloading work onto the voluntary sector. Of course, the economic argument for this concept works only if doctors are appropriately rewarded for their skills and training, so it doesn't always apply in English hospitals.

There are areas of general practice where this substitution is well developed. As a rule, blood samples are taken by a dedicated phlebotomist rather than a nurse, and tasks such as dipping urine specimens or recording ECGs are carried out by a healthcare assistant. This makes sense for practical tasks and for some medical consultations that can be carried out according to a protocol, which in most practices are nurses' responsibility.

But there's a risk of fragmented care and inefficiencies when a

patient makes many visits to the GP surgery, seeing a different member of the team each time. There's a balance to be struck, as tasks that other staff members could do can sometimes be woven seamlessly into my consultations. I can take a blood pressure, do a pill check, discuss a recent mental health admission, look at a suspicious mole, and review the patient's medicines all in the space of a single appointment. Looking after the patient as a whole, while paying attention to their physical and psychological needs in the context of their family and community, is what constitutes practising at the top of my licence as a GP, even if some individual components of a consultation don't require my level of training.

The long term workforce plan envisages a 49% rise in hospital consultants between 2021 and 2036—but only a 4% rise in fully qualified GPs, as noted by the National Audit Office this week in a critical report. This seems foolish. For our health service to function efficiently what we need is more fully trained expert generalists providing continuity and holistic care.

We should take note of the results of a recent experiment in Mississippi, where replacing doctors with (cheaper) advanced nurse practitioners and physician associates as primary care providers proved to be an expensive mistake, resulting in increased testing and referrals, more emergency room visits, and worse medical care.

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Looking after the patient as a whole is what constitutes practising at the top of my licence



LATEST PODCAST



Sharp Scratch: Perfectionism

This episode of the Sharp Scratch podcast explores why medics are prone to perfectionism, and how they can use it to their advantage rather than falling victim to it. Psychologist Thomas Curran, an expert on perfectionism, joins the panel and begins by defining what it is:


“Perfectionism contains two main elements: an excessive need to achieve really high—almost impossible—goals, which is accompanied by emotional baggage, so if we haven't quite met those goals, we can be very harsh and self-critical. We worry about making mistakes and fear failure. The best way to think about it is high standards fused with insecurity.

“Perfectionism has a really nasty habit of turning our dreams into dead ends because we think this is going to be the pinnacle, and then suddenly we reach the top of the mountain, and there's something more. That's why perfectionism can be so exhausting. Perfectionism makes acceptance of being a fallible human being almost the hardest thing to do, and that's why turning the corner requires a lot of work reconnecting with ourselves.”

Curran talks about how medics can work with the traits that predispose them to perfectionism:

“There are some really good elements of perfectionism—high standards are important—but we have to rid ourselves of the insecurity that's driving them.

“What is really important is for us to hold onto the vocation of our job. Why are we doing this job in the first place? We wanted to help people. That kind of motivation is far more sustainable than the kind that's pushing us forward to meet targets all the time—you never feel content because there's always another target to hit. But if we can focus on the vocation of our work, then we can immerse ourselves in the joy of making a difference.”

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

Statins, risk, and personalised care

Sam Finnikin and colleagues argue that guidelines should focus less on population level risk thresholds and more on shared decision making conversations based on individualised risk and patient preferences

Statins are the most prescribed medications in England with over 82 million prescriptions issued in the 12 months to July 2023.¹ However, the 2023 update of guidelines from NICE suggested they could now be given to millions more people with lower risk scores.²

The recommendations raised concerns about the reduced benefit for lower risk patients and extra workload for general practitioners, who already spend considerable amounts of their time managing risk of cardiovascular disease (CVD).³ A change of emphasis is needed to achieve the overall goal of helping people make healthcare decisions based on effective risk communication, holistic care, and shared decisions.

