

# comment

‘Morale will worsen, and NHS staff will leave or choose to do less—a vicious circle’

**ACUTE PERSPECTIVE** David Oliver

## Workforce crisis needs joined-up plan

In 1997 the prime minister, Tony Blair, coined the phrase “joined-up government.” When policy problems didn’t fit neatly into departmental and ministerial boundaries the idea was to collaborate on and coordinate aligned approaches and messaging.

Unfortunately, the recent response to the NHS workforce crisis is the antithesis of this, across departments and a confusing array of national NHS arm’s length bodies created by the 2012 Health and Social Care Act. Let me take you on a quick tour.

NHS England’s new chair, David Prior, stated on arrival that the three biggest challenges facing the NHS over the next 10 years were “prevention,” “integration,” and “technology.” He has long experience in ministerial, regulatory, and NHS board roles. Yet, bizarrely, he didn’t mention the growing gaps in the clinical workforce or the looming threat of worsening recruitment and retention.

Without adequate staffing in clinical roles NHS performance will decline, and services will become unsustainable. Morale will worsen, and staff will leave or choose to do less—a vicious circle. The workforce is surely the most pressing existential threat.

Don’t take my word for it. NHS Providers surveyed organisational leaders who cited workforce gaps as their biggest challenge. This aligns with numerous surveys of frontline clinical staff who list workload, workforce, and rota gaps as their main causes of stress and the biggest threats to patient safety. Those same organisations found around one in 10 consultant, nursing, and allied health professional posts unfilled—and more in busy acute specialties and some regions.

Within a month of Prior’s comments Dido Harding, NHS Improvement chair, said that “The NHS’s biggest problem is that not enough people want to work in it.” This realism is consistent with NHS Digital’s own recent



workforce report, which reported gaps just as big. My worry is that NHS England and NHS Improvement are now meant to be working in ever closer alignment, yet here their chairs don’t seem to be in the same book, let alone on the same page.

To be fair, last year Health Education England produced the first attempt at a transparent national workforce plan for the NHS in its 70 year history. Since it went out

to consultation I’d say it’s pretty light on tackling gaps in secondary and tertiary care, it’s silent on social care and public health, and it says little useful about allied health professions.

I’m not especially confident that the strategy will be fully funded or implemented. Nor do I see solutions to many issues in junior doctors’ working lives, which they’ve clearly told system leaders about. They’re leaving training programmes in growing numbers at every grade, and we don’t know how many will return.

The House of Commons’ own briefing reported that 12.7% of NHS staff are not British nationals and 5.7% are EU nationals. Continuing uncertainty over Brexit means that those from EU countries are less inclined to come or stay. The home secretary, Sajid Javid, having made visa exemptions for doctors from non-EU countries, has now said that this was only temporary, probably under pressure on immigration policy. Meanwhile, despite the Care Quality Commission’s *State of Care* report having found short staffing a major issue in its inspections, England’s health secretary, Matt Hancock, spoke last week about a “crackdown on agency staff.” How will this help when there aren’t enough permanent staff?

From my tour bus window, the view of NHS workforce planning shows lots of fragments and not many joins.

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## Social care funding: what can we learn from Germany and Japan?

Any long term solution will need to take people with it

**T**he government will announce the autumn budget on 29 October. All eyes will be on the chancellor to see how he plans to fund the promised extra £20bn a year for the NHS and what he will do to fund social care.

The Care Quality Commission's (CQC) recent list of "blackspots"—areas where patients face the double whammy of a failing local hospital and poor care services—brings home the impact on the NHS of our threadbare system of looking after frail older people. If the public can be persuaded that social care is crippling the NHS, they are more likely to support new taxes to pay for it.

Until now, social care has not been a salient political matter. While almost everyone sees their GP at some point, few people have any idea what social care means

unless they have an elderly relative who needs help to cope—or until they become elderly themselves. Many are then horrified to discover that the long term consequences of living with dementia, Parkinson's disease, or arthritis don't fall within the ambit of our free universal health service.

Theresa May tried to tackle this in the 2017 election manifesto, by proposing people pay more of the costs of social care. The proposals were branded a "dementia tax" and she had to do a swift handbrake turn to escape from the resulting fury of millions of people who were, in part, waking up to the reality of bills that they'd never even thought about.

Any long term solution for social care will need to take people with it. It must be trusted to be sustainable, stable, and fair. That is one of the lessons from Germany and Japan,



**Many Japanese people now have more confidence in their long term care insurance fund than in their pensions**

countries that I visited this summer as part of the wider research I am conducting into our ageing world.

### German model

Germany's mandatory long term care insurance system was introduced in 1994, when its care system looked as frayed as England's does now. The scheme was painstakingly built to ensure that no one gets something for nothing, that everyone gets something, and that everyone—workers over 40, employers, pensioners—puts something in. The government widened access by abolishing means testing. The deal with voters was simple: you will pay more in, but you will get more out.

