By Loch Long, a couple of hours’ cycle ride from Glasgow, the wind was biting, the sun was shining, and the nuclear weapons were just across the water. I went to my first protest at Faslane when I was a medical student in the late 1980s. The Campaign for Nuclear Disarmament was a visible protest group then, rather than a symbol seen on T-shirts sold to fashionable people with no allegiance to the cause.

I was a student member of the Medical Campaign Against Nuclear Weapons—now known as MedAct—which was affiliated to International Physicians for the Prevention of Nuclear War (IPPNW). Truth be told, since then I’ve often forgotten about my membership, but the standing order is still running.

We learn about Nazis at school and about the cruelty and immorality ordinary men and women are capable of. We learn about the horror of the world wars and the people who sacrificed their own lives to benefit generations to come. We learn about astounding bravery and selflessness and the best of the human spirit. The men and women on parade on anniversaries are fewer and fewer each year.

War seems so far away from us. But it isn’t. It never has been. The past year in politics has been a series of extraordinary events. Last month Donald Trump was inadequate in his response to the neo-Nazis who led violent protests in Charlottesville, Virginia. A woman in a counter protest was murdered in an act of terrorism.

Nothing has gone away, including nuclear weapons. Trump is currently in the midst of a Twitter row with North Korea and China. I typed that and then had to read it again in disbelief. Yes, really. Nuclear weapons, which those countries all possess, are a disaster not just because of their indiscriminate, mass killing but because of the long term health and environmental cost to humans and the planet.

The purpose of IPPNW—founded by physicians from the former Soviet Union and the US—was to present the medical case for preventing nuclear war. Even if the weapons are never used, they do harm. We skimp and save by telling pensioners that there’s only enough money to replace one of their knees or to take out one of their cataracts, just as we commit to spending £31bn on renewing Trident.

Is the flexing of nuclear muscles really the best use of precious resources? The risk of cyberhackers or accidental launch is ever present: and the mutually assured destruction that we thought was unthinkable is nothing to a toddler having a tantrum in the White House.

It’s tempting to think that this is all so distant that it’s not going to happen. If so, I’d suggest cycling down Loch Long. You can watch the patrols around the beautiful loch—nuclear weapons tucked under the hills and sparkling in the water—and wonder why the UK didn’t turn up to a UN vote in July to approve banning them.

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Cite this as: BMJ 2017;358:j3978
OBITUARIES

Samuel Arthur Biggart
General practitioner (b 1924; q Durham 1947; FRCP), died from the effects of dementia on 6 June 2017
Samuel Arthur Biggart (“Sam”) did national service in Egypt, followed by a commission in the Royal Army Medical Corps, where he developed an interest in respiratory medicine and reached the rank of colonel. After the army, Sam worked briefly for the National Coal Board, investigating miner’s lung, before becoming a partner at what is now Greystone House in Redhill. He maintained his interest in respiratory medicine and cardiology, and was diligent in ensuring he kept up to date long before appraisal became a requirement. He retired in 1985, became involved in voluntary work and remained a keen golfer, historian, cultivator of roses, and avid reader. Sadly in later life, his eyesight deteriorated, robbing him of the pleasure of reading. Predeceased by his two children, he leaves Anna, his wife of 58 years.
Andrew Inglis
Cite this as: BMJ 2017;358:j4015

John Brown Morris
General practitioner Greenock, Renfrewshire; regional medical officer, DHSS, Glasgow and Inverness (b 1924; q Glasgow 1949), died from a gastrointestinal haemorrhage on 16 August 2016
John Brown Morris (“Ian”) spent 18 months working in obstetrics and gynaecology before deciding on a career in general practice. After posts in Bo’Ness and on the Orkney Island of Shapinsay, he joined a group practice in Greenock. He had difficulties with his health, having had Crohn’s disease since he was a teenager, and left general practice in November 1973 to take up a post with the regional medical service, initially in Glasgow. He enjoyed travel to the more remote locations of Scotland and completed his career in Inverness, providing support to general practitioners within the Highlands and Islands. Predeceased by his wife, Robina, in 2015, he leaves four children, nine grandchildren, and seven great grandchildren.
Gordon Morris
Cite this as: BMJ 2017;358:j4010

