> Social isolation and loneliness are prevalent in older people precisely because of a lack of human contact

ACUTE PERSPECTIVE David Oliver

Robots cannot solve the social care crisis

Ara Darzi, a surgeon and former health minister, has called for "full automation" of "repetitive tasks" in health and care services.

In June Darzi was quoted as saying that the NHS could free up £12.5bn worth of staff time by investing in a "far reaching programme of automation." What also piqued my interest was the reported claim that automation could achieve a "further £6bn productivity gain" in social care.

Where had Darzi's figures come from? The Institute for Public Policy Research (IPPR) published its report *Better Health and Care for All: A 10 point plan for the 2020s*, of which Darzi is a lead author. Section 2 of the report recommends full automation to fill staffing gaps and improve productivity.

The IPPR claims that robots can provide rehabilitation currently given by trained human therapists or rehab assistants, encourage independence, deliver personal care, and reduce social isolation. In a table of estimated savings of time and money it makes the oddly precise claims that 24% of care workers' time, 25% of occupational therapists' time, and 29% of registered nurses' time in social care settings can be saved, and it estimates the millions of pounds saved.

It shows no workings or figures, no appendices to explain how these extraordinary efficiencies were calculated. To support these claims the IPPR cites the 2017 *Robotics in Social Care* report by an interested party, the UK Robotics and Autonomous Systems (UK-RAS) Network. This claims that home help robots will be able to help people to "get out of bed, to wash and dress, to eat and drink, and with mobility and social engagement" and will enable older people to live better, longer, more fulfilling lives and remain more connected to friends and family. Detailed empirical evidence remains elusive in this report, which sets out many "research challenges," none of which concerns proving such claims.

See for yourselves the eligibility criteria for receiving statutory social services, and look at the people receiving them: many are extremely frail, often with severe dementia and multiple dependencies.

Read independent reports on the falling number of people now receiving social care—even those with "substantial" or "moderate" needs—and the stark lack of support for their unpaid carers. Look at the detailed mapping in NHS Benchmarking's intermediate care audit on capacity, staffing, cost, and experiences of rehabilitation and reablement at home.

Look at the alarming prevalence of loneliness among older people precisely because of a lack of human contact. Examine credible projections of unavoidable increases in the numbers of people with dementia, multimorbidity, frailty, and dependence. Then ask yourself how credible and well evidenced UK-RAS's and IPPR's data-lite assertions and assumptions are and whether automation will be the silver bullet its evangelists claim.

The current overclaiming about technology seems to be a solution in search of a problem, driven by industry lobbying and passive acceptance of workforce gaps. We should never forget that health and social care is a people business and that those people might prefer more, not less, human contact.

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PERSONAL VIEW
David Ingleby and colleagues

Why we shouldn't use the term "illegal migrant"

Talking about migration requires a careful choice of words

Words have consequences, especially in situations where strong emotions, as well as social and political conflicts, are endemic. Raj Bhopal's rapid response in *The BMJ*, in which he objected to the use of the phrase "illegal migrant" on the grounds that only actions, not persons, can be deemed illegal, merits further reflection and dissection.

Some people think those who protest against this phrase are siding with migrants in conflict with the law. On the contrary: the idea of an illegal person is incompatible with the rule of law, which is founded on the idea that everyone has the right to due process and is equal in the eyes of the law. Labelling a person illegal insinuates their very existence is unlawful.

For this reason, bodies including the UN General Assembly, Council of Europe, the European Commission, and the International Organisation for Migration, have all deemed the phrase unacceptable, recommending instead the use of "undocumented" or "irregular." It would be appropriate for the medical profession to do the same.

While people cannot be illegal, actions can: but here, too, words have to be chosen carefully. For example, the vast majority of irregular migrants did not enter the UK clandestinely; their asylum application has been turned down, they have overstayed a visa, or breached its conditions. Moreover, it is never correct to label someone's actions illegal until the appropriate authority has determined they are. Until then, the presumption of innocence should apply.

Due process must have been followed, including the right to legal advice, representation, and appeal—rights the UK government, especially where migrants are concerned, has been only too willing to sacrifice on the altar of cost cutting. Even after an official determination that a person is residing unlawfully, we must have confidence in the fairness of the procedures before it is safe to assume the decision was correct. This confidence has been badly shaken by the recent finding that the Home Office has lost almost half of its immigration decisions that go to appeal.

Loss of confidence in the law

In their zeal to implement the government's "hostile environment" policy, some Home Office officials appear to have forgotten the rule of law still applies in Britain. People who had lived legally in the UK for decades have been suddenly branded as "illegally resident" and denied healthcare because they couldn't provide four pieces of evidence for each year of residence since they arrived—even when some

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COMMENT Tom Moberly

How doctors should warn public of Brexit risks

Report after report has warned that, whatever the details of the final Brexit deal, the NHS will be hit hard. Yet many people outside the health sector, and some in it, are still unaware of how the NHS will be affected.

These risks certainly shouldn't be kept hidden from the general public. In fact, the BMA has argued that doctors need to speak up about them, as they may prevent patients receiving the care they need.

"We have a professional responsibility to raise concerns when we believe there will be

Talking about Brexit poses a political challenge

detriment to patient care," Chaand Nagpaul, the BMA's chair of council, told a meeting on Brexit organised by *The BMJ* and the BMA last week.