Cardiovascular risk estimation is fundamental to prescribing guidelines

Statins have consistently been shown to reduce the risk of CVD,⁴ and greater use of statins at a population level could be a cost effective and clinically effective way of reducing the disease burden. However, the benefits of statins for otherwise healthy individuals are relatively small and, at an individual level, for many people, the benefits may not outweigh potential harms.⁵

To balance underuse and overuse international guidelines have, for many years, recommended using estimated cardiovascular risk to guide treatment recommendations. For example, the US Preventive Services Task Force and NICE use a 10 year risk threshold of 10%,^{2,6} whereas the World Health Organization uses 20%⁷ and the European Society of Cardiology uses risk categories combined with lipid levels.⁸

Informed patient preference should take precedence over clinical guidelines



Risk factors for CVD such as age, sex, blood pressure, and lipid concentrations are well established and can be used to estimate risk relatively quickly for most people without existing disease. At a population level, models show benefit which can be used to facilitate economic evaluations for treatment at different risk thresholds. If the threshold is set too high, we miss the opportunity to prevent numerous cardiovascular events; if it is too low, the costs of treatment can outweigh the benefits.

The box, overleaf, summarises how NICE treatment thresholds have changed over time in response to changing clinical and economic evidence. While these treatment thresholds are sometimes justified on health economic arguments, they can be at odds with the preferences and values of individual patients.

KEY MESSAGES

- Risk estimation is fundamental to strategies to reduce the risk of cardiovascular disease but is not being used optimally
- Clinical guidelines give risk thresholds for starting statins based on population benefit
- At an individual level, risk estimation should be used as the basis for communicating benefit in shared decision making
- Applying risk thresholds rigidly to individual patients is antithetical to personalised care

Using risk estimation in shared decision making

We believe the key risk informed decision is the one made by the patient: whether to take a statin. When people are faced with decisions about their health, it is the clinician's responsibility to provide balanced information and guidance through shared decision making.¹²

The clinician should present the options (including doing nothing), explain the potential harms and benefits of the options, then encourage patients to use their preferences and values to arrive at a decision. The benefit someone could expect from statins is proportional to their baseline risk. Statins for primary prevention provide a relative risk reduction of 25-30%,⁶ so, for example, someone with a 10 year risk of 10% would have their absolute risk reduced by about 3%. However, the potential harms (eg, side effects, inconvenience, labelling, cost) are independent of a person's cardiovascular risk, although some adverse outcomes are related to individual patient characteristics or comorbidities.

The problem with using cardiovascular risk thresholds to decide on treatment is that these risk thresholds may not concord with the preferences of all patients,¹³ and informed patient preference should take precedence over clinical guidelines. For example, a 2017 systematic review reported that one third of patients would not consider preventive medication that offered an absolute 5 year risk reduction of 5%¹³—much greater than the 3% benefit someone with a 10% risk over 10 years would get from a statin. In a 2021 survey, the cardiovascular risk had to be 20% before 75% of respondents reported they would want to take statins, and preferences varied considerably.¹⁴

Recommendations from recent NICE guidelines on lipid lowering treatment

CG69 (2008)⁹

1.4.3: Statin therapy is recommended as part of the management strategy for the primary prevention of cardiovascular disease (CVD) for adults who have $\geq 20\%$ 10 year risk of developing CVD⁹

CG181 (2014)¹⁰

54: Offer atorvastatin 20 mg for the primary prevention of CVD to people who have $\geq 10\%$ 10 year risk of developing CVD. Estimate the level of risk using the QRISK2 assessment tool

Draft update CG181 (Jan 2023)¹¹

1.3.17: Offer atorvastatin 20 or 40 mg for the primary prevention of CVD to people who have a 10 year QRISK3 score $\geq 10\%$

1.3.18: Consider atorvastatin 20 mg for the primary prevention of CVD for people with a 10 year QRISK3 score $< 10\%$ where there is patient preference for taking a statin or concern that risk may be underestimated

NG238 (Dec 2023)²

1.6.7: Offer atorvastatin 20 mg for the primary prevention of CVD to people who have a 10 year QRISK3 score $\geq 10\%$

1.6.8: Do not rule out treatment with atorvastatin 20 mg for the primary prevention of CVD just because the person's 10 year QRISK3 score is $< 10\%$ if they have an informed preference for taking a statin or there is concern that risk may be underestimated

We need to consider how to help patients understand and use risk in their deliberations

The NICE guidelines, as with many other guidelines, do not seem to take account of the literature on patient preferences regarding statins when deciding cardiovascular risk thresholds for treatment. NICE does, however, stress the need for shared decision making both within the lipid lowering guidelines and in separate guidance on shared decision making.¹⁵ If guideline writers truly believed in shared decision making they would make risk and benefit data more prominent and use thresholds either to promote timely discussion of the options or to make it clear when not to offer a treatment (because the evidence suggests no benefit, or the treatment would be cost prohibitive).

