If we hand over clinical triage to smartphone apps they need to work to a standard we can set and test independently

Innovation is risky with weak evidence

Breeding with the vigour of rabbits, a variety of private GP services are springing up and jostling for your attention. Why spend hours phoning your own GP when you can choose a private GP by looks and price, having immediate access online or by app without needing to leave your home? Recruitment for GPs in such companies is increasingly competitive, with advertisements promising hourly rates and perks unfamiliar to NHS employees.

Some of these companies have bigger ambitions. “Why couldn’t Babylon be a patient’s NHS GP?” asks Ali Parsa, chief executive of Babylon—an IT company whose app, he says, is faster and more accurate than doctors in risk assessing cases. The NHS in north London has gone further, commissioning his company to offer “symptom advice” through a smartphone app service—“NHS 111 powered by Babylon”—although the NHS 111 telephone service still exists.

Babylon has several offerings intersecting medicine and IT. It provides private GP services by video link and has corporate contracts with Bupa, Sky, and Boots. Earlier this year the Advertising Standards Authority, after I’d contacted it, told Babylon to stop saying that it had the “world’s best doctors” and the “world’s most advanced AI [artificial intelligence].”

Good IT is something the NHS has struggled for years to provide. It’s clear that NHS 111 has been beset by problems. But how do we put better technology into the NHS? If we want to hand over clinical triage to smartphone apps we need to know that they work to a standard we can set and test independently. That should mean robust and independent trials. But we don’t seem to have them.

The initial information sheet that Babylon co-wrote with the NHS contained a set of “frequently asked questions.” Under “Is it safe?” the answer was, “An independent study tested the app’s symptom checker against nurses and junior doctors. It found that the app gave safe advice 100% of the time, whereas doctors gave safe advice 98% of the time… it also

found that the app is more accurate than doctors or nurses.”

But this study was not “independent”: it had six authors, and five are current or past Babylon employees, while the sixth is its owner (Parsa). The study itself—not indexed in PubMed—was not a real life trial of how humans use the app but a simulation using actors and invented scenarios. I would not regard it as a trial but a description of a development process, omitting essential details about the clinical scenarios tested. I can’t find any other publicly available testing of this system. Although this claim on safety has now been removed, a pilot project such as this is, in my view, not adequate.

Babylon says that its partnership with NHS 111 is itself an independent pilot programme set up to evaluate the technology. “Before the pilot commenced, the local NHS conducted their own validation of the Babylon triage service against all their serious incidents over a recorded period, and found the service to be completely safe,” the company says. Babylon also says that its symptom checking products have been shown to work well for UK patients, relieving pressure on healthcare systems.

It’s not that I don’t think technology has potential. It does. But we need high quality evidence, which should mean high quality trials. Is an automated app better than NHS 111, or are humans needed to over-ride problems in automation? When we drop the threshold to consultation we change the demographic such that false positives easily become more common, potentially leading to unnecessary emergency department or GP attendance—which, in turn, makes it harder for sick people to get attention. If this happens we will be creating more dilemmas, not solving them. Innovation without sufficient evidence is a disservice to all.

Margaret McCartney is a general practitioner, Glasgow margaret@margaretmccartney.com Follow Margaret on Twitter, @mgtmccartney

Cite this as: BMJ 2017;358:j3980
The way radiologists work needs to evolve

The technology has improved incredibly, but the basics of our methods and environment have stayed the same.

The advances in medical imaging over the past few decades are often cited as being among the most important achievements of modern medicine. The diagnostic possibilities afforded by new imaging modalities have driven an explosion in demand for scans of all types.

And yet the ways in which radiologists work have not evolved to the same extent. Yes, the light box has been replaced by a workstation, but the principle of an individual reviewing the images on a single occasion and then issuing a definitive report remains unchanged.

Our current working model was established when an examination consisted of a small number of images and the time taken for interpretation was no more than a minute or two. We now apply the same technique to examinations that consist of thousands of images and take at least half an hour to assess.

In addition, we often work in poorly designed environments and are subject to frequent interruptions and multiple distractions. Fatigue is a constant concern: sustaining focus for the time needed to review and interpret thousands of images is difficult, and a moment’s lapse in concentration can result in a significant abnormality being overlooked. We are set up to fail.

Around 40m radiology reports are issued each year in England. We can estimate that the reporting error rate in daily practice is around 3%-5%, rising to 20%-30% for more complex studies such as computed tomography and magnetic resonance imaging. A rough calculation therefore suggests that, each year, at least a million reports will contain errors. Most of these errors will not result in harm to patients—but some do.