Paul Williams, a GP and MP for Stockton South, told the same meeting that NHS workers needed to create a "wave of realism" about the impact of Brexit on the health service. "This is a time when the NHS has to be political," he said. "We all have to be using every voice that we have in order to tell this story."

But communicating the likely impact of Brexit to the public poses a huge political challenge. The population is deeply divided into "leave" and "remain" voters. Most people are firmly in one camp or the other, and their views are difficult to shift, Gideon Skinner, research director at Ipsos MORI, said.

"Just hitting people with more facts doesn't work," he told the meeting. "What the evidence suggests is that these misperceptions are a sign of something that you are worried about. So, just to say, 'No, you're wrong, because of this fact' doesn't address that.

It is unprecedented, and unacceptable, for health professionals to be conscripted as agents of state control

of the evidence had been destroyed by the Home Office itself.

Hundreds of highly skilled migrants, including doctors, have been denied the right to remain because minor tax or income discrepancies were taken as evidence of their undesirability under the new immigration rules. A recent case in which the Home Office separated a 3 year old girl from her only available parent, in contravention of its own policies, led to an award for damages of £50 000.

What of the medical profession's involvement? The 2014 Immigration Act links a person's healthcare entitlement to their residency status. Health professionals in the UK are now required to satisfy themselves that a person is eligible for NHS care by virtue of being "ordinarily resident in the UK," the definition of which has been narrowed. In practice, this has meant that people who do not fit certain stereotypes are more likely to be questioned—a potential route to an institutionally racist system. They can instantly be denied not only care, but also the ability to work, hold a bank account or driver's licence, or rent accommodation. It is unprecedented, and unacceptable, for UK health professionals to be conscripted as agents of state control in this way.

Given the unrelenting vendetta of sections of the press against people who may be residing unlawfully, it should also be borne in mind that such migrants cannot "sponge off the welfare state," since there are virtually no benefits they can claim.

Exploitation and abuse

They are routinely exposed to exploitation and abuse by employers, while "free choice" has often played a minimal role in creating their situation. Consider, for example, migrants who lose their right of residence as a result of losing their job, or asylum seekers whose claim has been rejected but cannot return to their country because it is unsafe or it refuses to accept them.

To sum up: abolishing the dehumanising term "illegal migrant" is an important first step, but the responsibility of health professionals goes further. In the UK, they are obliged to collaborate in the implementation of current immigration policy. To be able to do this with a clear conscience, they need to know that rights to residence in the UK are administered justly and humanely. Regrettably, as can be seen from the above examples, this is not always the case.

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"You have to address the emotional concerns of why people are worried about it in the first place."

Peter Holden, chairman of the BMA in the East Midlands, also pointed out that some of the areas where the NHS will be hit hardest have a high proportion of leave voters. "Somehow we've got to get through to locals," he said.

"It needs a little bit more than me going on local radio to say, 'It's your own fault, stupid, you voted for this, and that's why your waiting lists are rising.' We've got to get ordinary voters to understand what this is about, and how it will affect their local area: it's not just staffing difficulties but complete collapses of many hospitals."

Doctors need to think carefully about how they approach the issue and about what works to shift people's views. The classic advice that we should seek first to understand, then to be understood, may help. But as people increasingly discuss ideas in bubbles with like minded people, doctors need to find new ways to break down those barriers and use their status as trusted professionals to make that "wave of realism" a reality.

Tom Moberly is UK editor, *The BMJ*

View the BMA and *BMJ* Brexit session at http://bit.ly/2BlLM6v.

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BMJ OPINION Naomi Delap

Improving care for pregnant women and babies in prison

Research has recently revealed the extent and nature of the risks experienced by perinatal women and their babies in the English prison system. Urgent changes are needed to ensure better care for these women and their children. There are clear opportunities for the Ministry of Justice, NHS England, and others to provide prisons with legislation and resources to tackle these matters.

Few can fail to be shocked by the experiences of Layla, a woman interviewed by Laura Abbott during doctoral research, reported in the *Guardian* last week. Layla was 24 weeks' pregnant with her second child when she was sent to prison, and had a footling breech birth at 36 weeks' gestation in her cell. Healthcare staff didn't believe her when she said she had lost her mucous plug, and again later when she told them she was in labour. There were no provisions for Layla and her baby in the transfer to hospital, and she was not able to debrief her traumatic labour experience in the months that followed.

Layla's experience and other examples of inadequate care are reported from across the prison estate. They represent significant risks not only to prisoners and babies, but also to prison and health staff, who should not be making decisions or supporting births for which they are unqualified. To make matters worse, as the *Guardian* revealed, no data are kept on the numbers of pregnant women, births (in cells or otherwise), miscarriages, stillbirths, or adverse incidents in prisons. How can proper care be planned, or accountability delivered, if no one knows the numbers involved?

There are positive signs advice is being listened to

For more than two years—since the publication of our Birth Charter for Women in Prison in England and Wales, which contains comprehensive recommendations—Birth Companions has advocated for change. These include giving all pregnant women 24 hour phone access to midwives; allowing pregnant women the opportunity to live on a designated wing; access to antenatal education; and recognition that unqualified staff should not make decisions about labour or the need for midwifery care.

There are positive signs this advice is being listened to: some prisons are implementing some recommendations; Public Health England's Standards to Improve Health and Wellbeing of Women in Prison contains strong aspirations for better care; and the prisons and probation service will soon publish guidance. However, as highlighted in the damning report by MPs on the Health and Social Care Committee, good practice is hard to maintain without systemic change.