### BMJ OPINION

Adam Fraser, Sally Ross, and Pritti Aggarwal

## Walk in another's shoes: GP-consultant exchange schemes



As the NHS celebrates its 70th birthday, recognition is growing that the primary-secondary care divide has become a gaping chasm that is adversely affecting patients, particularly those with complex illness. In a recent column Margaret McCartney urged doctors to start talking to their colleagues to tackle such problems. In Wessex a GP-consultant exchange scheme has taken off that allows us to do exactly that.

The first such scheme was set up in Portsmouth in 2015 by Sally Ross. The idea spread among GP educators, and further schemes were run in Basingstoke, Southampton, Poole, Dorchester, and Bournemouth. More than 200 pairs of consultants and GPs have volunteered to spend half a day with

each other. Some GPs took their consultant colleague on home visits, some joined team meetings, some spent 15 minute slots with different staff in the practice, most sat in surgery together.

GPs visited a range of hospital departments and experienced acute stroke units, cardiology catheter labs, theatres, outpatient clinics, ward rounds, and medical assessment units.

We provided a reflective learning template to use as evidence of quality improvement activity for annual appraisal. These reflections were shared and discussed by participants and other interested colleagues at an education event after the exchange.

Almost unanimously, participants enjoyed the scheme and were



The burden is shared, the risk is pooled, and everyone in need can benefit.

Stable funding is vital. Many Japanese people have more confidence in their long term care insurance (LTCI) fund than in their pensions, which have been tweaked so often that some young people no longer bother to pay in. LTCI payments are reviewed every three years and have been updated, but within clear mechanisms for capping costs. Hypothecation helps to assure people that their money will not be siphoned off.

The UK Treasury would need to overcome its dislike of hypothecation if we implemented a version of the German or Japanese models. Despite

been to take part again. There was a strong sense that the experience of observing a colleague in a different specialty rekindled a sense of compassion for them. One GP said he was struck by the “seeming ‘chaos’ on the wards, with lots of people doing things independently” and talking over or interrupting the consultant. Yet the same GP was also impressed by the “care shown by the team and the knowledge they had of patients within a system that felt chaotic and disjointed—very encouraging.”

Everyone completed the scheme feeling better about being a doctor. One consultant said, “It got me thinking a lot about much of what we do. There is a lot of risk taking in primary care, which takes great skill and confidence to manage. I am concerned that we do not talk

the differences in our systems, that would mean raising national insurance for everyone over 40, including over 65s who are now exempt from national insurance payments even if they are still working. I think this is a system that could be fair—and I hope it may be one of the options floated in the forthcoming green paper—but I have no doubt that it will take years of painstaking consultation and explanation.

#### Growing worries

One reason that the German and Japanese systems have commanded cross party support is that both were created at a time of growing worries about bills for disability. By centralising funding, revenue raising, and eligibility criteria, LTCI takes pressure off local authorities, while keeping assessments local. In England and Wales, the widely differing resources and council tax bases of local authorities—with councils in deprived areas often facing the greatest need—are a strong argument for centralising social care funding. Until we can do that, the care injustices identified by the CQC will only grow.

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about this enough, that the NHS does not support us enough (protect us from decisions that do not turn out well), and that there are several contradictory messages given by the NHS (refer less versus refer more; admit less versus make the service safer).”

Many participants have considered new ways of working together based on their newfound trust. Examples include a shared directory of GPs and consultants, formal liaison forums, and IT interoperability projects.

Mark Twain wrote that travel broadens the mind. After walking in each other’s shoes, we have certainly gained a different perspective.

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Sally Ross is a portfolio GP in Portsmouth

Pritti Aggarwal is a GP partner in Southampton

## BMJ OPINION

Sinéad Howley

### Mothers-to-be need GPs to be more proactive about folic acid



Folic acid is likely to be added to UK flour in an effort to reduce birth defects—a move that has been praised by medical groups and health charities.

While this is very welcome, it is important to remember that fortification and supplementation are complementary measures to reduce neural tube defects. We need to ensure that we don’t become complacent about continuing to educate women of reproductive age about taking a daily folic acid supplement. Fortifying flour will serve as a safety net to catch those who don’t take supplements, but it is by no means a replacement.

There is still poor awareness among women regarding folic acid supplements. Recent studies from Spain and Ireland show that less than 25% of pregnant women take folic acid supplements correctly in the preconception period.

In my own work as a GP, I meet on average one woman a week who presents for her first antenatal visit at around five weeks’ pregnant. When I ask her when she started taking folic acid, a

frequent reply is “yesterday, when the pregnancy test was positive.” This is frustrating to me as a doctor as she has missed most of the critical period to reduce the risk of birth defects. As medical providers we bear some responsibility for not getting the information to these women in advance of their pregnancies.