Artificial intelligence

Radiologists have come a long way in acknowledging the extent of the problem, but have made little progress in reducing the number of errors. In the future, advances in artificial intelligence will mean a growing role for computer assisted interpretation. For now, the only clear solution is for images to be reviewed independently by more than one radiologist.

“Progressive dwindling,” frailty, and realistic expectations

Relatives of sick older patients have an understandable need to know why their loved ones are deteriorating or failing to recover, or exactly why they died. This can lead to misunderstandings, formal complaints, fraught meetings, or upsetting inquests.

Over the years I’ve seen my share of this in my own practice. I’ve also worked on numerous cases as an independent investigator or expert witness. In some cases aspects of care were poor, sometimes indefensibly so. And even in someone with serious health problems, failings in care can worsen decline or cause avoidable harm and distress.

Often, however, the medical care was good or exemplary, communication was open and frequent, but still the complaints and misunderstandings came. During my career society has become ever more high tech and “can do”—and perhaps less comfortable with death and dying. I’d say that people have become less willing to accept the very real limits of medicine.

Often, no one is to blame when older, frailer people with long term conditions and acute illness deteriorate. That’s just (late) life.

I’m not the only doctor who’s had meetings with families asking why a 90 year old relative—who had complex multiple conditions and was admitted with, say, a hip fracture, pneumonia, acute kidney injury, and delirium—died. I’m also not the only one who’s had discussions with families who rewrite history by claiming that patients were “perfectly all right” and “very independent” before admission, when in reality they were admitted acutely ill, having been deteriorating for months, increasingly dependent.

Frailty, dementia, and related presentations drive much modern hospital activity. So too do the needs of patients with multiple, life limiting, long term conditions.

A key validation study of the electronic frailty index in more than 200 000 of England’s over 75s showed that those with severe frailty were four times more likely to be admitted to hospital, five times more likely to die, and six times more likely...
person (or perhaps by the same person on more than one occasion).

Workforce constraints have limited our ability to do this, but perhaps it is time to put quality and safety first and start to define high risk, “high stakes” examinations where interpretation by a second reader is mandatory. Examples might include those in which there is a strong clinical suspicion of new or recurrent cancer.

Structured reporting templates can perform the role of checklists in other disciplines in helping to ensure that all relevant aspects of a study are considered and communicated to the referrer. Attention to the working environment and system factors which result in fatigue can almost certainly help. Awareness of the many cognitive biases which may contribute to a discrepant report should theoretically be of assistance although the evidence to date is limited.

Second pair of eyes

Of course having a second pair of eyes looking at the images would not guarantee a correct diagnosis in every case but it would improve the chances and would carry the additional benefit of highlighting to the patient and referrer the level of uncertainty associated with a particular opinion.

I am as wary as the next doctor of drawing parallels between medicine and aviation, but most passenger flights do not rely on a single pilot in the cockpit. Should we? By persisting with outdated working practices we are putting patients at greater risk of an incorrect or delayed diagnosis, and radiologists at risk of the consequences of making a significant error.

Giles Maskell is a radiologist, Truro

This article first appeared at blogs.bmj.com/bmj/2017/06/19/giles-maskell-the-practice-of-radiology-needs-to-change

Cite this as: BMJ 2017;358:j4102

BMJ OPINION Wendy Burn

Girl X has a bed for now, but what next?

“Securing the right support for others like X should not be, and cannot be, dependent on one of the highest judges in the land showcasing his outrage and frustration.” I said this after the case of a 17 year old girl, named X for anonymity, for whom no hospital bed with necessary facilities could be found despite warnings that she would die by suicide within hours of discharge, was heard in high court.

I was relieved when an appropriate hospital was found for her, but remain worried about the dearth of health services for young people and adults suffering from serious mental disorders.

What will happen to others who are in similarly impossible situations, but whose cases don’t make it to the high court or news headlines?

X needed a bed in a low secure mental health ward—of which England currently has only 124 for those under 18. There should be enough beds so that these young people can be admitted to hospital rather than “contained” in penal institutions or police stations—or even abandoned altogether. It is also vital that patients are able to keep in close contact with their family, friends, and community team. This is impossible if they are admitted far away from home, which currently is not uncommon.

I hope that the media attention will lead to improvements in child mental health services

Work on expanding and improving the availability of children’s inpatient services is long overdue and needs action. Equally important is ensuring that there are enough trained staff and other community resources to provide support and treatment to prevent admission.

Now that the media furor around X’s case has moved on, I hope that the attention brought to this area will lead to improvements in children’s mental health services.

