Antidote to conference addiction

Fear of missing out (FOMO) is the experience, when on social media, of noting that other people are at a party, concert, or film when you aren’t. They are having a better time than you; either you made the wrong choice or you weren’t offered it. Your Instagram, Twitter, or Facebook feedback is not as beautiful—and you missed out. That may not be important in the grand scheme of things, but what about fear of missing out on conferences—maybe we should call it FOMOOC?

Sometimes I scroll through Twitter and see hashtags furiously churned out from conferences that look brilliant. There are people tweeting whom I like but have never met, or I have met and very much like. These people post selfies of themselves giving keynote speeches, writing notes, looking at interesting posters, or drinking cocktails after an evening session. I am lonely and not there. We onlookers—we easily outnumber the attendees—are all missing out.

While I feel that I am missing out, I’m also acutely aware that conferences are inefficient, there are already too many of them, and they are breeding. We who do clinical work can only manage, maybe, one or two a year. One trip is likely to eat up half a month’s part time pay cheque. If you have any caring responsibilities it becomes even more complicated, and you still may need to find a locum.

Some people clearly don’t have such problems as they tweet endlessly from conferences. It seems to me that there are some people employed by the NHS whose entire job is to go to conferences and to tweet meme-ish management tips in between times. Even when you get to a conference you may go to the “wrong” session, and then see the people you saw at breakfast tweeting from the “better” session next door.

Conferences are where people meet each other and where private conversations happen; and where power, in invisible networks, is laid and strengthened. In this way, conferences are anti-democratic—healthcare professionals who aren’t there miss out and probably don’t know they are missing out. The Manel—the all male panel—is, however, well represented at medical meetings and is emblematic of the under-representation of minority groups and women at conferences.

Many conferences are key money earners for organisations, often through sponsors or advertising stands. This may or may not bring problems, depending on what is being presented.

Many conferences don’t pay their speakers for preparation or presentation. This is fine if the speaker is one of those employed by the NHS to go around giving talks. But for many other doctors this means using up holidays or days off. This could be fair and good fun in a gig economy but, when it’s not, it rankles.

Many patient speakers, who are expected by organisers to be delighted with an invitation, have talked about the difficulties of going to conferences when there are also wages that need to be earned. Then there is the thundering carbon footprint of conferences, whether reckoned in hotel sheets, airplanes, cars, or taxis.

We could reduce FOMOOC by having fewer conferences. We could have whole conferences by video link: what is the point in one speaker giving the same talk to 10 meetings when it can be online forever? But then, most of the allure of conferences is not really the speakers but in seeing people and having time to share and gather our thoughts. Maybe a little more time day to day in our own workplaces to see our colleagues might help?

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Cite this as: BMJ 2017;359:j4515
PERSONAL VIEW  Heather Logghe, Christian Jones, Alison McCoubrey, Edward Fitzgerald

#ILookLikeASurgeon: embracing diversity

The stereotype of the arrogant, white, male surgeon is a barrier to professionals who do not fit the mould

In the two years since the launch of #ILookLikeASurgeon, an online campaign celebrating women in surgery, it has been included in more than 150,000 tweets by more than 35,000 users, making nearly a billion impressions.

More importantly, it has brought focus to issues that women and minorities have long understood: the arrogant, white, male surgeon stereotype is a barrier to surgical professionals, and those not fitting this dated mould are less likely to be recognised as one of our field.

People using the hashtag have acknowledged both the need to change the image of surgeons, and that there must be no singular image—appearance, motivations, and behaviours are as varied as humanity. From the single dad to the launch of Women in Surgery Africa, diversity has been recognised and applauded, and a new global community has emerged.

The movement has evolved to include more specific calls to action. Caprice Greenberg’s 2017 presidential address to the Association for Academic Surgeons cited #ILookLikeASurgeon, but also reported on the discrimination and inequality perpetuated by unconscious bias. Around the same time, the online community took aim at the Annals of Surgery for publishing an editorial with a headline that asked whether a modern surgeon was still “a master of his trade.” The controversy resulted in a retraction and re-publication with more gender inclusive text.

Against this backdrop, a recent study has demonstrated slightly superior outcomes for patients treated by female surgeons. The authors posit multiple possible explanations including that the barriers women face result in a higher bar. In other words, as Charlotte Whitton, a former mayor of Ottawa once said, “whatever women do, they must do twice as well as men to be thought half as good.”

Adversity overcome

Even in the absence of double standards for survival and success, it behoves the surgical community to recognise that women and minorities are not merely as good as the stereotype, but have overcome more adversity with fewer opportunities. Comments such as “we’re all surgeons” or “only quality matters” can render barriers invisible. Recognising that different

A recent study has demonstrated slightly superior outcomes for patients treated by female surgeons

ACUTE PERSPECTIVE  David Oliver

How much information should families expect on wards?

One of the biggest stressors in work for me and my colleagues, junior and senior, is the relentless demand for information—not from patients themselves but from their relatives.

It’s taboo to talk about this in public for fear of appearing callous and uncaring. But it comes up whenever a group of medics unburden themselves in safe spaces. I’m happy to break the taboo and to be found wanting for doing so.

The source of this stress is rarely visitors who are involved carers, supporting the patient day in, day out. These visitors are often highly present on the wards, making frequent interaction and updates easier. It’s crucial to involve these carers as we plan care jointly and make key decisions. But other visitors, who may be more distantly involved or come from further away, often arrive at evenings or weekends when regular ward staff aren’t there. They can struggle to get the information and updates they seek or may get it secondhand from less well informed staff.