John Stratton Gatecliff
General practitioner (b 1924; q Leeds 1953), died from old age on 1 February 2017
John Stratton Gatecliff was enlisted in the Royal Navy in the second world war and saw active service as a leading radio mechanic. His ship, HMS Limbourne, was lost in 1943, and it was while recovering from injuries sustained in that incident that John decided to undertake medical training after the war. While at medical school in Leeds, he met a fellow medical student, Margaret (Kemp), whom he married in 1954. His medical career was mainly spent as a general practitioner and GP trainer in Featherstone, west Yorkshire, where he worked from 1959 up to his retirement in 1989. He involved himself fully in local life and was well known locally for his impressive photographic record of events and changes in the town over the years. He leaves Margaret, three sons, and five grandchildren.
Richard Gatecliff
Cite this as: BMJ 2017;358:j3933

James Kenechukwu Onwubalili
Consultant physician and nephrologist, honorary senior lecturer (b 1947; q Ibadan, Nigeria, 1975; MD, FRCP), died from renal carcinoma on 4 May 2017
James Kenechukwu Onwubalili (“JK”) was appointed senior consultant physician and nephrologist at the North Middlesex Hospital, London, in 1995. He established the renal services as a singlehanded physician with a special interest in hypertension and helped to develop the haemofiltration service in the intensive care unit along with other intensivists. James was a royal college examiner and tutor for several years as well as an honorary senior lecturer. An associate professor of medicine at St George’s International School of Medicine, Grenada, he spent 42 years practising medicine in the UK, Nigeria, and Saudi Arabia. He retired in December 2016 because of ill health, James enjoyed sports, travelling, football, music, and politics, and he was active in his local church. He leaves his wife and three children.
James Chidi Onwubalili
Cite this as: BMJ 2017;358:j4009

Raymond Seidelin
Consultant cardiologist Wharfedale General Hospital, Otley, Leeds Area Health Authority (b 1924; q Oxford/Middlesex Hospital 1947; DM (Oxon), DPM, FRCP), died from pneumonia on 13 January 2017
Raymond Seidelin (“Ray”) did his national service in the Royal Air Force in 1950-52. In 1955 he rejoined the RAF as a consultant in medicine. In 1968 he retired from the RAF and was appointed consultant physician in Otley, Wharfedale, where he practised until 1989. He was clinical tutor and senior clinical lecturer at the University of Leeds from 1974. He loved to study medicine and language, being fascinated by France and the French. In retirement he successfully completed a BA from the Open University. Ray had many and varied interests. He played squash into retirement, fell walked, and ran daily in Yorkshire. He was married for 61 years and leaves his wife, Anne (née Orr); three children; and seven grandchildren.
Peter Seidelin
Cite this as: BMJ 2017;358:j4001
**Angela Brodie**

Pharmacologist whose work on aromatase inhibitors transformed the treatment of breast cancer

Angela Hartley Brodie (b 1934; PhD chemical pathology, Manchester, 1961), died with Parkinson’s disease on 7 June 2017

Angela Brodie, whose work around aromatase inhibitors transformed the treatment of breast cancer two decades ago, continued her groundbreaking research until a few months before her death in June at the age of 82. The resulting treatment is regarded as one of the most important breakthroughs in the treatment of hormone related breast cancer.

Brodie was inspired to focus on improving breast cancer treatment options after seeing footage of radical mastectomies during her first research role at the Christie Cancer Hospital in Manchester.

**American life**

She moved to the US having secured a fellowship funded by the National Institutes of Health to train at the Worcester Foundation for Experimental Biology in Massachusetts. There she found a team—including her future husband, Harry Brodie—researching the oral contraceptive pill. A synthesised aromatase inhibitor developed by Brodie, an organic chemist, did not provide the basis for effective oral contraception, but his future wife felt that the work might deliver a new treatment for hormone dependent breast cancer.

She remained at the institute after her fellowship ended, marrying Brodie and starting research work in his team’s laboratory. By the time she moved to the University of Maryland School of Medicine in 1979 she had a substantial body of preclinical data on 4-hydroxyandrostenedione—including its efficacy as an inhibitor in animals.

Although her work is now seen as a massive contribution to breast cancer treatment that has saved thousands of lives, Brodie found it difficult to have the compound developed and tested in clinical trials. Her first paper outlining the lab results was rejected as “they thought the findings too obvious,” Brodie noted many years later.

**Frustrations, and eventual recognition**

She was also frustrated by a lack of interest from both pharmaceutical companies and the National Cancer Institute (NCI). Of the latter, she observed: “The NCI set aside some funding for its development, but things progressed very slowly; there always seemed to be other priorities.” Of the pharmaceutical companies, she commented dryly: “They were either not inspired by curing breast cancer in rats or they felt tamoxifen was perfectly good enough.” A colleague recalls her saying of the experience: “If you have something you think is a good idea, stick to it.”