While the plight of adults diagnosed with personality disorder is unlikely to garner the same level of outrage as that of a child, their situations are no less shameful. Stigma must not stop investment. Apart from the personal suffering it inflicts on individual patients, the current approach makes no financial sense.

We need a national strategy for this group of patients. Establishing the resource deficit with a review of all available models of intervention and their cost effectiveness would be a good start. There then needs to be a coherent and coordinated plan to ensure that these people get the help they deserve.

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**Problems in the NHS and social care raise questions about the long term sustainability of the system. Sustainability is not just about finance and affordability, important as they are; nor is it purely about the efficiency and effectiveness of the system. It also depends on factors outside the control of the health and care sector. Here I argue that sustainability depends on seven factors, all of which need to be tackled, and that new emphasis should be given in particular to cross-sectoral partnerships that help create healthy and resilient people and communities and to understanding and increasing the health and care sector’s contribution to the economy.**

**Changing context for sustainability**

Sustainability is a moving target in a system that is changing rapidly. A transition is under way around the world from hospital and illness based systems to person and health based ones, where, aided by technology, more services are provided in communities and homes. This is a long and difficult transition dating back at least to the Alma Ata Declaration of 1978 and most recently represented in England in the Five Year Forward View and related policies.

Much of the pressure on hospitals can be attributed to this transition being incomplete or, in some areas, going into reverse. The greatest burden of disease (and associated cost) worldwide now comes from long term chronic conditions and increased numbers of very frail elderly people, both of which require community based models of care. But the UK health and care system, like all others in the West, is still largely using a 20th century acute care model of service delivery to meet 21st century needs.

This approach is ineffective, wasteful, and leads to suboptimal care and perverse decision making. A mismatch exists between the needs of patients and the services available, with the result that, for example, many patients with mental illness are unnecessarily admitted to hospital and kept there longer than necessary owing to a lack of community support. This puts enormous operational and financial pressures on hospitals.

The transition needs to be accelerated, but financial pressures are leading to further reductions in social and community services, in part because cutting these is easier than closing hospital services. NHS England has tried to promote this transition by requiring NHS and local authorities to cooperate in producing local sustainability and transformation plans. These were designed to tackle three factors: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. But in many places they are seen as purely finance led hospital and service closure programmes.

I would argue that these need to take account of other factors and aren’t radical enough in tackling sustainability.

**Seven factors involved in sustainability**

A recent commission on the Portuguese health system, which I chaired, identified seven factors that needed tackling in the pursuit of sustainability. Its main recommendations have since been accepted as policy by the Portuguese government. The box, adapted from the commission report, shows that sustainability is dependent on three factors internal to the system and three external ones.

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**ANALYSIS**

For services to be fit for the future the UK needs a strategy that involves all sectors of society and that would maximise the system’s contribution to the economy, writes Nigel Crisp.
Underpinning all factors is the need for any health and social care system to have public and political acceptability and support. No system, however expertly designed, will be sustainable without the commitment of its staff and the support of the public.

These factors are interdependent and interconnected and need to be tackled separately and together. Here I highlight only the central problems and suggest ways forward. Each of these topics needs to be examined and understood in detail.

**Efficiency and effectiveness**

This is a health problem, and not a financial one. Economic and financial measures are important, but the greatest gains will come from improving the way diseases (particularly chronic diseases, which account for about 70% of budgets)\(^1\) are managed and health and disease prevention are promoted. Community and home based models of care already exist and can be enhanced with technology, new scientific discovery, and the engagement of patients, families, and communities.

**Well trained health and care workers**

Staffing is the greatest cost and the greatest vulnerability of the healthcare system. There is a lack of health workers globally, with an international market for their skills,\(^1\) and Brexit has dramatically increased risks for the UK system.

Roles must be developed to meet changing needs, with some demarcations between professions being broken down and a greater use of technology. This requires vision, leadership, and a determined programme of training and development.

**Costs and economic benefits**

The affordability of a health and care system depends on a country’s resources, on how effective and efficient the system is, and on political choices. A country’s health expenditure generally rises as its economy grows,\(^2\) although expenditures differ between countries. The UK, for example, spends 20-50% less than similar countries such as Australia, France, Germany, and the Netherlands.\(^3\)

These differences can partly be explained by differences in the efficiency of the system, on which the UK scores well,\(^4\) but also by political choices.

Recent thinking in health has emphasised the importance of measuring the value of procedures and services and of doing, in effect, cost-benefit analyses that compare outcomes with inputs. This approach needs to be extended to the whole system, yet the contribution to the national economy is often overlooked. Health and care are not just costs.