Given patients differ in the level of risk at which they would want to take a statin, we need to consider how to help them understand and use risk in their deliberations. Although it is a simplification, patients will generally take a statin if they believe that the potential benefits outweigh the potential harms. Harms are often conflated with risks of adverse effects and, although these are a concern for many patients when considering taking a statin,¹⁶ the potential harms from medications are broader than this and vary between patients.

The deleterious effects of taking a medicine can include an altered sense of self and wellbeing, prescription costs, monitoring and

review burden, and the hassle of having to take a medication every day.^{16 17} Statins are often the first long term medication a person starts taking, turning them into a lifelong "patient." People have different views of the harms of medications and, therefore, the point at which the benefits outweigh the harms is variable and may not be attainable given the benefit many medications can reasonably offer.¹⁸ Additionally, statins, perhaps more than most drugs, have received considerable media attention, which may also influence patients' perceptions.¹⁶

People's interpretation of the values of the benefit and the inconvenience or impact of the harms should inform their decision making. However, people find it difficult to contextualise their individual risks and benefits¹⁹ and so the skill of the clinician is required to help patients weigh-up the relevant information, voice their preferences, and then reach a decision. Such support poses the biggest challenge.

Prescribing a statin based on risk thresholds alone, without incorporating patient preferences and values, requires little skill, time, or knowledge. To provide higher quality, personalised care clinicians must have the skills, tools, confidence, and freedom to operate without directive protocols. This is particularly difficult when resources are limited.



Focusing on risk thresholds may restrict shared decision making

Although a risk based approach is better than focusing on surrogate marker thresholds (lipid levels), setting fixed cardiovascular risk thresholds for initiating statins, even with caveats about personal preference, creates a heuristic that may restrict shared decision making: "if the CVD risk is $> 10\%$, initiate a statin; if it is lower, then don't." We are all "cognitively miserly" so clinicians and patients will use decision making shortcuts (heuristics) when they are available. This could be compounded if external agencies evaluate or incentivise prescribing decisions based on CVD risk thresholds rather than patient preferences.²⁰ The new NICE recommendation including the term "do not rule out" (box) could be an attempt to counter this heuristic, but it is not clear it is sufficient to achieve this aim.

Individual risk communication would improve care and credibility

The 2023 NICE recommendation proposes that instead of discounting the option of a statin based on the risk threshold, clinicians should use their clinical judgment to augment risk estimates for individuals and



Guidelines are a starting point for tenable medical practice, not strict rules to abide by

taken into account.²⁵ Consideration must be given to the frequency of such an offer and an appropriate targeting strategy. The current NHS screening programme intends that people aged 40 and above are offered a CVD risk assessment every five years, but evaluation of this approach has shown that around three quarters of people attending have a low (<10% over 10 years) cardiovascular risk²⁶ and some higher risk groups may be under-represented.²⁷

Age and sex are the biggest contributing factors to cardiovascular risk, so the population can be stratified initially without full risk data into those who may be at a stage where they would consider medical intervention to reduce their cardiovascular risk and those who would be best supported to reduce their risk through lifestyle improvement.

Public health engagement, improved access to personal health information about CVD risk, and support from the multidisciplinary care team could help people better understand their CVD risk. They could then instigate conversations about medication when they feel it's right for them, rather than at a predefined threshold. Identifying and targeting higher risk people, whose individual "risk threshold" for taking a statin is more likely to be exceeded, should realise greater benefits.

We definitely should be talking about cardiovascular risk estimates when we think about the primary prevention of CVD, but instead of focusing on population level risk thresholds we should pay more attention to how and when risk is calculated and communicated. We should ensure patients receive high quality information and support during and after the decision making process, and help people make the right decisions for them.

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that an individual's preference for the levels of risk at which they would like to take a statin should be considered. The fact these two elements of clinical decision making need to be explicitly stated reveals an over-reliance on rigid recommendations in clinical guidelines. If a patient with a 10 year risk of <10% understands the potential harms and benefits of taking a statin and would like to start taking the medication, the clinician should provide a statin prescription.