Naomi Delap is director of Birth Companions, a charity working to improve the lives of women and babies who experience severe disadvantage during the perinatal period

ANALYSIS

The "surgeon ego" must be excised to accelerate progress in surgical culture

Healthy self confidence has an important role in the operating theatre, but we must take care that it doesn't become disruptive, say **Christopher G Myers and colleagues**

Recent years have seen a palpable change in the surgical community, with major efforts made to shift towards a more positive, humanistic surgical culture.[1-3] This reflects a broad recognition that ego driven behaviours and disruptive attitudes pose a risk to surgical culture and to patients.[2-5] The objective and subjective evidence that has prompted these efforts, however, has not been thoroughly explored and understood by the surgical community.

Periodically, drastic examples of ego driven behaviour generate increased scrutiny and discussion, but these are often fleeting and do not fuel substantive changes. In December 2017, for example, transplant surgeon Simon Bramhall was convicted of assault in Birmingham for cauterising his initials on patients' livers during operations.[6] The judge in his case described the action as "conduct born of professional arrogance of such magnitude that it strayed into criminal behaviour."[6]

KEY MESSAGES

- Surgical culture is shifting to be more positive and humanistic, in part as a response to extreme and subtle ego driven disruptive behaviours
- Accumulating evidence from both the medical and organisational sciences shows substantial negative consequences for ego driven behaviour in complex work environments such as surgery
- We need more research and systematic exploration of ways to further reduce ego driven behaviour in the practice of surgery

Fortunately, such cases of extreme arrogance are rare among surgeons—although, this is not the first time patients have been allegedly marked with surgeons' initials.[7] But milder forms of ego driven behaviour are still observed in modern surgery. A study of "unsolicited patient observations" among surgeons[8] found examples of patient complaints about arrogant, intimidating, or rude behaviour, such as: "I asked Dr Y how long he thought the operation would take. He said, 'Look, your wife will die without this procedure. If you want to ask questions instead of allowing me to do my job, I can just go home and not do it.'"[8]

Though high profile cases garner widespread attention, recognising the milder forms of ego driven disruptive behaviour, and their consequences, is important for healthcare organisations and those who work in them. We draw from research in the medical and organisational literatures to outline the deleterious effects of "surgeon ego" in healthcare organisations and discuss the progress made in shifting surgical culture in a more positive direction, as well as potential solutions to accelerate change.

What is the problem?

Overconfidence has long been noted as a potential problem among doctors,[9] but the practice of surgery has a particular reputation for arrogant, ego oriented behaviours. In a study of personality traits among UK healthcare professionals, surgeons were found to have significantly higher levels of narcissism (a personality characteristic that manifests in egotist, arrogant, or dominant attitudes[10]) than their non-surgeon colleagues.[11] Other research has found greater numbers of disruptive behaviours and patient complaints among surgeons than non-surgeons, which could be the result of more arrogant attitudes (alongside the high stakes, high stress environment of surgery).[12-16]

Arrogant behaviour among surgeons is certainly not universal and very likely varies across specialties or departments, though existing data at the specialty level are insufficient to draw more substantial conclusions.[11] But just a few "bad apples" can disrupt patient care and perpetuate the reputation of surgical culture as ego oriented.[3] Medical students often perceive surgeons as overly self confident to the point of arrogance, and think that they need to fit this stereotype to be successful.[12-17] This perception is shared by other health professionals. In a Swiss study, ratings provided by nurses showed a shared perception of surgeons as less socially oriented and more aggressive than internists.[18] Notably, these perceptions were supported by self reported ratings from doctors in the study, with surgeons rating themselves as more aggressive than internists.[18]

This perception raises a concern about self selection, where people comfortable with this behaviour

Healthy self confidence has an important role in medicine, especially surgery

are more likely to enter the specialty and, more importantly, where the profession loses promising candidates who are averse to such behaviours. A study of US medical students found that those who chose technique oriented specialties (including surgery) tended to be more dominant and less warm than those who entered person oriented specialties.[19]

Compounding this selection effect, surgical training may perpetuate ego oriented behaviour "down the chain" as trainees model the behaviour of more senior surgeons, and unintentionally encourage trainees to carry forward disruptive behaviours in their future practice.[3 12] These dual pressures of selection and socialisation are worrisome as they may push well intended individuals from reasonably confident to problematically arrogant through the course of surgical training.

Conceptualising the "surgeon ego"

One obstacle to tackling the effects of surgeon ego is the fragmentation of research in this area, with studies focusing on different manifestations—such as narcissism, arrogance, dominance, and disruptive behaviour. The figure overleaf shows how these disparate findings relate to each other, offering an integrated understanding of what is meant by the surgeon ego.

Many of the surgeon attitudes and behaviours described in research are manifestations of an underlying characteristic of narcissism, considered a subclinical personality characteristic possessed by most people to varying degrees.[10] Narcissism, evident to others as "arrogant, self promoting, aggressive" attitudes,[10] is a driver of disruptive behaviour. Other drivers can also result from situational stressors or other cultural conditions.[12] In turn, these attitudes and disruptive behaviours can have a detrimental effect on outcomes relevant to patients and providers.

What are the consequences?

Healthy self confidence has an important role in medicine, especially surgery.[21] The ability to take decisive action in the face of complex, time sensitive, and high stakes procedures requires a confident disposition and belief in one's own abilities to step up and lead. But in the modern era of multidisciplinary care, where the "captain of the ship" is less clear,[22] this confidence should not give way to a more disruptive ego.