The NHS, as the largest and most integrated health system in the world, is an invaluable platform for research and development. The UK is a world leader in health, with top rated universities, and leads G7 countries in citations in peer reviewed journals. This brings economic benefits, with around 4800 biomedical companies turning over £55bn annually.\(^5\)

In addition, the NHS contributes to productivity by helping support a healthy workforce and by supporting education and skill development in this important sector of the economy. An average London firm of 250 employees loses an estimated £250 000 a year owing to ill health, and the productivity loss to the UK from cardiovascular disease alone is £8bn a year.\(^6\)

**Like all Western systems, we still use a 20th century acute care model to meet 21st century needs**

Population health is of obvious importance to sustainability, with the compression of morbidity into as few years as possible before death having a large effect on quality of life, demands on the health and care system, and costs. Health status is markedly different around the country, largely related to economic and social factors.

Children’s health and wellbeing in particular have long term effects on the health and care system and its sustainability. Legislation on areas such as food and air quality as well as programmes to tackle inequalities have an important role here.

**Carers and informal networks of care**

Carers and voluntary and community organisations provided care with an estimated value of £132bn in 2015, compared with UK spending on health of £134bn.\(^7\) Any reduction in the contribution of the informal system increases pressure on the formal system, whereas strengthening takes pressure off health and social care.

**Healthy and health creating communities**

Pilots and demonstrations have been set up between the NHS and local authorities to link health and social scare. Others, such as in Greater Manchester, bring a wider range of services together with a focus on “health, wealth, and wellbeing” to create new types of holistic services (www.gmhs.org.uk/).

Employers, educators, designers, planners, and others also determine health status and have responsibilities for protecting and promoting health. Some employers run health programmes...
for their staff, while organisations in the arts, horticulture, and design and individual schools are establishing new programmes in the absence of national policy.

In St Paul’s Way in east London, employers, the NHS, schools, local businesses, and the local authority are combining to build a health creating society (www.stpaulsway.com). This area needs further development.

Public and political acceptability and support
Maintaining and increasing support will depend not only on the quality of services but also on the political and media narratives that are developed to support the necessary changes in service models and facilities.

The major changes stemming from the 2000 NHS plan led to an almost doubling of public support for the NHS thanks to service improvements and to active marketing of the changes and promotion by clinical and other champions.18

The way forward
Some of the seven factors that contribute towards sustainability receive a great deal of attention, while two need far more emphasis: the economic benefits derived from the health and care system and the potential for multisectoral partnerships to provide the environment to improve health and health services.

The seven factors and how they apply to health and care in the UK will be explored in greater detail in a new series on the future of the NHS coming soon to The BMJ.

The health and care system can provide a wonderful service, but it can’t do everything by itself. It needs to be strengthened as an underpinning for the economy, and people from all sectors need to be brought together in creative partnerships to establish health in our communities, towns, and cities.

These ideas are not new but the timing is now right for the creation of a new strategy and a new narrative that will help to bring the public and its politicians on the journey alongside today’s many pioneers.

Nigel Crisp is an independent member of the House of Lords nigel.crisp@zen.co.uk

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BMJ OPINION

Stephen Bradley

The grade that dare not speak its name

More than 10 years after the term “senior house officer” (or SHO) was officially expunged by the Modernising Medical Careers programme and its creation of new training grades, the term retains a stubborn currency. Its informal persistence seems to be the cause of some well intentioned consternation from regulators and inspectors.

Recently a would-be social media campaign, #SayNoToSHO, was met with a ripple of derision on Twitter. In contrast to campaigns like #HelloMyNameIs, which inspired sincere reflection on practice and improved communication globally, the consensus on social media seemed to be that prohibiting the term SHO is a solution in need of a problem.

I have been dimly aware of the official displeasure with SHO for some years. As a trainee a few years ago, I received letters from the deanery and my trust addressed to all trainees that solemnly prohibited reference to SHO. Such correspondence is rare and was presumably informed by feedback from an inspection or quality assurance visit. A brief Google search shows that at least one other trust has had to contritely commit to the “elimination” of SHO.

The theory goes that since SHO can refer to trainees across at least three years, it introduces ambiguity as to the individual’s experience. There may be something to this. For senior doctors, the routine use of terms that pinpoint more precisely where a doctor is in their training could be helpful. Although in my own experience, diligence, rather than time served, marks the reliability of colleagues.