Guidelines should not need to explicitly state that clinicians must consider an individual's particular circumstances and values. Guidelines are a starting point for tenable medical practice, not strict rules to abide by. While guideline writers can help override treatment threshold heuristics through considered use of language and flexible thresholds for offering treatments, we require a cultural shift and a renewed emphasis on shared decision making skills to avoid rigid adherence to guidelines. The careful and skilled application of the recommendations to the individual patient is the foundation of evidence based practice.²¹

Rather than focusing on when statins are offered it would be preferable to focus on how the offer is presented. A careful, skilled, shared decision making conversation that helps people understand their CVD risk score

and consider all their risk factors and their pharmaceutical and non-pharmaceutical options is essential. This allows patients to make the right decision for them, rather than be led by population level risk thresholds. To support this, risk scores can be used as discussion thresholds rather than treatment thresholds, as in the Canadian lipid guidelines that one of us (JM) helped develop.²²

We know adherence to statins can be an issue (adherence levels are 18-79%).²³ Uncertainty around the necessity, utility, and benefits of treatment, as well as confusion and constantly changing treatment targets, all contribute to poor adherence.²⁴ If a statin does not provide people with the benefit they want, they are unlikely to take the medication regardless of the recommendations of guidelines or their clinician. Perhaps by ensuring we prescribe statins only to patients who have truly chosen to take them and respecting other patients' right to accept their risks and decline statins, intentional non-adherence to prescriptions would reduce.

Risk reduction conversations

Good quality consultations about cardiovascular risk require a skilled clinician with sufficient time. The "time needed to treat" needs to be

Sobering assessment of Scotland's NHS

Leaders must prioritise prevention, primary care, and the social and commercial determinants of health

Audit Scotland's latest report on the Scottish NHS is sobering reading.¹ It highlights costs rising because of inflation, higher utility costs, and pay and prescribing pressures; demand for services rising faster than activity post-pandemic; and operational challenges affecting patient safety and experience.

It concludes that, without reform, the financial sustainability of services is in doubt. It calls for investment in prevention to tackle the causes of ill health, and the development of a clear national strategy for health and social care. Without this, according to Audit Scotland, long term planning will be more difficult for NHS boards.¹

It is important to understand why the NHS is under such pressure. The demand for healthcare is a function of need and supply. Need is largely determined by trends in population health and illness (although need can also increase through expansion of what is deemed treatable over time).

Average life expectancy in Scotland stopped improving around 2012, as in the rest of the UK. It worsened for people living in the most deprived areas.² The causes are well understood—*austerity* and its effects on benefits and public services being the most important.³⁻⁶ Trends in ill health are similarly worrying,^{7,8} exacerbated by the direct effects of covid-19, and the indirect effects of economic, social, and care disruption during the pandemic.^{9,10}

Population ageing is adding to these pressures. How much this drives growth in demand and expenditure is contested, especially compared with inflation and adoption of new technologies. However, the effect of population ageing depends on the extent to which prevention delays the disease, disability, and dependency more prevalent in older populations.¹¹

Audit Scotland's warning that disease prevention is effectively being de-prioritised by current pressures and the incentives created by performance



LESLEY MARTIN/GETTY IMAGES

Measures to reduce the underlying causes of ill health are essential

indicators is, therefore, important. Along with inflation, staff shortages, and continuing austerity policies, it is difficult to see how the NHS can improve population health and reconcile demand and supply.^{3,12}

Supply and demand

How healthcare need translates into service demand is mediated by supply. Audit Scotland's report highlights the potential role of "realistic medicine" to change this dynamic and reduce healthcare that does not add value.

The Scottish chief medical officer's first report on realistic medicine in 2016 noted the influence of supplier induced demand, driven by clinicians' varying interpretation of evidence on effectiveness and side effects, pressure from industry, perceived risks of litigation, and patient expectations, leading to care in excess of what clinicians or patients would choose for themselves when fully informed about the risks and benefits.^{13,14} Primary care has a vital role in promoting realistic medicine but faces its own challenges. Disappointingly, Audit Scotland's report contains scant mention of primary care services (including dentistry).