As GPs there are plenty of occasions to discuss folic acid supplementation in consultations with women of reproductive age, in much the same way as we promote regular cervical smears and smoking cessation. We could also be incorporating a reminder to women to take daily folic acid as part of their “pill check” consultation. No form of contraception is 100% effective so all women, even if they are using contraceptives, should also be taking daily folic acid.

Doctors must make time to encourage women of reproductive age to make these supplements part of their daily routine, whether or not they are planning a pregnancy and whether or not they live in a country with fortified flour.

Sinéad Howley is a GP based in Dublin

**Doctors must take time to encourage women to make these supplements part of their daily routine**

## ANALYSIS

# Intensive care: balancing risk and benefit to guide informed decisions

More efforts are needed to engage with the wider healthcare community and the public about what ICUs can—and can't—achieve, say **Jamie Gross and colleagues**

### KEY MESSAGES

- Intensive care can be associated with substantial physical and psychosocial burdens for patients and may have adverse psychological consequences for families
- Potential harms of intensive care are commonly overlooked in times of crisis when timely decisions need to be made about escalation of care
- Frail, elderly patients have poorer outcomes after a stay in an (ICU) and are rarely consulted about their wishes for life sustaining treatments
- The decision to admit a patient to the ICU should include assessment of whether the likely benefits outweigh the risks
- Where possible, patients and their families should be involved in the decision making process
- Earlier information about intensive care practices and outcomes may help patients make informed choices about their future care

Changing population demographics and improved chronic disease management have led to a growing proportion of patients being admitted to intensive care units (ICUs) with co-existing chronic disease and frailty.<sup>1,2</sup> This has contributed to greater demand for intensive care services, which is steadily increasing at a rate of about 4% a year.<sup>3</sup>

Limited bed capacity in ICUs results in cancelled urgent operations and in non-clinical transfers to other such units.<sup>4</sup> Given that intensive care is an expensive resource with healthcare costs for survivors that commonly extend well beyond admission,<sup>5</sup> this trend is unlikely to be sustainable. Crucially, for patients with chronic disease and established frailty, undergoing the burden of a prolonged stay in intensive care for an acute illness may not deliver sustainable benefit,<sup>5,6</sup> with the important caveat that the definition of “benefit” is a very individual thing.

Can anything be done to tackle the mismatch between supply and demand for intensive care? Perhaps part of this increasing demand is due to unrealistic expectations of what medicine—in particular intensive care—can achieve, along with an underappreciation of the burdens of both a critical care stay and future survivorship.<sup>7</sup> One approach might be to increase public awareness about what admission to intensive care could mean for patients and their families, to facilitate informed decision making.

### Pitfalls of intensive care

The onset of critical illness can be a highly stressful time for patients and their families. Most people do not express their wishes for the management of a future hypothetical life threatening crisis, so when a patient is incapacitated by acute illness relatives are often faced with the burden of trying to determine what that person would have wanted. Adding this to the confused framework around surrogate decision making increases anxiety

for all. No prognostic scoring systems currently available can reliably predict meaningful individual patient outcomes, so, understandably, the default pathway is often to give that person the perceived best chance of “survival.” This is further compounded by the historic view held by medics, patients, and relatives that survival is the overriding goal that defines success or failure of medical intervention.

For most patients admitted to intensive care, the outcome might initially seem favourable. But the life sustaining treatments provided might come at a cost to patients and to family members. This is commonly overlooked or underappreciated at the time of considering whether admission is appropriate.

Organ support (particularly for those receiving mechanical ventilation) is commonly associated with discomfort, pain, delirium, and delusional perceptions as patients drift in and out of consciousness brought about by sedation and the effect of acute illness.<sup>8</sup> Delusional perceptions contribute to frightening and distressing sensory experiences that may be re-experienced and may contribute to the development of post-traumatic stress disorder (PTSD).<sup>9</sup> Any prolonged stay in intensive care may also result in physical weakness, which can persist long term<sup>10</sup> and can coexist with lasting cognitive impairment and memory problems, anxiety, depression,<sup>11</sup> and PTSD.<sup>9</sup>

These may all contribute to a poorer quality of life, which may never return to that experienced before being admitted to the ICU.<sup>12-14</sup> These major adverse effects can affect anyone, irrespective of age, frailty, and comorbidity. They may not be well recognised among non-intensive care healthcare professionals and are generally not understood by the public.

Families of patients in intensive care can experience fear and helplessness, especially when survival is uncertain. They may then begin to recognise possible long lasting physical limitations, psychological or cognitive impairment, and requirements for



support after their relative leaves hospital. Anxiety, depression, and PTSD in family members may persist long after the patient is discharged from the ICU or has died.<sup>15</sup> Should the patient survive beyond discharge, families are often faced with the added strain of providing most of the support in the community.<sup>16</sup>

#### **To admit or not to admit?**

Deciding which patients are likely to benefit from admission to the ICU is a daily challenge for intensivists. Patients referred with signs of impending or established organ failure should undergo an ethically guided decision making process. This should assess whether the patient has a reversible acute condition or progression of chronic disease that is unlikely ever to improve; the patient's ability to recover medically and functionally based on their physiological and functional reserve; and, as far as can be determined, the patient's values and wishes.