One benefit of terms like SHO, registrar, and consultant is that almost everyone—not just doctors, but also nurses, allied health professionals, and administrative staff—understands them. The principal reason for this is probably that, despite Modernising Medical Careers, SHOs still exist. Most junior doctor rotas are still broken down by foundation year 1 (formerly “house officer”), SHO, and registrar. Many SHOs work as staff grade, locum, or in standalone posts and don’t have another designation. Because of the official prejudice against SHO, trusts are now under pressure to find less well understood terminology to describe the same roles.

Precision matters. On written notes designation should, and in my experience almost always does, follow the doctor’s printed name and signature. Yet the kind of action that would be needed to abolish the useful shorthand SHO, and the confusion of inventing new terms to describe the same thing, makes the effort appear ludicrous.

This insistence on stamping out SHO is one of many irritations: each in isolation is almost inconsequential, but in combination they become utterly corrosive to morale. However well intentioned they are, injunctions like this can seem out of touch with the daily slog of keeping the NHS afloat. The useful, if imperfect, term SHO is likely to persist as long as SHOs exist. Perhaps we should accept that so we can focus our efforts on the problems that really need to be addressed.

Stephen Bradley is a GP and clinical research fellow

The action that would be needed to abolish the useful shorthand SHO, and the confusion of inventing new terms to describe the same thing, makes the effort appear ludicrous

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SHORTAGE OF GPS

Capitation based funding is flawed

I disagree with Majeed’s call for activity based funding for primary care (Editorial, 15 July). The current capitation based funding is not fit for purpose, for two reasons—funding is inadequate and the Carr-Hill formula is flawed.

In Leicester we have shown substantial variation in disease prevalence between neighbouring practices, with corresponding workload implications, despite identical geographies. Current funding formulas miss this, as they don’t use patient level data. The core funding per head has been largely equalised across Leicester by raising all to a common baseline. In other words, practices are not funded in proportion to clinical demand. This wastes NHS resources and partly explains why some practices seem more stressed than others, despite similar funding per head.

Modifying capitation based funding to an adequately resourced, case mix adjusted method, based on patient level data is essential and possible. We need to adjust for variation in multimorbidity between practices.

David Shepherd, GP and CCG board member, Leicester
Cite this as: BMJ 2017;358:j4075

Shortage is a mismatch problem

Majeed makes valid points about the GP shortage (Editorial, 15 July). But a shortage points to a mismatch between supply and demand.

Many actions to increase the supply of services have been taken—more nurses, healthcare assistants, paramedics, and ancillary staff. But no action has been taken to reduce demand—this is where the co-payments debate is focusing. The shortage could disappear if demand was curbed to match supply. The funding formula for General Medical Services is based on workload. But using a different database for the formula results in 30% swings in practice income.

Majeed may remember the clawback: if practices “overperformed,” overall funding of all practices was reduced to fit the budget. At least this is not the case for formula based pay. Recruitment and retention of GPs, however, might not be sensitive to method of pay, but would probably respond to the balance of effort versus reward.

Hendrik J Beerstecher, GP, Sittingbourne
Cite this as: BMJ 2017;358:j4078

LETTER OF THE WEEK

All tests can cause some harm

Hofmann and Welch warn of the downsides of diagnostic tests (Analysis, 22 July). Arguably all tests cause some harm. The challenge for clinicians is to choose the right test for the right patient at the right time.

When we interviewed GPs about their use of inflammatory marker blood tests in primary care, all doctors mentioned potential harms, which could be divided into several categories: harms of the test itself, workload and financial costs, medicalisation of a patient’s problem, patient anxiety, downstream costs, and harms of overdiagnosis.

Harms from the test itself are often overlooked and include cost of patients’ time off work, needle phobia, bruising, and vasovagal syncope. Rising workload is a major concern, and many GPs thought that time spent dealing with pathology results was often inefficient or wasteful. Medicalisation can occur when tests cause “somatic fixation,” with patients or clinicians focusing only on the biomedical aspects of complex illness. Patient anxiety is perhaps the hardest to capture yet most important harm of unnecessary testing.

Overuse of diagnostic tests might reflect a societal culture of increasing risk aversion and rising medical litigation, as well as a culture in medicine that “evinces a deep rooted unwillingness to acknowledge and embrace uncertainty.” Technological advances and new tests provide ever more information, yet without wisdom we risk making well people sick, rather than sick people well.