Coincidentally, it was her home country that provided a route to market. After she presented her work at a 1980 conference in Rome, Brodie was approached by Charles Coombes, who two years later conducted a clinical trial including 11 patients at London’s Royal Marsden Hospital, using a supply of the compound synthesised by Brodie’s students. The drug was finally licensed in 1994. It is now one of four aromatase inhibitors widely licensed for use in the treatment of hormone related breast cancer.

Brodie’s work on inhibiting oestrogen has been used by neuroscientists to help improve understanding of the hormone’s impact on the brain as it develops both inside and outside the womb.

At the time of her death, clinical trials were under way on more potent and specific inhibitors that work in combination with other agents. It is hoped that these will provide further treatment options for women whose breast cancer does not respond to the current inhibitor treatments or where resistance develops.

A third stage clinical trial on a possible treatment for prostate cancer, that Brodie developed with colleagues at the University of Maryland, is also due to begin shortly. It centres on a compound aimed at inhibiting androgen synthesis—a key factor in the development and growth of prostate cancer.

Born into a Quaker family as Angela Hartley and educated at a Quaker boarding school before attending the universities of Sheffield and Manchester, Brodie appeared to embrace the religion as a philosophy and way of life rather than as a faith.

Colleagues say this may have been a factor in both her drive to find treatments for a disease that maimed and killed many and the warmth and support she offered students and those she worked with. She talked little about her achievements—which ultimately led to her becoming the first woman to receive the Kettering Prize for an outstanding contribution to the diagnosis or treatment of cancer. She was made a fellow of the American Association for Cancer Research in 2013.

She leaves her husband, Harry, and a son. A second son predeceased her.

Chris Mahony
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Cite this as: BMJ 2017;358:j3557
The GMC is listening to your revalidation gripes

The General Medical Council is often at the sharp end of questions from doctors about the value of annual appraisals and revalidation, especially from doctors who’ve practised for many years and who are thinking of winding down or retiring.

As an experienced consultant paediatrician myself—and preparing to revalidate for the second time, as I’m still practising—I’m more than familiar with the challenges of collating feedback from patients and colleagues, reflecting on my practice, and ensuring that I meet the various requirements for my annual appraisal.

At University College London Hospitals (my main employer) this includes regular updates on everything from resuscitation training, infection control, and blood transfusion to the correct use of firefighting kit, how to lift heavy items, and equality and diversity. Added to that are the requirements of my royal college, and it doesn’t take long before it looks a formidable burden.

Yet the requirements of employers, which quite rightly expect their staff to know one end of a fire extinguisher from another, and of royal colleges, keen to ensure that their members keep abreast of new developments, shouldn’t be confused with the GMC’s requirements for revalidation.

The GMC simply requires, over a five year period, one collection of colleague feedback; one collection of patient feedback; annual whole practice appraisal; evidence of quality improvement or audit activity; a discussion of any complaints and compliments; and a self declaration of health. It does not require mandatory

What GPs told me about how they see the future

In June I wrote a column (BMJ 2017;357:j2949) that was very supportive of primary care but asked, in view of serious current problems and an uncertain future, for a consensus from GPs themselves on the future of primary care. An excellent collection of rapid responses (see bmj.com) helped me (and hopefully other non-GPs) to understand the current mood.

One point of consensus seemed clear: there simply is no consensus about models of general practice, and we shouldn’t expect one. General practices and the communities they serve are too diverse, and different doctors want different things from their careers. That’s OK. Most respondents considered delivery and employment models secondary. Some were happy to work as salaried GPs in networks or integrated care providers and for others to take on partnership.

There were points of agreement: first, that the most pressing crises were the chronic underfunding of general practice—which has fallen as a percentage of NHS spending even as activity has risen—and major workforce gaps. An editorial in The BMJ in July suggested that we are underestimating the workforce gap—and that it isn’t likely to be tackled either by recruiting GPs trained overseas or by the GP Forward View, which is not on track to provide all of the full time equivalent GPs it planned or to plug the hole left by retirees.

In a hierarchy of needs, general practice’s very survival was what mattered most. The constant undermining narrative that general practice is unsustainable or not fit for purpose—and that it should be subsumed into scaled up collaborative models of primary care beyond the traditional group practice or bigger locality health systems—was seen as partly driven by politics and as a threat to general practice as we know it. Some respondents did argue, however, that modernisation is needed to deliver more care for increasingly complex patients at scale outside hospital.