These form the basis of reasoning whether the benefits of treatments offered on the ICU outweigh the

**The life sustaining treatments provided might come at a cost to patients and to family members**

burdens, and, if not, investigating what alternative care is available. Such care might include antibiotics for sepsis on the ward or even mildly invasive cardiovascular support on the high dependency unit to give the patient a chance of survival, but with the understanding that further escalation of organ support (such as mechanical ventilation) in the event of further deterioration is a "step too far" for some, where harm is likely to outweigh benefit. In these situations, when active treatment to reverse any acute condition has failed, a focus towards palliative interventions might be more appropriate to ensure comfort and a dignified death.

#### **Frailty, physiological reserve, and the capacity to recover**

Frailty is an increasingly recognised multidimensional phenomenon (encompassing physical, psychological, cognitive, and social impairment) and relates to a state of increased vulnerability caused by illness or age related decline in the body's physical and psychological reserves.<sup>17 18</sup>

Older people with frailty can live for many years if free from illness but are at risk of a dramatic decline in health and functional status from an apparently minor stressor, such as a fall or infection.<sup>17</sup> Frailty affects 14% of people over the age of 60, and prevalence increases from 6.5% in those aged 60-69 to 65% in those aged 90 or over in England.<sup>19</sup> The prevalence of frailty in ICUs exceeds 40% in patients over the age of 80,<sup>20</sup> and consistent evidence shows that frailty is associated with lower survival and higher hospital re-admission rates.<sup>21 22</sup>

Frail patients that leave the ICU are less likely to be discharged home and often have worse physical and psychosocial outcomes (compared with baseline and overall) than their non-frail counterparts, which translates to a poor quality of life for individuals and increased demand on health and social care resources.<sup>21 22</sup> Trajectory of frailty may also be important; evidence indicates that a more rapid progression of frailty or decline in functional status is associated with

worse outcomes above and beyond frailty itself.<sup>23</sup>

This doesn't mean that frail elderly people should never be admitted to ICUs; many survive without any long term burden, particularly if their illness and stay in the ICU are short.<sup>24</sup> But careful consideration is needed, as their physiological reserve and ability to recover from more prolonged critical illness are diminished, which has major implications not just for survival but also for rehabilitation.<sup>21 22</sup>

Although medical teams have the final decision on ICU admissions, patients' views are important, as they (and their families) will have to live with any consequences, which may be acceptable to some people but not to others. Unfortunately, patients are rarely consulted about their wishes for intensive care—only 12.7% in a French study cohort<sup>25</sup>—despite evidence showing a decreased willingness of elderly patients with severe chronic disease to undergo highly burdensome therapy or to risk severe disability to avoid death.<sup>26</sup>

Yet critical illness often occurs when patients lack capacity to have meaningful discussions about their wishes for care, so efforts should be focused on engaging with elderly, frail, and multimorbid patients at an earlier stage. This may include guiding them to more easily accessible information about the potential hazards of intensive care and encouraging them to discuss their wishes with their relatives or primary healthcare professional. The outcome of such discussions may vary substantially between individuals, which is likely influenced by family and social circumstances, religion, values, cultures, and beliefs, and these are important considerations.

### The last phase of life

Since publication of the government's end of life care strategy in 2008,<sup>27</sup> much effort has been made to improve the quality of such care, with a focus on ensuring that patients receive the right care in the right place and at the right time. In Scotland, the Realistic Medicine programme<sup>28</sup> challenges doctors to look for ways



**Critical illness often occurs when patients lack capacity to have meaningful discussions about their wishes for care**

to minimise burden and harm from overinvestigation and overtreatment and to ensure that patients are at the focal point of decision making.

In parallel, national pilots have aimed to improve the training of healthcare professionals in holding such conversations (such as the serious illness conversations guide<sup>29</sup>), the process of acute care where recovery is uncertain (such as the AMBER bundle<sup>30</sup>), and the documentation of patient's wishes across healthcare settings (such as ReSPECT<sup>31</sup> and Coordinate My Care<sup>32</sup>) so that they are known before the onset of acute illness and are easily accessed by any treating clinician. The Speak Up<sup>33</sup> and Choosing Wisely<sup>34</sup> campaigns, originating from Canada and the US, respectively, are designed to increase public engagement and support people to explore options and openly communicate and register their wishes about future care.