Jessica C Watson, GP and NIHR doctoral research fellow, Bristol
Cite this as: BMJ 2017;358:j4070

Author’s reply

I agree with Shepherd that increasing funding and moving from the Carr-Hill formula to one with more patient level clinical data would be helpful. But case mix adjusted formulas have limitations—particularly when used for smaller populations. An entirely capitation based formula would not prevent the shift of unfunded work from specialist care to primary care, one of the major problems facing general practice.

Beerstecher is correct about supply and demand. Practices need a tightly defined contract with the NHS—the current contract is vague, setting few limits on the quantity or range of services that GPs are expected to offer. Government policy has been to encourage GPs to offer even more services and make themselves more available to patients, without increasing the workforce.

GPs are also faced with patients expecting them to fill gaps in local health services. These are all problems that need to be tackled by NHS commissioners.

Azeem Majeed, professor of primary care, London
Cite this as: BMJ 2017;358:j4088

MANDATORY VACCINATION

When compulsion may become necessary

Mandatory vaccination should be debated before an epidemic or public health emergency to assure that public health law is graduated and proportionate (Communicable Disease, 22 July).

Mandated vaccination of children is not currently warranted in light of herd immunity. But two matters might tip the balance in favour of enhanced measures of compulsion. One is child welfare—arguments that focus on the best interests of the child rather than herd immunity. Courts in England and Wales already favour vaccination in cases of parental dispute, even (in one case) if the adolescent children object.

The other is a fall in vaccine uptake or rise in infection. The spectre of epidemics and pandemics can warrant emergency measures and threaten the proportionality of the response (and civil liberties).

The debate should extend beyond what is appropriate today to encompass the circumstances in which degrees of compulsion would be defensible.

Emma Cave, professor of healthcare law, Durham
Cite this as: BMJ 2017;358:j4100
Anthony Allibone
General practitioner
Norfolk (b 1925; q King’s College Hospital Medical School, London, 1949; OBE, DCH, FRCP), died from congestive cardiac failure and ischaemic heart disease on 6 August 2017
After what can only be described as an undistinguished student career, house jobs at his teaching hospital, and national service in the Royal Army Medical Corps, Anthony Allibone (“Tony”) had the good fortune to find himself in Norfolk, where he remained until his death. The Norfolk and Norwich Hospital did much to remedy the deficits in his medical skills. He worked in general practice in Norwich, and then, most happily, for 24 years in Blakeney, in a traditional country practice. He was an elected member of the General Medical Council, served on NHS statutory bodies, and established a community caring scheme for elderly and infirm people. Tony leaves his wife, Celia; three daughters; and four grandchildren.
Anthony Allibone
Cite this as: BMJ 2017;358:j3909

Peter Joseph Wilkinson Monks
Consultant general surgeon Torbay Hospital, Torquay, Devon (b 1922; q University of London, St Bartholomew’s Hospital Medical College, 1944; FRCS), died from old age on 11 August 2016
Peter Joseph Wilkinson Monks was a medical student and junior doctor during the second world war, treating casualties of the London Blitz and experiencing direct bombing of the hospital itself. In 1958 he was appointed as a consultant to Torbay District Hospital. His interests included abdominal surgery—especially biliary problems—breast cancer surgery, and thyroid surgery, in which the neatness of his scars was legendary. He was also interested in training his junior staff, and many later became eminent in their own right. Towards the end of his career he bought a farm. After retiring he served for several years on the regional panel of the Medical Practitioners Tribunal Service. Predeceased by his wife, Phyllis, he leaves three daughters.
P Sleight, V Sleight, A Dawson, N Januszewski
Cite this as: BMJ 2017;358:j3857

Terence John Cain
Consultant orthopaedic surgeon Hull Royal Infirmary (b 1945; q Manchester 1969; FRCS Ed), died from metastatic melanoma on 16 May 2017
Terence John Cain (“Terry”) was appointed consultant to the Hull and East Yorkshire hospitals in 1979, where he remained until he retired from the NHS in 2008. A naturally gifted operator, he was one of the rare breed of surgeons who operated quickly but safely and made surgery look easy. Terry pioneered knee arthroscopy in Hull and specialised in hip and knee replacements. That was he much in demand by friends and colleagues was testament to his skill. Largely dismissive of administration and academia, operative orthopaedics was his métier. In his spare time Terry was a gifted sportsman—football, cricket, and golf—and had a lifetime love of fast cars. He leaves Pat, his wife of 46 years; and much loved children and grandchildren.
Peter Lee
Cite this as: BMJ 2017;358:j3851