Second, “one size fits all” models of big general practice are seen as pointless in remote communities, where distances are bigger and where the skilled expert generalist, confident in subacute care, is at a premium.

Third, patients still value the continuity and personal approach of traditional general practice, although
The system does not require mandatory training in fire extinguishers

training in fire extinguishers or minimum credits for continuing professional development, but it is possible your employer or college does. Patients expect that the doctors treating them are up to date and fit to practise, and they largely assume that some sort of system to that effect has been in place for many years. In fact, as we know, it’s relatively new.

Patients need assurance

To a patient it makes little difference whether the doctor is a fresh faced youngster just beginning a career or a semi-retired GP working just a couple of days a week: they just want assurance that they’re in safe hands.

Annual appraisals have been a fact of working life for professionals in most fields for many years. They’ve been in the NHS for more than 10 years, and the Royal College of General Practitioners championed appraisals before revalidation ever existed. But when the pressures on UK healthcare, and on GPs in particular, are undeniable, I understand bureaucracy, however necessary, can be unwelcome.

Keith Pearson’s review of revalidation, published in January, acknowledged this, and one of his recommendations was for more to be done to make the process as straightforward as possible for doctors.

Making differences clearer

He also recommended that the GMC work alongside employers and royal colleges so the differences between the GMC’s guidance and theirs are clearer. This work is ongoing—and we have recently published a plan to implement Pearson’s recommendations—but in the meantime, if doctors are unsure or suspect they are being asked to go beyond what the GMC requires I urge them to raise it with their appraiser, employer, or responsible officer.

The fact the GMC is often the misguided target—because we introduced revalidation—for the ire of those frustrated by the burden of regulation, shows how important it is to progress this and to get it right.

We are listening to what doctors are telling us, but we remain committed to the value of a system that meets the expectations of patients and upholds the importance of professional development for doctors.

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Cite this as: BMJ 2017;358:j4215

Peer review of referrals already goes on in most practices—it’s called coffee time

they might trade some of this for rapid access. Several respondents argued that small group practice models are still best able to provide this cost effectively and that GPs are best placed to support people with diagnostic uncertainty, multiple morbidity, and undifferentiated symptoms.

To my mind, a problematic dissonance still exists in the push from some leading GPs to devolve care to the community and out of hospitals, when primary care is already overwhelmed and underfunded. I also perceive a mismatch between the values of younger doctors, often wanting less than full time or fully clinical roles (often salaried), and those promoting the partnership model.

This is perhaps why the most interesting responses to me were from the GP and academic Richard Byng and from the GPs Jonathon Tomlinson and Martin Marshall. In their own way, all raised the meta-questions of what general practice is really for, how its approach differs from the rest of medicine, and what parts of it require the skills of a doctor, as opposed to other staff groups or self care. But I saw surprisingly little discussion of the serious workforce gaps in district nursing or community health and social care services, which surely hamper good general practice.

With the population’s health needs changing so drastically, it’s surely vital to reflect on what general practice is and isn’t for, and what it should and shouldn’t do, as Margaret McCartney set out in a recent BMJ column (BMJ 2017;358:j3457).

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Cite this as: BMJ 2017;358:j3976

Peer review of referrals undermines professionalism

When was the last time you saw the phrase “could reduce by up to . . .?” An advertisement for an anti-wrinkle cream, perhaps? No, for me it was in an NHS England document calling for the peer review of all routine referrals by GPs.

Many GPs are furious that NHS England continues to focus on problems with access in secondary care and seems unaware of or uncaring about the crisis in general practice. Regarding variation in referral rates as a “problem that needs to be fixed” seeks to blame GPs for generating “unnecessary” activity, distracting attention from underlying problems caused by underfunding.

Despite intense workload pressure, the vast majority of GPs try to manage problems within primary care whenever possible. The decision to refer a patient is not made in isolation. It is part of a complex process of management, which includes consideration of the patient’s medical, psychological, and social situation. Referral decision making is an integral part of GP training, and the notion that all such decisions must be reviewed is a slur on the education, competence, and professionalism of our colleagues.

The document seems to take no account of the effect it will have on GPs’ ability to provide good care. There is a real danger of undermining patients’ trust.

As soon as patients think a recommendation not to be referred is based on anything but their best interests they will seek alternative routes to a second opinion—not only for that condition but for future ones too. It is only this trust that ensures so much activity to take place in primary care, and any erosion of this will damage the entire NHS.