These approaches, which fit under the umbrella of advance care planning, have been shown to not only improve patient and family satisfaction in the last phase of life<sup>35</sup> but to also reduce healthcare costs by preventing unwarranted hospital and ICU admissions and reducing length of stays in the ICU.<sup>36</sup>

Information relating to intensive care could be introduced for some patients in advance care planning discussions, which may also include those relating to cardiopulmonary resuscitation, as "successful" resuscitation efforts almost always result in admission to an ICU. With this come fresh challenges,

particularly as few healthcare professionals involved in advance care planning have a background in intensive care. Conversely, intensive care clinicians may not be familiar with the process of advance care planning; their first involvement in care is usually at the time of crisis. Thus, future cross specialty training should be explored, giving healthcare professionals the right information to disseminate to patients and helping to empower patients to openly explore and communicate future treatment preferences.

In addition to training, more research is needed to accurately identify which patients are least likely to benefit from intensive care, preferably at an earlier stage in the community setting; this was identified as a key topic in a recent research priority setting exercise.<sup>37</sup> Identifying patient pathways and interactions with health and social care services in the months that lead to a hospital or ICU admission would determine opportunities where active engagement could be explored.

Perhaps the greatest challenge relates to how and when information is best shared with the public about the benefits and burdens of hospital care (including intensive care) and how health services should be restructured to support patients and their families to make informed choices and decisions about their wishes for future care, which is reviewed on a regular basis. This is a key area for policy change set out in the Institute for Public Policy Research's *End of Life Care in England* briefing paper,<sup>38</sup> the goals of which align with improving quality of care while reducing the cost of care towards the end of life.

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Barry Williams, patient and public representative, Bishop's Caundle, Dorset  
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## PATIENT ROLES IN RESEARCH

**Including underserved patient populations**

We agree with Wicks et al that ensuring patient diversity in research is challenging (Editorial, 18-25 August). Migrant patients may be excluded for not speaking the researcher's language, thus perpetuating inequalities in health and access to care.

Patients can help to determine which research questions are important to their communities and prioritise a research agenda. They can support researchers to construct understandable and culturally appropriate information, and they can be language concordant interviewers. They can be part of the research team to support data analysis and writing results.

Investing in long term relations with underserved populations is worthwhile. We must heed their input, communicate findings, and recognise their role by offering compensation or discussing shared ownership. To truly obtain equity in healthcare and reduce inequalities in health, researchers must learn to become responsive to diversity by recognising and lowering specific barriers for patients from underserved groups.

Jeanine Suurmond, assistant professor; Marieke Torensma, PhD student, University of Amsterdam

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**Greater challenge in Africa**

The large educational and societal gap between researchers and patients in Africa affects patient participation. This can lead to well meaning but misplaced research questions, unsuitable consent processes, and inappropriate protocol and outcomes for the local context.

Information sheets used for informed consent rarely have patient input leading to complex forms full of legal jargon, which can hide important information.



## LETTER OF THE WEEK

**PHE is not in thrall to the alcohol industry**

The health harms of alcohol require action, and Public Health England has promoted a range of effective interventions, including minimum unit pricing.

Partnership with the charity Drinkaware enables us to ensure that the messages about harm in its campaign are hard hitting and accurate. It has not threatened our independence, and the content of the campaign is based directly on the UK chief medical officers' current guidance. The campaign may only be a small step towards reducing the harm from alcohol, but it is a step in the right direction.

We recognise the potential dangers of direct engagement with industry. PHE has no plans for partnership with the alcohol industry and has emphatically not been captured by it (Editorial, 22 September). Drinkaware is an educational charity regulated by the Charity Commission. A code of conduct that excluded partnerships with charities that received similar funding would be hopelessly restrictive. Public health agencies worldwide must work with a wide range of partners to have impact.

We do not want to alienate our respected colleagues with this partnership, but we must work in the world as we find it, not as we would like it to be. National public health agencies need to engage to effect change, how they do so is an important topic for debate.

John Newton, director of health improvement, Public Health England

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Our project assesses public involvement in women's health research in Uganda. Our preliminary findings show that women fare better with short, pictorial information on a flip chart than with the standard six to seven pages of participant information.

We are working with the James Lind Alliance to develop a context specific approach to understanding important research questions with women and the public in Uganda.

James Ditai, PhD fellow, Uganda; Andrew Weeks, professor of international maternal health, University of Liverpool

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**One step in a long path**

Patients have little input into funding decisions. One excuse is that they do not understand research. But why can't we train them? Patients may be lawyers, engineers, or care providers, with

a host of life experiences giving them a unique perspective.

An antiquated academic system also contributes to the problem, where merit is based on the journal in which research is published, not on how it affects society. If a researcher does participate in extensive patient engagement, it goes unrewarded.

We also need to engage patients with mobility or other limitations due to their disease. These are the patients that clinical research is working to help, so their inclusion is vital.

*The BMJ's* leadership is a crucial first step, which others should follow.

Scott A Lear, professor, Simon Fraser University, Vancouver

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**Still many roadblocks**

Numerous roadblocks need to be recognised, tackled, and removed on the road to

successful patient involvement. At least seven types of roadblock exist: mental, communication, logistical, organisational, legal, financial, and administrative. Most of these are challenging, complex, and persistent.