Notwithstanding the preceding examples, we found relatively little research directly examining the performance consequences of surgical ego. Yet drawing on established literature in the organisational sciences, we can infer the consequences of ego driven behaviour among surgeons. Higher levels of arrogance in the workplace, for example, are associated with worse job performance,[23] and meta-analytic evidence shows a strong association between narcissism and counterproductive behaviours in organisations and between narcissism and worse job performance for those in positions of authority.[10 24]

Some surgical research has examined the outcomes of surgeon ego indirectly. Cooper et al found that patient complaints about intimidating or disrespectful behaviour predicted complication and readmission rates for that surgeon.[8] At the same time, substantial research has shown how disruptive behaviours can divert attention from patient care, while also increasing medical errors and affecting the wellbeing, turnover, and collaboration of others in the perioperative environment.[5-25]

Conversely, surgeons' interpersonal effectiveness and non-technical skills (such as teamwork, communication, and cooperation) are increasingly being identified as drivers of technical performance[26] and the differential ability of surgical units to rescue patients after major postoperative complications.[27-29]

One particular consequence of the surgeon ego is that it may deter women from pursuing surgical careers.[30] Alongside perceptions of arrogance and intimidation, medical students report perceiving the practice of surgery as "masculine" and feeling pressured to conform to that norm (or feeling that they must be highly exceptional to succeed without conforming).[17]

Much attention has been paid to recent evidence of better outcomes for the patients of female surgeons than those of male surgeons.[30-32] Though we cannot say definitively that surgeon ego is linked to sex, more than half of doctors and nurses who responded to a survey on disruptive behaviour reported that male doctors engage in more disruptive behaviour, whereas only 2% reported that female doctors engage in more disruptive behaviour, and 41% reported no difference.[25] Moreover, meta-analytic findings in the general population show that men consistently score higher on measures of grandiose narcissism than do women.[33]

What are the paths forward?

Considering these negative consequences for teamwork, wellbeing, and patient care, the surgical community must recognise and tackle practices and norms that might unintentionally encourage or condone ego oriented behaviour.

Effective change will require a multidisciplinary effort from surgeons, anaesthesiologists, nurses, and the many other professionals vital to perioperative care. Bramhall was not alone in the operating room when he cauterised his initials into patients' livers, yet no one stopped him. It wasn't until years later that he was held accountable. A key first step is simply acknowledging that this behaviour—both in its extreme and less severe manifestations—disrupts

interprofessional teamwork, decreases situational awareness, and inhibits communication in ways that ultimately affect patients.

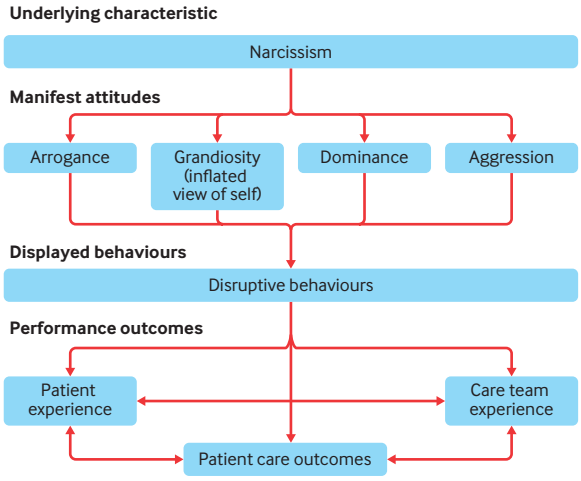
Creating lasting change, however, necessitates systematic efforts to understand and deal with these behaviours (with grounded interventions and reliable assessment of key outcomes) and will require altering the fundamental norms and practices that may unwittingly encourage these behaviours. We need more research to directly assess the effects of surgeons' differing interpersonal behaviours on care outcomes and patient perceptions.

Responsibility for developing this evidence based, interprofessional approach lies with all levels of surgical practice, including not only professional associations and regulatory bodies but also the leadership of hospitals and departments and the peer community of surgeons.

Setting the agenda for change

Professional associations can set the agenda for dealing with ego concerns by setting guidelines and developing training materials regarding these disruptive attitudes and behaviours—similar to the non-technical skills training modules developed by the Royal College of Surgeons of Edinburgh.[34] Surgeons look to these associations and regulatory bodies for not only awareness of important issues, but also concrete recommendations for action.

Some surgical governing bodies have stepped up efforts to combat negative traits in surgical culture, including the Royal Australasian College of Surgeons' 2016 Let's Operate with Respect campaign, which focused on e bullying, discrimination, and sexual harassment.[35] These surgery specific endeavours can bolster existing, broader efforts, such as the American Medical Association's development of health systems science as the third pillar of medical education (joining basic and clinical sciences).[36] This curriculum provides a framework for understanding aspects of healthcare delivery not traditionally taught in medical schools, such as teamwork and leadership.



Organising framework for causes and consequences of surgeon ego

At the same time, the leadership of surgical departments, hospitals, and medical schools should focus on attitude and disruptive behaviour when recruiting and promoting people. Many healthcare systems and their leaders have made efforts in recent years to create the necessary infrastructure and support to curb ego driven behaviour across the profession (not only in surgery).