David Cosgrove
Professor of clinical ultrasound (b 1938; q St George’s Hospital Medical School, London, 1963; FRCP), died from cancer on 16 May 2017
David Owen Cosgrove (“Doc”) obtained an MSc in nuclear medicine from the University of London in 1975 and became a research fellow in the department of nuclear medicine at the Royal Marsden Hospital. In 1993 he moved to the Royal Postgraduate Medical School at the Hammersmith Hospital, where he was awarded a personal chair as professor of clinical ultrasound. He retired in 2004 and became emeritus professor at Imperial College and a senior research investigator at King’s College Hospital. Although David published more than 200 peer reviewed research articles and 30 teaching books or book chapters over his career, teaching is something for which he will be particularly remembered, much of it conducted at a very personal level. He leaves his partner, Zhen Li (Jason), and his brother, John.
Jeff Bamber, Robert Eckersley, Chris Harvey, Adrian Lim, Paul Sidhu, Meng Xing Tang
Cite this as: BMJ 2017;358:j3854

Vicky Mary Osgood
Consultant obstetrician Portsmouth; postgraduate dean Wessex; director of education and standards General Medical Council (b 1953; q 1977; FRCOG, FRCGP, FRCP), died from breast cancer on 23 March 2017
Vicky Mary Osgood was the first female consultant obstetrician in Portsmouth. As director of medical education in Portsmouth, she helped to redesign maternity and postgraduate education in the new private finance initiative. As dean of Wessex she led changes needed with foundation years, contributing to the workforce review team. In June 2011, Vicky joined the GMC as deputy, then director of education and standards. She worked to transform the perception of the GMC among doctors. She engaged with trainees, understanding their needs in the educational and pastoral sense. All who knew her over her varied career will miss her dedication, integrity, and sense of fun.
Danny Dubois
Cite this as: BMJ 2017;358:j3859

Albert David Rowlands
Former general practitioner Gloucestershire (b Bristol 1919; q London Hospital 1952; MRCGP, DObst RCOG), died from old age on 8 August 2017
Albert David Rowlands (“David”) was inspired by his wartime experiences to study medicine. He and his young family moved to the Cotswolds, where he joined a practice in Bourton-on-the-Water. This later amalgamated with the practice in Northleach. David was a founder member of the Royal College of General Practitioners. In retirement he was a prime instigator in founding the Naught Club, where local people afflicted by strokes and other disabilities could meet and learn crafts. For many years he spent a day a week at the centre, sharing his practical skills with the members. In 2010 he moved to Exeter, so that his older daughter could care for him and his wife, Beth. He leaves Beth, two sons, two daughters, two granddaughters, and a great granddaughter.
Sam Rowlands
Cite this as: BMJ 2017;358:j3911
Sir Bernard Tomlinson

Pathologist, researcher, and administrator

Sir Bernard Tomlinson (b 1920; q University College, London, 1943; CBE, MRCS Eng, MD, FRCPath), died from heart disease on 26 May 2017

Sir Bernard Tomlinson, who has died at the age of 96, helped transform the understanding of age-related mental illness; but he was left scarred by the viciousness with which the medical establishment and the media fought his proposals for the transformation of healthcare in London in the 1990s.

Having served as a specialist pathologist during his national service from 1947, Tomlinson was appointed assistant pathologist at Newcastle General Hospital on his discharge two years later, rising to deputy director of pathology and consultant pathologist in 1951, and assuming the post of director of pathology in 1955.

Mental illness and Manx cats

Over the next three decades he was a prominent administrator, clinician, and researcher in the north east. Much of his clinical and research work involved neuropathology and he was appointed consultant neuropathologist in 1972. His research included papers that rebuffed the accepted wisdom that mental illness in old age was caused by “senility.” Working with colleagues, such as Garry Blessed and Martin Roth, he showed a correlation between levels of cognitive loss and brain lesions.

Through the 1960s and into the 1970s, he did much groundbreaking work in neurochemistry and related areas with Blessed, Roth, and Robert and Elaine Perry. In the mid-1970s, Tomlinson, the Perrys, and Blessed published a series of papers that established the cholinergic hypothesis of dementia. He also worked with Robert Perry and Ian McKeith on pathology of other areas of the brain, the outcomes of which included identification of Lewy body dementia.

Perhaps his least known research was a tangential study of Manx cats—the Isle of Man felines that have either a stumped tail or no tail, and severe mobility problems. Prompted by a paediatrician and neurosurgeon, his research found that the cats had brain lesions similar to those found in children with spina bifida.