Full implementation of patient involvement will require effort from multiple stakeholders.

The medical and research communities, the patient community, contract research organisations, hospitals, the drug industry, and governments need to commit to the process.

Eric C Roos, executive board member, Dutch Clinical Research Foundation

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**The dead hand of research committees**

Suggesting that patient collaboration would ameliorate the decline in research quality is nonsense. It runs counter to the way research operates.

The logic of a novel finding often becomes apparent after experiments are done, but research committees want it before. Our discovery that patients with dermatitis herpetiformis have jejunal changes "indistinguishable from coeliac disease" would have failed as a research committee proposal, because its novelty was based on little more than my personal "hunch."

Of course, *The BMJ's* proposal for patient coproduction wouldn't harm the dull academic labour that now masquerades as clinical research—the double blind, case controlled, randomised studies that confirm what we already know or don't need to know. But when applied to clinical research that is inspired to find and create new things, it will serve only to kill its few remaining shoots. *The BMJ* should know better.

Sam Shuster, emeritus professor of dermatology, Suffolk

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## OBITUARIES

### Nicolas Edwin Baldock

Surgeon commodore (b 1945; q Bristol 1969; QHP, CBE, MRCS, FRCP, FFOM, DAvMed), died on 21 September, having been diagnosed with carcinoma of the oesophagus in June 2018



After house jobs in Bristol and Bath, I was sent to Royal Naval Air Station Brawdy in Pembrokeshire and stayed with the Fleet Air Arm until 1991, apart from a year back in hospital to obtain MRCP(UK). Occupational medicine appointments then followed, and I became a commodore in 1997 and held that rank on the staffs of Second Sea Lord and Commander-in-Chief Fleet; as medical officer in charge, Institute of Naval Medicine; and, finally, as president of the Central Air and Admiralty Medical Board (a post I had held as a lieutenant commander). I retired from the Royal Navy, after 40 years, in 2006. From 2005 to 2015 I served on the War Pensions Tribunal. I leave my wife, Virginia; three children; and five grandchildren.

Nicolas Edwin Baldock

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### James David Pettit

Consultant in anaesthesia and intensive care Hull and East Yorkshire Hospitals NHS Trust (b 1973; q Leeds 1997; MMedSci (Anaes), FRCA, FFICM), died from myocardial infarction on 16 March 2018



James David Pettit was appointed to his consultant post in 2007. He was highly regarded for his clinical skills, vast depth of knowledge, and never ending enthusiasm to pass on that knowledge. James was heavily involved in the training of anaesthetists and associated clinical staff. At the time of his death, he was deputy head of the Yorkshire School of Anaesthesia, with a particular remit for intensive care training. He established in Hull the first simulator courses for critical incident management within anaesthesia. He was chairman of the trust's resuscitation committee and lead for outreach and deteriorating patients. He leaves his wife, Amanda (a general practitioner), and a son.

Caroline Hibbert

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### Sam Michael Tucker

Consultant paediatrician (b 1926; q University of the Witwatersrand 1952; DCH (Eng), FRCP Ed, FRCP Lond, FRCPCH), died suddenly after a fall at home on 11 June 2018



Originally from South Africa, Sam Michael Tucker was appointed a consultant at Hillingdon Hospital in Uxbridge in 1965. Additional medical and academic appointments followed. As professor of paediatric audiology at Brunel University, Sam developed a new standard in neonatal hearing. Privately, he had rooms in Harley Street and saw patients at the Portland Hospital. He was an authority on the treatment of attention-deficit disorder (ADD) and attention-deficit/hyperactivity disorder. In retirement, he continued in private practice for as long as he was able, but he developed disability and renal failure that required dialysis in his later years. Sam leaves his wife, Barbara; three children (one the author of this obituary); nine grandchildren; and a great grandchild.

Dana Cukier

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### Rob Pickard

Consultant urologist (b 1961; q London Hospital Medical College, University of London, 1984; MD, FRCS, FRCS (Urol)), died from glioblastoma multiforme on 24 July 2018



As consultant urologist at the Freeman Hospital, Rob Pickard was interested in service development. He honed his education and mentoring skills and provided a specialist supraregional service for urethroplasty, adolescent urology, and urinary tract reconstruction to the north of England. As senior lecturer and, since 2009, professor of urology at Newcastle University, he worked on multidisciplinary projects, led national clinical trials, supervised postgraduate students, and achieved more than 120 peer reviewed publications. Outside medicine Rob's passions included Ordnance Survey maps and walking. He was originally diagnosed in November 2015, and a scan showed tumour recurrence in March 2018. Rob leaves his wife, Caroline; two children; his mother; and two brothers.