One particular consequence of the surgeon ego is that it may deter women from pursuing surgical careers

The Center for Professionalism and Peer Support at Brigham and Women's Hospital in Boston has pioneered interventions for reducing disruptive behaviours and improving the quality of physician peer interaction.[37] Likewise, the University of Michigan Department of Surgery's "Michigan Promise" is a longitudinal investment to create an inclusive and welcoming environment for current and future surgeons.[38]

Yet these efforts are often not fully integrated into the systems used for training, selecting, or promoting surgeons, representing a key opportunity for matching intention with action. Departments could develop in-depth, interpersonal simulations for assessing and training surgeons as they engage in the complex interprofessional dynamics of an operating room. Simulation methods have been used to evaluate these types of interpersonal, non-technical skills when hiring department chairs,[39] revealing key insights into leadership skills and attitudes. Interpersonal simulations can also be beneficial if incorporated into the training of surgical residents,[40] helping to break the cycle of selection and socialisation described earlier.

These organisational efforts would undoubtedly advance the field's understanding and ability to tackle the causes and consequences of surgeon ego, but they may be isolated to specific institutions or regions, emphasising the need for the entire surgical community to recognise and deal with these behaviours among their peers. Social media campaigns such as #ILookLikeASurgeon,[31] for example, have highlighted longstanding biases and problematic attitudes within surgery, sparking important discussion and change.

Understanding the accumulating evidence in the medical literature—and the broad existing evidence in organisational sciences—that show the deleterious effects of ego driven behaviour may provide impetus for this movement and generate more sustainable change. After all, the bulk of surgical education still occurs through informal mentoring and apprenticeship models, as surgeons look to their community of peers and mentors to model effective behaviour.

The typical surgeon today no doubt possesses an appropriate degree of confidence and self assurance, as well as a healthy level of humility. But as we continue to see cases of behaviour that depart from the normal bounds of confidence, the field at large must reiterate its commitment—in both word and deed—to selecting, training, and maintaining a population of surgeons prepared to act and interact in ways that deliver the best outcomes to patients in the modern healthcare environment. Given the monumental shifts and progress made in just the past few years, the future is bright.

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TREATMENT BURDEN

Adding practical issues to Rapid Recommendations

Treatment burden (Analysis, 20 October) could be appraised in a broader framework of "practical issues" related to how a treatment or test will affect a patient's daily life. These include issues related to drug routine, the need for subsequent tests, coordination of care, and the implications for social activities, work, and travel. Clinicians need to raise these topics with patients to find out what is best, ideally through shared decision making.

Our team in the non-profit MAGIC research and innovation programme has developed a platform that enables organisations to easily add practical issues to their evidence summaries, recommendations, and decision aids.

As our work with *The BMJ* on Rapid Recommendations shows, guideline panels can explicitly take practical issues into account and provide them to clinicians and patients to support their decisions. The experience has been educational, with direct effects on the recommendations. We have partnered with patients to systematically include their perspectives. This information is incorporated in our SHARE-IT decision aids, accessible in MAGICapp through each Rapid Recommendation.

Anja Fog Heen, physician, Gjøvik; Per Olav Vandvik, physician, Oslo; Thomas Agoritsas, physician, Geneva; on behalf of the MAGIC research and innovation programme

Cite this as: *BMJ* 2018;363:k4871

STOPPING OF VIAGRA TRIAL

STRIDER Consortium replies to letter

Symonds and Budge's comments about the Dutch STRIDER trial are erroneous (Letters, 29 September). They state that the "intervention resulted in 11 infant deaths due to lung related problems." But the study was stopped after an interim analysis showed possible (but unproven) harm and to allow detailed review of the increased incidence of persistent pulmonary hypertension of the newborn. To attribute newborn death to this lung complication is presumptive in the absence of a more thorough analysis.

They selectively cite just one study, from 2009, in support of their incorrect assertion that animal studies gave a clear signal of harm. But a recent meta-analysis supports the hypothesis that sildenafil improves fetal growth and maternal blood pressure regulation in animals.

STRIDER was the most effective way to conduct this much needed trial. It was essential to prevent the persistent "creep" of the prescription of sildenafil for this indication, contrary to advice.

We are disappointed in *The BMJ* and note, with frustration, how this coverage compares with the ongoing difficulty of publishing negative results from large, well designed randomised controlled trials.

Louise C Kenny, executive pro-vice chancellor, University of Liverpool, on behalf of the STRIDER Consortium

Cite this as: *BMJ* 2018;363:k4872

LETTER OF THE WEEK

Helping patients stay in work

Dobler and colleagues rightly say that clinical practice guidelines should incorporate information on treatment burden to help patients make informed decisions (Analysis, 20 October). For people of working age, this should also include acceptability and feasibility in the work context.

Many people in employment have a health condition or disability, and this is set to rise as the workforce ages. Work gives people a sense of purpose, an opportunity for social interaction, and a way of structuring time, as well as providing money and other resources needed for material wellbeing. Work contributes to happiness, helps build confidence and self esteem, and provides a sense of identity and personal achievement. People who are out of work have poorer physical and mental health overall.

Disease treatment (such as an intensive rehabilitation programme or a tight insulin regimen), the cumulative treatment workload, and its sequelae (such as frequent visits to health professionals or side effects) can affect returning to work or may be incompatible with work demands. Enlightened employers will make provisions for disability leave or adjust shift patterns and work tasks. But if the employer is unable or unwilling to accommodate such adjustments, this may result in loss of employment, with often devastating consequences to the patient's physical and emotional health and wellbeing.