As a pathologist, Tomlinson carried out the postmortem examinations on the two children murdered by 11 year old Mary Bell, requiring him to give evidence in her 1968 trial. Two decades on, as the chair of the Northern Regional Health Authority, he was involved in disciplinary proceedings against two paediatricians found to have misdiagnosed child abuse in what became known as the Cleveland abuse scandal. While the pair were disciplined, Tomlinson is credited with ensuring they were not “thrown to the wolves.”

The son of the manager of a Co-op hosiery factory in Nottinghamshire, Tomlinson joined the Socialist Medical Alliance during the second world war and campaigned for the Labour Party in the 1945 general election, to secure a national health service.

Health inequalities

While working with “One nation” Conservative health secretaries such as Ken Clarke and William Waldegrave, Tomlinson took a keen interest in health inequalities and public health. He sparked fury in No 10 by commissioning and publishing a report on poverty and health inequalities in the north east by Peter Townsend, a member of the “Black report” team, whose 1980 report had been binned by the Tory cabinet.

Disenchantment with the latest round of health reforms prompted his resignation as chair of the regional health authority in 1990. The same year he stood down as the first chairman of the Department of Health’s Joint Planning Advisory Committee, which encountered “fierce resistance from London and the royal colleges,” as it sought to rebalance the numbers of consultants and trainees towards the provinces.

Reviewing London’s health services

In 1991 Waldegrave asked Tomlinson to chair a review of London’s health services—including its medical schools. It was to bring him to national attention and define his later years.

The team’s proposals to close or downgrade several high profile hospitals to release funds for general practice and community services sparked a vicious counterattack. Although his recommendations for the merger of medical schools are now seen as far sighted contributions to the development of internationally important centres of research and medical education, he was stung by the ferocity of the media and London’s medical establishment.

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He leaves his wife, Betty; and two children, Elizabeth and David.

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The World Bank and global health

Last week The BMJ published a collection of articles on the World Bank and its evolving role in global health. Along with the five papers, an infographic timeline, and a podcast to accompany each article, we also published a BMJ Opinion article on why medical practitioners should be interested in the World Bank. The authors, Darrin Baines and Zaheer-Ud-Din Babar, say that the five articles in the series “suggest that recent developments in the bank’s operations are reframing the practice of large scale medicine and the delivery of health services for global problems.” They argue that “big, evaluated, privately backed healthcare programmes [which the bank is investing in] are not usually focused on individuals in the same way as the personalised practitioner-patient relationship.” Whether this difference is a matter of concern is an issue that the medical profession should discuss openly, they say. See all the content from this collection at bmj.com/world-bank.

FROM THE ARCHIVE

Staffing the NHS: Now and then

Low morale in the NHS and the uncertainty about Brexit has left many NHS commentators voicing worries about the future staffing of the health service. In an editorial in The BMJ in 1976 (Br Med J 1976;1:112), three years after Britain joined the then European Economic Community (EEC), the authors express similar fears about the future of the workforce. “Without a doubt,” they say, “there will be a greater exchange of doctors within the EEC as a result of the directives on mutual recognition of medical qualifications.” Yet they wonder how this exchange will play out, with the UK “firmly at the bottom of the league table of European medical salaries.” They write, “How many British doctors decide to try their luck in Europe depends on imponderable factors such as morale in the NHS, the quality of life in our society, educational opportunities, and future trends in income tax: no estimate can be better than a guess.”

The editorial quotes Rudolph Klein in saying that “the current NHS manpower policies ‘were devised for a great imperialist power and not for Europe’s poorest offshore island constantly sinking into genteel poverty.’” The authors observe: “So far we seem to have been reluctant to contemplate any radical change in that system. A combination of inertia and conservatism within the medical profession and lack of imagination at the Department of Health has restricted change… Unpleasant, unpopular decisions have been avoided simply because migrant doctors and recent graduates have been available to plug the worst gaps in the service. “Given the constraints of the economic climate, there are only two possibilities for the future,” they conclude. “If current policies and the present staffing structure of the NHS remain unchanged standards will undoubtedly continue to decline, morale will stay low, and we shall find that much of the NHS has become a second-class service... The other possibility requires recognition that, more than any other profession, medicine has to compete with every other country for talent. We cannot hope to retain first-rate doctors in Britain unless they are recognised as such.”

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TWITTER RESPONSE OF THE WEEK

Last week’s column by Margaret McCartney (BMJ 2017;358:j3955), positing the impossibility of GPs practising excellent medicine in 10 minute appointments, was our most read and shared article. GP Graham Kramer @KramerGraham responded on Twitter to observe: “General practice is a daily contest between idealism and pragmatism—what we could/should do versus what we can do.”

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