In response to the report, the Royal College of Physicians of Edinburgh has called for a national conversation on NHS funding, priorities, and whether we can afford to provide every treatment available, free of charge at the point of access.¹⁵ The introduction of further NHS service charges has already reared its ugly head.¹⁶ Proponents rarely make

clear whether they expect NHS charges to reduce demand for services or raise income. Either way, it is unlikely to be effective, efficient, or fair.¹⁷

Audit Scotland rightly highlights that measures to reduce the underlying causes of ill health are essential. Notwithstanding the challenges associated with UK economic policy,^{3,18} effective measures have improved health, reduced health inequalities, and mitigated (some) demands; these include vaccinations, the smoking ban, minimum unit pricing for alcohol, and the Childsmile dental intervention.¹⁹ Further legislation and regulation to address commercial determinants of health,²⁰ as well as measures to reduce poverty and provide good public services across the determinants of health, are all likely to be effective.³ Prevention is no financial panacea.²¹ But there is ample evidence prevention is cost effective in its own right.²²

Audit Scotland calls for reform, but reforms need careful evaluation. Scottish government ministers may contemplate merging health boards to reduce costs and increase efficiency, but this won't change service needs or demands, and would incur substantial costs and disruption. At a service level, reforms shaped by improvement science and "collaboratives" may help reduce low value services, but they might also encourage changes not based on robust evidence.²³

Financial sustainability is more likely to arise from stripping out ineffective or low value services; reducing "failure demand" (reactive public spending on the consequences of persistent health, social, and economic inequalities)²⁴⁻²⁶; focusing on prevention; and increasing capacity and quality in primary care.

However, managing need, demand, and supply will become increasingly difficult the longer UK economic and social policy undermines funding for public services and social security.³

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Comprehensive policies to reduce harm caused by homelessness

Homelessness is a global public health issue, and in many countries the number of homeless people is rising (Editorial, 24 February).

Williamson and

Brunjes rightly draw our attention to some of the many causes of homelessness, the profound effects on people's health, and some effective solutions.

A range of factors can contribute to a person becoming homeless, including inadequate affordable housing, immigration policies, social security policies, unemployment, family breakdown, and domestic abuse. The risk of homelessness is higher for those leaving institutional settings such as prisons, psychiatric hospitals, the child welfare system, or the military. Another very important cause of homelessness is armed conflicts. Wars in Myanmar, Palestine, Ukraine, and Yemen, for example, are destroying homes and whole communities and having devastating effects on people's health.

In the few countries with leaders who have prioritised this public health issue, there are examples of success. Governments need to put in place a comprehensive, long term strategy that includes an increased supply of affordable housing; more security of tenancies; access to welfare and benefits to cover housing costs; and free, accessible support services for vulnerable people.

The Institute of Health Promotion and Education supports a "housing first" model, in which a secure tenancy is arranged first and then the other problems that people have can be more readily dealt with. We agree with Williamson and Brunjes that "inclusion health" is important, tackling root causes as well as aiming for maximum participation of homeless people.

In the UK, policies must draw upon the successes from elsewhere and enable the implementation of evidence based guidelines as a matter of urgency. Internationally, our leaders urgently need to rise to the challenges and find peaceful solutions to the many armed conflicts that are promoting homelessness and having devastating effects on people's lives.

Michael Craig Watson, trustee; Karen E Neil, trustee, Institute of Health Promotion and Education

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MEDICAL APPRENTICESHIPS

Consider longitudinal integrated clerkships

Lynn's article clarifies what is known about medical apprenticeships (Cover, 13 January). The specific educational approaches and oversight in host practices or partner institutions remain unclear.

Longitudinal integrated clerkships (LICs) are a well established method of clinical education that address educational and workforce mandates. They offer an evidence based route for clinical placements for medical apprenticeship programmes.

Students in LICs participate in the comprehensive care of patients over time; have continuing learning relationships with these patients' clinicians; and meet most of the academic year's core clinical competencies across many disciplines simultaneously.

Learning and practice are not partitioned; students become part of the clinical team. LICs foster professional identity formation and drive social accountability with a patient centred approach with capacity to positively affect socioeconomic inequalities.

Educational continuity, the fundamental principle of LICs, elevates professional relationships among students and supervisors, patients, and the healthcare system—perfectly suited to support medical apprenticeship programmes.