Peer review of referrals already goes on in most practices—it’s called coffee time. Discussion among GPs of patients with complex or uncertain conditions is an essential part of high quality general practice, and such discussions include far more than just referral decisions. These good habits will be nurtured by ensuring that GPs have enough time to meet informally with colleagues and by working in stable, supportive practices where their professionalism is valued.

NHS England’s initiatives should be aiming to ensure these conditions exist. This document will do the opposite, by undermining professionalism and increasing time pressures on GPs and their patients.
INCREASING ACID ATTACKS

Empowering lay bystanders to respond
Grundlingh et al discuss the critical role of bystanders after an acid attack, emphasising the need for fast and effective action from the first person on the scene at an emergency (Editorial, 5-12 August). The actions described are evidence based and focused on outcomes yet do not require complex medical knowledge and training.

Research shows a lack of proactive intervention from bystanders beyond an initial call for help—a missed window of opportunity for bystander intervention. For the victim of an acid attack, this window could be the difference between acute and minor coagulation necrosis of the skin. Inaction could be devastating. Lay responders need to know that they can and should do more to help.

The British Red Cross prioritises “plan and prepare” in its education because it is fundamental to resilience and to the essence of learning first aid and the social responsibility it carries.

Emily Oliver, senior education research manager, London
Cite this as: BMJ 2017;358:j4243

CANCER SURVIVAL DATA

Time for action on NHS access for poorer people
The Association of the British Pharmaceutical Industry’s report on cancer drugs (Seven Days in Medicine, 22 July) uses data that are not new. But it shows that as well as slow uptake of new drugs, the UK also spends less than its economic peers on some well established drugs. This implies that patients in the UK have less access to cancer treatment.

The latest Mirror, Mirror report from the Commonwealth Fund shows the UK to rank best among 11 nations for healthcare with the exception of the outcomes domain. The high ranking of the UK in the access domain is flattered by affordability associated with a “free at the point of access” service, as is the equity domain.

Patients who live in poorer neighbourhoods have less access. Many articles show this—they simply haven’t been collated. We must urgently assess how the financial distress of the NHS affects poorer people.

S Michael Crawford, clinical lead for research, Keighley
Cite this as: BMJ 2017;358:j4195

WORKFORCE STRATEGY

Joined-up planning for improved mental health
How delightful to foresee 21 000 new posts in mental health (This Week, 5-12 August). As an academic, I would assume population mental health and developments across the whole system is essential. Improvement needs new collaborations at grass roots level and social policy interventions to address the determinants of mental health.

Cite this as: BMJ 2017;358:j4199

DEBATE ON 24 HOUR SHIFTS

Working when exhausted is unacceptable
Stain’s argument for 24 hour shifts is flawed (Head to Head, 29 July). Most worrisome is the suggestion that doctors should work such shifts because it’s inevitable. “Bad practice to gain experience in more bad practice” is not a valid strategy.

Stain says that “the commitment to provide continuity of care . . . is an important part of professionalism.” I reject the insinuation that any doctor who says “I’m too tired to work safely” is acting unprofessionally.

He cites a study that found no difference in patient mortality between two groups of doctors, both working 80 hours a week, in different shift patterns. Comparing overworked doctors is hardly compelling.

Doctors must recognise that working at the limits of exhaustion leads to unacceptable low performance. Emergencies may dictate that they work when tired. The aim should be to minimise emergencies—not to encourage bad practice with shifts that promote exhaustion.

Paul D McGovern, specialty registrar in occupational health, Northampton
Cite this as: BMJ 2017;358:j4191

LETTER OF THE WEEK

Engaging patients when doctors disagree
The narrative on the Charlie Gard case has centred on parents disagreeing with doctors (Editorial, 5-12 August). But this case really turns on how parents respond when doctors disagree.

Patients will invariably affiliate themselves to one side of a medical argument; Charlie’s parents’ stance was predicated on the offer from the American professor to treat their son. If the debate is public, political and religious figures will equally align themselves to one side. To suggest that public opinion is merely ochlocracy is a misrepresentation.

We must learn how best to engage patients when doctors disagree. Furthermore, we must encourage a greater appreciation of how to integrate conflicting medical evidence into the deliberative process. If we fail to do this, the courts will increasingly be the arbiter of medical disputes, which has resulted in some antithetical verdicts.

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Jagdeva Meher, specialty doctor, Redditch
Cite this as: BMJ 2017;358:j4175

LETTERS Selected from rapid responses on bmj.com. See www.bmj.com/rapid-responses

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