Shared decision making should take into consideration patients' values and preferences to help them remain in and benefit from employment. This can be facilitated by the inclusion of work variables in guideline frameworks.

Anna Trakoli, consultant in occupational medicine, Bradford

Cite this as: *BMJ* 2018;363:k4870

CORONER REPORT LESSONS

Coroners' reports should be published online

Coroner's regulation 28 reports should be in the public domain (This Week, 20 October).

We wanted to cite a regulation 28 report in our paper on raised intracranial pressure for *The BMJ*, but they are not always freely accessible. We cited a similar Australian case instead, which took only a few minutes on Google to find.

Is it not time for all regulation 28 reports to be published on the chief coroner's website? Learning as much as possible from tragic cases to improve patient care is clearly in the public interest.

David J Nicholl, consultant neurologist, Birmingham

Cite this as: *BMJ* 2018;363:k4873

FITNESS TO PRACTISE

Healthcare staff need training in human factors

Seeing the GMC take human factors seriously is reassuring (This Week, 20 October). But in terms of preventing serious incidents, it's like telling someone to mind the step after they have fallen over it.

Human factors being "hardwired into investigations" is nice, but too little, too late. They should be hardwired into clinical practice. Training in human factors must be included in basic education for healthcare professionals to improve safety for patients and staff.

Educating professionals only after serious incidents have occurred is woefully inefficient and will have an unacceptably high human and financial cost. That human factors training is lacking for healthcare professionals is bizarre and unacceptable.

Paul D McGovern, specialty registrar in occupational medicine, Northampton

Cite this as: *BMJ* 2018;363:k4874

Felicity Clare Edwards

Senior employment medical adviser Health and Safety Executive (b 1927; q 1952; OBE, DM (Oxon), FRCP, FFOM), died from lung failure on 26 February 2018

Felicity Clare Edwards (née Toussaint) changed from clinical and social medicine to occupational medicine. At the Health and Safety Executive, she advised on occupational orientation, particularly for physically disabled people. She was the author and editor of numerous publications and sat on several committees. With her husband, John Hilton Edwards, a geneticist, she lived in London, Oxford, and Birmingham, with sabbatical years spent in Philadelphia and New York. In 1988 she received her OBE for services to occupational medicine. After retiring in 1992, she continued with editing and writing, studied French, and earnt a first class honours degree. John predeceased her in 2007, and she spent her last few years in her Headington home, supported by a carer. She leaves four children and eight grandchildren.

Krishna Somers

Cite this as: *BMJ* 2018;363:k4592

Peter Bailey

General practitioner Marske-by-the-Sea (b 1948; q Edinburgh 1971; MRCGP, DObst RCOG, DFFP, FPCert), died from a malignant brain tumour on 15 November 2017

Peter Bailey ("Pete") received an offer of a partnership in general practice in the north east of England in 1977. He moved his family there from Scotland in early 1978 and settled into life on the edge of the North York Moors. By the late 1980s, he was the senior partner in the practice and had taken on an even greater role in its management. Active on the local medical committee, he was also medical director of the local commissioning group and clinical medical officer in family planning and to the huge local petrochemical plant. Once diagnosed with an aggressive cerebral glioma, Pete underwent surgery but was never well enough for chemotherapy or radiotherapy. He leaves his wife, Sheila; three children; six grandchildren; and his beloved Labrador, Ailsa.

Sheila Bailey, Sarah Bailey, Brian I Duerden

Cite this as: *BMJ* 2018;363:k4682

Edward John James Davies

General practitioner (b 1926; q Liverpool, 1949; OBE, FRCGP, KStJ), died from old age on 19 January 2018

Edward John James Davies ("Eddie") was a GP in Cerrigydrudion in north Wales from 1950 to 1987. He grew up in the slate mining community of Tanygrisiau near Blaenau Ffestiniog. Eddie met Sybil when he was working at the Stanley Hospital in Liverpool; they married two years later. Eddie was a founding member of Y Gymdeithas Feddygol (the Welsh Medical Society) and helped publish the Welsh medical dictionary. He was awarded an OBE for services to the community in 1997. As a medical historian, Eddie published several books, including an account of the slate quarry hospitals of north Wales. He was admitted to the Gorsedd (Order of the Bards), and he received a fellowship in Welsh from Bangor University in 2007. Predeceased by Sybil, he leaves three children.

Iwan Roberts

Cite this as: *BMJ* 2018;363:k4704

Beverley John Abel

Consultant urological surgeon (b 1943; q Liverpool 1972; FRCS Glas, FRCS Lond, FRCS Ed), died from neuroendocrine carcinoma of the lung on 23 August 2018

Beverley John Abel ("Bev") was one of Glasgow's pioneers of percutaneous lithotripsy, a treatment that helped transform care in the city for patients with kidney stones. He published several influential papers on the treatment of bladder and kidney conditions—particularly with regard to spinal injury. Bev's work in championing further breakthrough treatments using fine scopes and instruments also led to his appointment as honorary lecturer at Glasgow University. Bev had a great sense of humour and was someone whose qualities enhanced the lives of those he encountered. Predeceased by his first wife, Wendy, in 2007, he leaves his second wife, Sandra; a sister; three children; and eight grandchildren.