Katie Webb, reader in medical education, Cardiff; Ffion Williams, head of graduate entry medicine, Swansea University; Stephen Riley, pro vice-chancellor, Cardiff; David Hirsh, associate dean of undergraduate medical education, Harvard Medical School

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BETRAYAL OF CHILD HEALTH

Children's voices must be included in policy development

Abbasi's article on the appalling decline in child health is sobering (Editor's Choice, 10 February). Failure to consider children in public policies has had profoundly negative effects. Policies related to the pandemic had a staggering effect on children. Data on health inequities consistently show disproportionately greater climate related health effects on children in disadvantaged countries.

Political conflict and instability negatively affect children, who account for 41% of displaced people globally.

The International Network for Epidemiology in Policy (INEP) works to tackle policies that affect global public health, including the right to a healthy future. It has three recommendations: commit to centring policies on children as a core value and operating principle in all agencies or organisations; take equitable and intentional action in engaging and listening to the voices of children, their families, and their communities; and tackle barriers to including children, develop approaches to overcome them, and evaluate these approaches.

Susan dosReis, professor of pharmacy and pharmacoepidemiology, Baltimore; Camille Raynes-Greenow, professor of perinatal epidemiology and public health; Katy Bell, professor of clinical epidemiology, Camperdown, Australia

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MENTAL HEALTH

Ministers' pledges to fix broken services must be monitored

Rimmer highlights the perception that mental health services in the UK are failing (This Week, 24 February). Services continue to lack sufficient investment in workforce and infrastructure and are letting down professionals, carers, and patients.

In 2018 the government promised to "increase funding for mental health services by at least £2bn a year in real terms by 2023-24." It pledged to pay for "comprehensive 24 hour mental health support in every major hospital emergency department in the UK and provide more mental health ambulances, more 'safe havens' in the community, and a crisis hotline."

We are all familiar with political promises—how much of the "£2bn a year" increased funding was actually spent?

We need a "promise checker" team at the BMA to monitor, evaluate, and make any necessary freedom of information requests to check whether specific current and future government spending commitments are actioned.

Chris Hewitt, retired GP, Colne

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OBITUARIES

Mary Ann Matthews

GP partner and associate dean (b 1954; q King's College Hospital, London, 1977), died from glioblastoma on 14 October 2023



Mary Ann Matthews was born into a family who lived by their Christian beliefs. She became a young GP partner at South View Lodge, Bromley, in 1980, serving that community for 34 years. Every Friday night, she helped run a youth club for young people living in the borough. She also taught in Sunday school. With her husband, Martin, Mary used family holidays from 1997 onwards to visit Kenya, founding a charity—Footsteps International—to care for orphans and street boys she met. At the time of her death, the Sunshine Centre in Naivasha cared for 144 street boys, providing them with security, food, and education and the opportunity to earn a living and care for families of their own. Mary leaves Martin, two children, and three grandchildren.

Nicola Payne

Cite this as: *BMJ* 2024;384:q648

Rose Buchanan

Consultant histopathologist Portsmouth Hospitals University NHS Trust (b 1937; q Royal Free/Oxford, 1961; FRCPath), died from cerebral infarction on 12 January 2024



Rose Buchanan and Keith Bearpark married in 1959. They moved from Oxford to the Wirral, and Rose worked as a locum before gaining a registrar post at Clatterbridge Hospital. They moved to Hampshire, and Rose was appointed as a consultant histopathologist in Portsmouth in 1979. She was instrumental in developing an appropriate bereavement service for parents who experienced miscarriages. After Keith's death in 2016, Rose moved with Anna, her remaining Maine Coon cat, to a retirement village. A fall in December 2023 led to her admission to Southampton General Hospital and a diagnosis of cerebral infarction. Rose will be missed by her nephews, wider family, friends, and former colleagues.

Margaret Jeffrey

Cite this as: *BMJ* 2024;384:q643

Bill Coode

Consultant in emergency medicine Newham University Hospital (b 1967; q University College London, 1993; MRCP, FRCM), died from heart failure on 31 October 2023



On Halloween, with trick or treaters roaming the streets, Bill Coode failed to turn up for work. He was uncontactable, we thought because his phone was broken after a bike incident the week before, but it wasn't that. We wondered if he was ill, an infected wound from a patient's bite, but it wasn't that. The coroner stated heart failure, but it wasn't that—not really. A good friend asked if working in emergency medicine had killed him, even though that didn't get a mention in the post mortem. At Bill's funeral his father asked that we learn from what happened to Bill, and perhaps in doing so we will live longer, better lives. Bill Coode leaves his wife, Sue, and three daughters.