Caroline Pickard

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### Barbara Mary Katić

General practitioner Aspull Surgery, Wigan (b 1928; q Trinity College Dublin, 1953), died from complications of Parkinson's disease on 28 September 2017



In 1956 Barbara Mary Cooke secured a work visa for the US. She trained in psychiatry and worked at St Vincent's and Bellevue hospitals in New York City. She met her future husband, Radovan Katić, in the queue for the Staten Island ferry. They married in 1958, had five children, and returned to the UK in 1969, where Barbara rejoined her brother in the family practice. She and Radovan often visited his native Croatia. Barbara was diagnosed with Parkinson's disease in 2005 and struggled to keep her independence. In 2014 the couple made a last visit to Croatia to celebrate her 86th and his 90th birthday on 28 September with family and friends. Radovan died in January 2017. Barbara leaves five children and two grandchildren.

Christina Katić, Catriona Barr

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### John David Eddy

Consultant physician and cardiologist (b 1935; q St Bartholomew's Hospital, London, 1958; FRCP Lond), died from multiorgan failure due to end stage heart failure caused by ischaemic heart disease on 6 November 2017



John David Eddy was appointed consultant physician and cardiologist to Good Hope Hospital, Sutton Coldfield, West Midlands, in 1970. He set up the coronary care unit and worked with the ambulance service, providing emergency cardiac care in the community. Later, he initiated a rehabilitation programme of carefully supervised exercise for patients who had recovered from cardiac infarction. He and his colleagues were honorary senior lecturers at Birmingham University, had academic links with Aston University, and worked at community hospitals in Lichfield and Tamworth. Predeceased by his wife, Priscilla, in 2001, he leaves four children and seven grandchildren.

Peter Hillenbrand, Pauline Manfield, John Milles

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# Peter Copeman

Pioneered new classification of skin diseases

Peter William Monckton Copeman (b 1932, q St Thomas' Hospital, London, 1955; MA, MD, FRCS, FRCP), died from a series of strokes on 13 July 2018

In 1958 the *Lancet* published "Treatment of Recurrent Styes" by Peter Copeman, a house surgeon in the eye department at St Thomas' Hospital, London. It was the start of a distinguished career, but, surprisingly, not one in ophthalmology; colleagues in the fledgling dermatology department read the paper and persuaded Copeman to join them. In those days knowledge of dermatology was primitive, but today it is a highly competitive specialty, and Copeman's career was instrumental in its transformation.

## A family tradition

Copeman was born in London on 9 April 1932. When war broke out he spent school holidays with his evacuated family in Shaftesbury, Dorset. He enjoyed studying flowers and trees and learnt to imitate sounds such as a wild duck's call.

In 1945 he went to Eton. He had a dry sense of humour and could take a joke against himself. A favourite story is how, as captain of the rifle team, he was on course to achieve a record score for the Ashburton Shield. He took aim and scored a bullseye—sadly, on his neighbour's target.

When he decided to go into medicine he was following a distinguished tradition. Sydney, his grandfather, had developed the smallpox vaccine; William, his father, the specialty of rheumatology.

In 1950 Copeman went to Cambridge University to study medicine and later studied at St Thomas' Hospital in London, qualifying in 1955. He worked in the eye department before moving to dermatology in 1958. There he researched a new classification of skin disease based on blood flow. He studied vasculitis at the Mayo Clinic in the US for a year and also worked

**Copeman had a dry sense of humour and could take a joke against himself**



with a Dutch dermatologist, Rudi Cormane, on immunofluorescence diagnostic techniques. In 1962 he became a fellow of the Royal College of Physicians for his work on vasculitis.

In 1965 he became a consultant at London's Westminster Hospital. It was small, with superb architecture and an intimate atmosphere that attracted the cream of medical talent in the 1960s. He thrived in this atmosphere and helped others to do so too. He exuded enthusiasm and was a mentor to many, including John Harper, who was working on the skin manifestations of graft versus host disease in children receiving a bone marrow transplant.

Copeman worked with Terence Ryan, and the *British Journal of Dermatology* published their research, "The Problems of Classification of Cutaneous Angiitis," as a supplement in 1970. Copeman went on to publish more than 100 papers, including research on malignant melanoma. He helped set up the Daniel Turner dermatology unit at the Chelsea and Westminster Hospital, which opened in 2003.

He had great sympathy for his patients, recognising how skin diseases can rob people of confidence, and he had particular compassion for young patients. He told his sister once that he dropped to all fours and entered the children's ward barking like a dog, so that they might be less frightened.

He married Lindsey Brims in 1973 and had four children. He understood the importance of family and said that, when looking after a child, you were caring for the wider family.

In 1997 Copeman retired from the NHS but continued his private practice in London's Sloane Street until 2014. In what had been his father's consulting room, he treated patients from all walks of life with courtesy and discretion. He also worked overseas, making visits to Qatar in the late 1970s and then, in the 1980s, travelling to Cyprus to work in Kyrenia.