Kenneth Stephen

Cite this as: *BMJ* 2018;363:k4598

John Kenelm Guly

General practitioner Blackfield and Hythe, Hampshire (b 1927; q St Mary's Hospital 1951; DMJ Soc Apoth Lond), died from heart failure on 28 September 2018

John Kenelm Guly entered general practice in 1953. He was also a GP trainer. His other interest was in medicolegal work, and for many years he was a police surgeon; he became an examiner for the Diploma of Medical Jurisprudence, and he was, for a while, a deputy coroner for Southampton and the New Forest. He was also a magistrate for two periods. He retired from his practice on his 60th birthday, but he carried on doing GP locums for another five years and industrial medical work for 10 years and he continued as an independent medicolegal expert witness until the day before his 80th birthday. He had a strong Catholic faith. He leaves his wife, Maureen; four children; eight grandchildren; and four great grandchildren.

Henry Guly

Cite this as: *BMJ* 2018;363:k4533

Anthony Victor Hirsh

Consultant andrologist and general practitioner (b 1945; q Westminster Hospital 1968; FRCS, DObst RCOG), died from complications of Parkinsonism on 30 March 2018

Anthony Victor Hirsh ("Tony") was a leading andrologist in the UK and a GP based in central London. He was the author or coauthor of numerous scientific papers, letters, and books, and he spoke at national and international meetings. He helped formulate the then National Institute for Clinical Excellence's national guidelines for treatment of infertility (2002-04). One of the first specialists in the UK to use microsurgical epididymal sperm aspiration (MESA), Tony worked as a consultant at the Hallam Medical Centre and London Women's Clinic, Bourn Hall, and Whipps Cross and the Roding hospitals; he held honorary and supervisory posts at Guy's and St Thomas' hospitals. He leaves his wife, Sara; three children; and three grandchildren.

Malcolm Scott

Cite this as: *BMJ* 2018;363:k4591

Ian Forgacs

Flamboyant and modernising president of the British Society of Gastroenterology

Ian Christopher Forgacs (b 1951; q 1975; MRCP), died from cancer on 23 October 2018

Those at the 2016 awayday of the British Gastroenterology Society (BSG) did not expect one of Hamlet's soliloquy to be on the agenda. But Ian Forgacs, the president, delighted in the unexpected. On the 400th anniversary of Shakespeare's death, he performed the speech to a rapt audience. He was a shrewd man with a disarming manner, and, as a colleague said, "He was born to be president. He handled it with aplomb."

Forgacs worked to modernise the BSG and promote links worldwide, securing a memorandum of understanding with the Chinese Society of Gastroenterology. He was instrumental in delivering better training, including developing the specialty certificate examination, and he championed initiatives such as getting faster access to endoscopy.

Ian Christopher Forgacs was born on 13 October 1951 in Bromley, Kent. His mother, Eileen, was a nurse and his Hungarian father, Paul, a chest physician.

Forgacs and his younger brother, David, attended Sevenoaks School, where he played rugby, but his abiding passion was football. As a young boy he wanted to play for England, and it was a highlight to be at Wembley seeing England win the World Cup in 1966. Throughout his life he supported Charlton Athletic and later Arsenal.

In 1969 Forgacs enrolled at Guy's Hospital in London to study medicine. He spent his elective year in the US, at Yale School of Medicine. He worked for gastroenterologist Howard M Spiro and decided to do his thesis on gastrin and make gastroenterology his career.

Forgacs qualified in 1975. In the same year he met his future wife, Helen, a nurse on the intensive care unit. They married in 1978 and had two children—Nicholas in 1979 and Sarah in 1983.

Consultant and president of BSG

In 1986 Forgacs became a consultant at King's College Hospital, where he remained throughout his career. The prestigious liver unit dominated gastroenterology, with more than 100 staff, whereas Forgacs was one of just four working in "hollow organ" gastroenterology. He made his career in this context, and a long term colleague believed it taught him resilience.

At King's, Forgacs developed his gift for teaching, delivering lively lectures with enough gut humour to hold his audience's attention. He was committed to supporting junior colleagues, one of whom said Forgacs brought to mind Barnabas, the biblical character who symbolised encouragement.

Although he had a playful side, Forgacs took medicine very seriously and was widely respected.

Not long after becoming a consultant, Forgacs joined *The BMJ*'s "hanging committee." Taking its name from the Royal Academy committee that decides which pictures to hang, *The BMJ*'s committee decides which research to publish. For more than 10 years, Forgacs volunteered insightful opinions.

Forgacs had a growing role at the BSG. He became chair of the training committee and chaired the specialist advisory committee, which in 2008 rewrote the curriculum, a task one colleague described as "gargantuan." He had a talent for running committees—he could think strategically and get the right people on board.

In 2012 he became president elect of the BSG and in 2014 president or, as he put it, "top banana." He used his position to encourage different groups, from nurses and GPs to trainees and fellow consultants, and helped the society to become more outward looking. One colleague described the alliance with China as "a game changer," and another said it was a triumph to set up the GMC recognised specialty certificate examination in gastroenterology.

HELEN FORGACS

At King's, Forgacs delivered lively lectures with enough gut humour to hold his audience's attention

Drama, music, and other interests

In parallel to medicine, Forgacs had many interests. He had a party personality and many friends. One said: "You'd think, 'Ian's here, now it's going to be fun!'"

In private, music nourished his soul, especially the works of Mozart. He went to the opera regularly and flew to New York to hear Wagner's *Ring Cycle*. His reading spanned Montaigne and the classics, as well as James Bond, of which he owned several first editions. He went to the theatre every week and when he retired applied to study acting at the Royal Academy of Dramatic Arts. He also travelled to France, Germany, and South Africa to support the England in the football World Cup.