James Napier

Cite this as: *BMJ* 2024;384:q644

Ubaka Gregory Ofili

Consultant and clinical director Department of Obstetrics and Gynaecology, Wishaw General Hospital, Wishaw, Scotland (b 1954; q University of Benin College of Medicine, Africa, 1978; FRCOG, MPhil (medical law and ethics)), died from a cardiac event in his sleep on 18 January 2024



Ubaka Gregory Ofili ("Greg") started his postgraduate clinical training at the University of Benin Teaching Hospital in Nigeria, and moved to Scotland, where he advanced in his specialty. He was appointed consultant at Law Hospital and eventually became clinical director at Wishaw General. Greg had a particular interest in the obstetric care of mothers with twins and multiple pregnancies. Orators at his funeral attested to his generosity, kindness, infectious laughter, and readiness to help colleagues in clinical or personal challenges. Greg leaves Esther (a paediatrician and GP), his wife of 41 years; three children; and two grandchildren.

Esther Ofili
Cite this as: *BMJ* 2024;384:q650

Colin MacKay

Surgeon, college president, university administrator (b 1936; q Glasgow, 1961; CBE, FRCPS Glas), died from dementia and metastatic prostate cancer on 17 December 2023



Colin MacKay was consultant surgeon at Gartnavel General Hospital and the Glasgow Western Infirmary from 1982 to 1996. Elected to the council of the Royal College of Physicians and Surgeons of Glasgow in 1972 he became honorary treasurer four years later. In the 1990s he chaired the joint committee for higher surgical training. He was awarded the CBE for services to medicine in 2000. In 2001 he was invited to chair the board of governors of the UHI (University of the Highlands and Islands) Millennium Institute and had a pivotal role in guiding it to full university status. His deep Christian faith underpinned everything he did. Colin leaves Helen, his wife of over 57 years; three children; and six grandchildren.

David Smith

Cite this as: *BMJ* 2024;384:q646

John Armitage Southam

Consultant surgeon Epsom District Hospital (b 1929; q Manchester, 1953; FRCS), died from frailty and heart failure on 15 February 2024



John Armitage Southam worked as an anatomy demonstrator at the University of Manchester. He was a surgical registrar at Manchester Royal Infirmary and a senior registrar at United Birmingham Hospitals. From 1968 to 1993 he was a consultant surgeon at Epsom District Hospital. He published on the inferior mesenteric ganglion, primary malignant tumours of jejunum and ileum, and benign tumours of the small intestine, among others. In retirement his hobbies included bowling, travel, bridge, walking, and sudoku. He enjoyed spending time with his grandchildren and great grandchildren, who all live in various parts of the country. John's health deteriorated gradually from August 2023. Predeceased by a daughter in 1999 and by his wife, Audrey, in 2018, John leaves two children, five grandchildren, and three great grandchildren.

Richard Southam
Cite this as: *BMJ* 2024;384:q653

Mahmoud Fathalla

Professor of obstetrics and gynaecology and international advocate for women's health

Mahmoud Fathalla (b 1935; q Cairo University, Egypt, 1957; PhD), d 10 November 2023

In 1988 the World Health Organization released a short, animated video *Why did Mrs X die?* Voiced by Mahmoud Fathalla, founder of the United Nations' Safe Motherhood Initiative in 1987, it is an eloquent story of a pregnant woman's fate.

Mrs X could be any of the thousands of mothers in poor countries dying needlessly each year. Her death certificate records a haemorrhage, but the road to her death features poverty, poor education, lack of antenatal care, scant hospital resources, no family planning, and much more. Fundamentally, Mrs X loses her life because of society's lack of imagination and failure to value women.