## Interests outside medicine

His retirement gave time for interests ranging from literature and language to drawing, Ancient Egypt, and history. He was the Willan librarian at the British Association of Dermatologists from 1999 to 2013. He was also a wine connoisseur and, as chair of the Athenaeum club's wine committee, persuaded the artist Eduardo Paolozzi to design the wine labels.

Copeman had a deep Christian faith. For many years he was churchwarden at St Mary's church in London's Bourne Street, and he volunteered his expertise to St Luke's, which provides the Anglican clergy with healthcare.

Finally, one of his abiding interests was conservation. On his farm in Northumberland he created wildlife corridors and ponds that earned him a place as a finalist in the Laurent-Perrier conservation awards.

Peter Copeman leaves his wife, Lindsey; four children; and nine grandchildren.

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FROM THE ARCHIVE

## Seeing ghosts



As Halloween approaches, it seems fitting to look back at what *The BMJ* has previously had to say on the subject of “ghosts, visions, and voices” (*BMJ* 1992;305:1518). “Up to one in six people in Britain and the US have seen, heard, or otherwise experienced ghosts or spirits,” wrote Frances Klemperer, a senior registrar in general psychiatry. “Although psychiatrists would describe these experiences as hallucinations . . . can they really be understood in terms of psychiatric syndromes?”

“As such experiences are transient and isolated,” Klemperer claimed that “major psychiatric illness is unlikely” and then gave earthly explanations of what may be behind these experiences: “Prolonged vigils may cause the illusions and hypnagogic hallucinations of profound sleep deprivation. Prolonged introspection may cause dissociative illusions and hallucinations. Cerebral dysfunction from any cause, including past head injury, may promote psychic experiences . . . Ghosts that appear at night may be illusions—that is, misinterpretations of real objects. Mistakes and misinterpretations are easily made when there is little sensory stimulation.

“Ghosts may also arise from hypnagogic and hypnopompic hallucinations—that is, normal phenomena of ‘waking dreams,’ which occur during the period of clouded consciousness that accompanies falling asleep and waking up.” Seeing figures or hearing music or one’s own name is a common experience during this state, said Klemperer, although hearing one’s name called aloud may also be “a misinterpretation of another sound.” She added, “We have a low threshold for hearing our name and therefore a strong tendency to misinterpret ambiguous sounds as our name. But some people describe having this experience in clear consciousness, in silence. What may be happening here is that they mistakenly identify a very quiet sound, which would ordinarily be subliminal, for their name.”

Klemperer concluded that “isolated hallucinations may be common and normal perceptual errors.”

MOST READ ONLINE

Pregabalin and gabapentin become controlled drugs to cut deaths from misuse  
 ▶ (*BMJ* 2018;363:k4364)

Junior doctor withdraws claim that whistleblowing ruined his career  
 ▶ (*BMJ* 2018;363:k4356)

Treatment burden should be included in clinical practice guidelines  
 ▶ (*BMJ* 2018;363:k4065)

Concerns about cardboard baby box as a place for infants to sleep  
 ▶ (*BMJ* 2018;363:k4243)



Should doctors share personal experiences of healthcare with patients?  
 ▶ (*BMJ* 2018;363:k4312)

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WHAT YOU'RE TWEETING ABOUT

## Recognising the burden of treatment

Last week *The BMJ* published an analysis arguing that the burden of treatment should be included in clinical practice guidelines (see most read online), a principle that met with readers’ resounding approval online. Here’s what you had to say on Twitter:

**Frank Barrera**  
 @frank\_barreraf  
 This should be implemented even in #MedicalEducation in order to increase the awareness of these concepts in future clinicians and make them able to deliver #HighQualityCare

**Lesley Fallowfield**  
 @FallowfieldLJ  
 This is so important and generally overlooked. There are substantial “costs,” financial, social and others associated with different treatments that are usually underestimated

**Terri**  
 @Terri27903773  
 The burden of treatment is sometimes worse than the condition

**Catherine Cassell**  
 @CassellCath  
 It’s so important that we listen to our patients taking into account what they can do and cope with . . . The workload of comorbidities is huge

**Moritz C. Wyler von Ballmoos, MD**  
 @DrMoritzWvB  
 Just like “an ounce of prevention is worth a pound of cure,” and we’re not doing enough of that, treatment burden of all



interventions deserves more attention  
**Anna Severwright**  
 @AnnaSeverwright  
 Yes! Having multiple long term conditions often feels like a full time job, loads of appointments, organising, monitoring,

side effects, all while not feeling well. Great to see this acknowledged  
**alf collins**  
 @alf\_collins  
 People should be aware of all available options and what is known of benefits, harms, consequences and burdens of those options  
**Bridget**  
 @bridgetmkiely  
 A person with three chronic conditions might spend 50 hours a month on healthcare related activities! Shows the need for shared decision making and prioritising of interventions, as that’s some burden