Shortly after he retired in 2016, Forgacs was diagnosed with cancer. He died in St John's Hospice 10 days after his 67th birthday. Ian Forgacs leaves his wife, Helen, and two children.

Penny Warren, London
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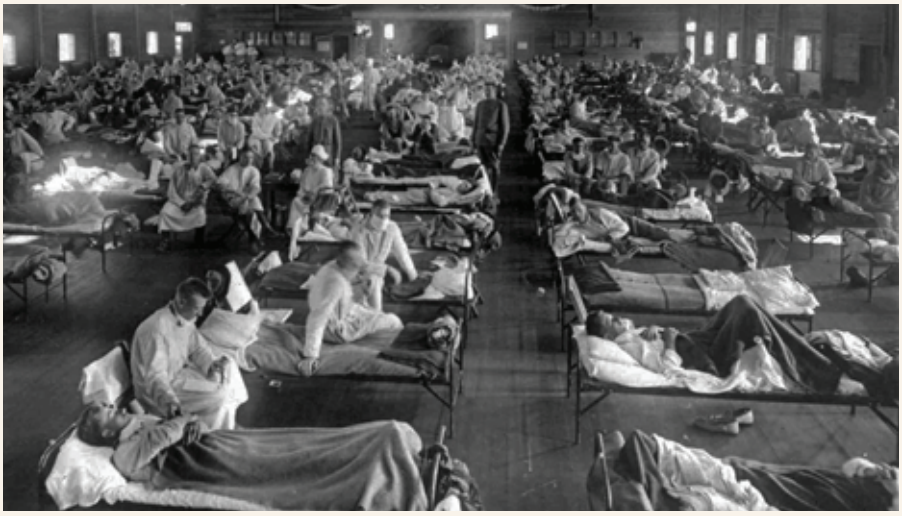

FROM THE ARCHIVE

Misery breeds disease: the 1918 flu pandemic

The 1918 influenza pandemic swept the world and killed more people than the first world war. Throughout the summer, news of the "mysterious epidemic" gathered momentum in *The BMJ*, with a report in the 27 July issue (*Br Med J* 1918;2:82) noting that "the present outbreak of influenza in epidemic form is claiming considerable attention from a medical as well as from an economic and even military standpoint."

In November, and "in view of the alarming and contradictory reports of the present epidemic of influenza that have appeared in the public press," the Royal College of Physicians issued "an authoritative statement" in *The BMJ* (*Br Med J* 1918;2:546). "The present epidemic is virtually world-wide, irrespective of race, community, or calling," it observed. The pages of the journal over this period were full of doctors writing in to share their observations of the virus, the patients they had treated, and those they had lost.

In 1921, as the world took stock of the pandemic, the Ministry of Health published a report that concluded there were still dangers ahead—a warning the journal saw fit to print in full (*Br Med J* 1921;1:348). The report cautioned that "If anywhere in the world there be large collections of men, whether through war or economic strife, or through that dissolution of society which a certain degree of collective misery and disorganisation entails, herded together en masse, there will be opportunities for the other modification of the *materies morbi*, which renders it apt to conquer the world. No sanitary cordon, no quarantine, will shield us from this danger.

"To realise that the material well-being of the inhabitants of a foreign—perhaps even a hostile—country is a pressing concern of ours is very hard. Yet the teaching of this pandemic is that it is a hard truth. Any supra-national organisation for the control of epidemics will need to face it. The popular belief that misery breeds disease is strictly true, and the influenza of 1918-19 is no exception to the rule."

LATEST PODCAST

Talking honestly about intensive care

"What I see as the fundamental limitation of AI systems in healthcare is the substitution of the physician-patient relationship, and that's because, as it is now, in that relationship there is a clinical encounter between people who are both engaged in the fundamentally uncertain task of living a life . . . The worth of the human physician, as opposed to an AI system, is the capacity to relate to a patient's illness and integrate it into a broader picture, taking into account the patient's values and preferences and life context."

Philosopher Vanessa Rampton talks with Jörg Goldhahn and Michael Mittelman about whether artificial intelligence could make doctors obsolete.

Listen to their debate, and read the Head to Head article that sparked their discussion at http://bit.ly/AI_doctors_obsolete

MOST READ ONLINE

Effects of a low carbohydrate diet on energy expenditure during weight loss maintenance
BMJ 2018;363:k4583

GMC should apologise for its handling of Bawa-Garba case, says RCP president
BMJ 2018;363:k4784

Medical cannabis in the UK
BMJ 2018;363:k4844

Robot assisted surgery is blamed for heart patient's death
BMJ 2018;363:k4791

Causes of concern for the NHS after Brexit
BMJ 2018;363:k4767

TWEET OF THE MONTH

Bullying in the NHS

"Over a third of doctors think that bullying, undermining, or harassment is a problem at their main place of work, finds @TheBMA survey."

This BMA survey of UK staff made for one of our top tweets of November, although many doctors were unsurprised by the findings. Gloria Esegbona (@athinkinbox) replied to say "#Bullying #undermining and #harassment are the biggest illnesses the #NHS sees on a daily basis and compounds the ill health of patients—yet it has no treatment, cure or preventive strategies in place and its attempts at palliative care fall short—#patientsafety is #cliniciansafety."

bmj.com highlights is curated by Kelly Brendel, assistant web editor, *The BMJ*