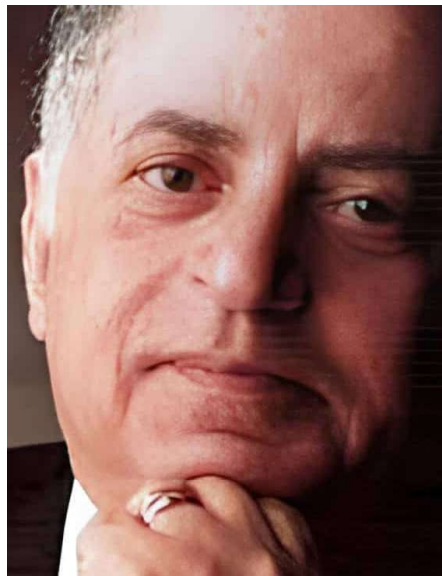
"Mothers are not dying because of diseases we cannot treat," Fathalla said. "They are dying because societies have yet to make the decision that their lives are worth saving."

Bigger picture

Fathalla was "unarguably the greatest women's health champion of the past century" according to Sabaratnam Arulkumaran, former president of the Royal College of Obstetricians and Gynaecologists. He had a particular gift for seeing the bigger picture. Once asked what women most needed for their health, Fathalla answered, "Power. Powerlessness of women is a serious health hazard, and particularly in maternal health."

Fathalla held several internationally prestigious positions including director of WHO's special programme on human reproduction from 1989 to 1992. He went on to be director of the International Federation of Gynaecology and Obstetrics (FIGO) from 1994 to 1997. He used these platforms to influence policy at the highest level and raise the status of women. At a time when many obstetricians were more interested in more glamorous monied areas of obstetrics such as IVF, Fathalla was able to shine a spotlight on basic maternal health and safety.

Able to transfix an audience with his eloquent language and calm demeanour,



MOHAMED MAHMOUD FAHMY FATHALLA

Fathalla campaigned for better maternity provision in poor countries

he used speaking engagements, lecturing, and writing (he was the author of more than 150 papers) to persuade governments, public health officials, and doctors to rethink their commitment to women's health, improve antenatal care, and bring down death rates. He saw it as a moral responsibility: "Society has an obligation to fulfil a woman's right to life and health, when she is risking death to give us life."

In 1990 Fathalla convened a meeting between WHO and the International Women's Health Coalition, inviting their input on subjects such as women's health, contraception, and abortion. He was also instrumental in forming the gender advisory panel at WHO and in making improved maternal health one of WHO's eight millennium goals along with promoting gender equality. As president of FIGO, Fathalla campaigned for better maternity provision in poor countries and as a result member countries established the Save the Mothers Fund in 1997.

In 2010 Fathalla got the UN Human Rights Council to class preventable maternal deaths as a violation of a woman's human rights. During his career, the global number of women dying from complications in pregnancy and childbirth

decreased from 546 000 in 1990 to an estimated 287 000 in 2010.

Early life and career

Fathalla was born in Abu Hammad, Egypt, on 1 May 1935. He was the middle child, with two brothers and two sisters. His father, Ibrahim, was a merchant and his mother, Fatma, took care of the family. After schooling in his home town, he studied medicine at Cairo University, qualifying in 1957.

He decided to pursue a career in obstetrics and gynaecology, and after several junior positions in Cairo he became a lecturer in obstetrics and gynaecology at Assiut University in 1962. He was profoundly affected by treating a woman who had to endure an unsafe abortion that left her uterus and intestines severely damaged and became convinced that women should have access to safe abortions and should be able to control their own fertility.

In 1967 Fathalla studied for a doctorate in ovarian tumours in Edinburgh. According to professor James Drife, he may well have come across the work of Dugald Baird, professor of midwifery at Aberdeen University, who had enlightened views on service provision and access to contraception and abortion, and who linked poor social conditions and frequent pregnancies to poor health.

After his doctorate, Fathalla returned to Assiut University, was appointed professor in 1972, and became dean of the university from 1978 to 1986. In 1964 he married Wafaa Ahmed Hammad, a professor of biochemistry, and had two sons: Mohamed in 1968 and Ahmed in 1972. Both are doctors.

After stepping down as president of FIGO in 1997, Fathalla became an adviser to the Rockefeller Foundation. He remained an active member of FIGO, the Safe Motherhood Initiative, and numerous other international obstetric initiatives and wrote and lectured well into his 80s. He died peacefully at home and leaves Wafaa, two sons, and five grandchildren.

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