We could, I guess, match the timing of medical staff shifts to times of peak visitor requests for updates. But, as the patients should be central, could we justify the opportunity cost for their care, running the wards with a depleted daytime team?

We have lots of less visible work to do away from our main inpatient wards, but I’d estimate that NHS doctors, especially consultants, could easily spend three to four hours a day, every weekday—maybe in a high visibility “DOCTOR” jacket in the middle of the ward—talking to patients’ families.

During the evening and at weekends, junior doctors often cover several wards and try to review numerous patients, some of whom are very unwell, while also struggling with endemic rota gaps. They may be repeatedly approached by relatives desperate for information, who think that this can come only from a doctor.
As a result, junior doctors can’t get on with the jobs they’ve arrived on the ward to do.

We should manage the public’s expectations in this area better: this includes public information in ward areas about how and when to speak to staff. Maybe visitors with particular worries should come in when the usual staff are present.

We must also ensure nurses on the wards are supported—as the trained professionals they are—to give key information to families, and they should be respected when they do.

Doing this well is difficult, when understaffing and vacancies leave them time poor and so focused on essential tasks that high quality handover and knowledge of the “script” for each patient can vary, as can confidence in “owning” the patient’s progress report.

Maybe we need to be radical and leave a written or electronic progress summary for patients’ families, or we could devote an hour or two a day to email correspondence with them.

In many cases families now want proactive, regular updates, given without even asking to speak to anyone. This might help avoid complaints and improve communication, but time spent with patients would suffer.

What do we mean by illness? What is a disease? What is the difference between mental and physical pain? And if there is a difference, does it matter?

For most of us, these questions are academic. For Jennifer Brea, they are the stuff of life. In her twenties she was felled by a mysterious illness. About to marry, studying for her PhD at Harvard, she was laid low by a succession of viral infections. Then came near catatonia. She fell into a condition of agonised, almost mitochondrial, depletion. To move she had to haul herself, elbow by elbow, across the floor.

She ran the gauntlet of specialists: bemused endocrinologists, rheumatologists, cardiologists, and psychiatrists. There were investigations, hypotheses, bewilderments. Some said it was psychogenic, the late dark flower of an early trauma. Some said it was her immune system.

The film takes us into the dark folds of a cruelly disabling condition

Then she turned to the internet and found a virtual continent of fellow sufferers. People hidden for decades, some permanently bedridden, some almost fetal with pain. Chronic fatigue syndrome, myalgic encephalomyelitis—call it what you will—here was a dispersed pandemic of unplumbed suffering.

Unrest is the film that Brea made about her condition. It is not an easy watch. She does not pull her punches. It takes us into the dark folds of a cruelly disabling condition. It is a defiant film though—not least because she makes it in dogged defiance of her condition. And it provokes ceaseless questions.

One that stayed with me is the long squabble between psychological and physical etiology. I understand that to treat a condition it helps to know its cause. But what I don’t get is the insinuation—not from the film maker, but from some of the commentators—that if it is mental rather than physical, choice is involved. The phrase “it’s all in the mind” suggests that all we need do is change our mind and the problem dissolves. But such a view of mental phenomena is puerile. Our minds are not all in the mind.

Unrest also provokes philosophical questions about other minds. Because a devastating condition is not well captured by current diagnostic possibilities, questions have arisen about its reality. Is this suffering or elaborate malingering? The truth is, the only way we know another is suffering is if they tell us. There is a lesson for medicine here. It is a reminder, if we need it, that the world of human suffering has not been mapped in its entirety by medicine.

Julian Sheather is ethics manager, BMA. The views he expresses in his opinion pieces are entirely his own

Unrest is released at UK cinemas on 20 October
Challenges of incentivising patient centred care

Rachel Foskett-Tharby and colleagues draw on recent experience in England to reflect on how best to increase the collection and use of patient reported information

Patient experience and patient centred care have become increasingly recognised as ethical imperatives over the past few decades. Although the definition is still somewhat contested, patient centred care incorporates aspects of the patient experience, such as communication, shared decision making, and the way services are designed, accessed, and delivered, including integration of care.1

Patient experience is now also seen as integral to quality of care,2 leading to international calls for measurement and incentive structures to place a greater focus on patient reported information.

Existing pay for performance schemes such as the Quality and Outcomes Framework (QOF) in England, have been criticised for focusing on clinical management above patient experience.3,4 However, although it is easy to identify the shortcomings of current incentives, incorporating measures using patient reported information has challenges.4

What is patient reported information?
Patient reported information is that which is gathered directly from patients or their families and carers, either as a narrative or through survey questions. Schlesinger and colleagues suggest that it can be organised into four subtypes: patient reported outcome measures (PROMs), which measure the outcome or effects of care; patient experience measures (PREMs), which measure processes or experience of care; patient narratives; and patient complaints.3

Though not mutually exclusive, these four forms of patient feedback present different challenges when seeking to incorporate them into an incentive structure, to differentiate between high and low performers, or to inform quality improvement efforts.

Feedback that can be quantified lends itself most easily to inclusion in an incentive structure as responses are standardised, enable direct comparison between providers, and can be given a financial value; however, it may offer a limited understanding of the patient experience.5

Getting measurement right
Using patient reported information in financial incentive schemes requires a fundamental shift in the importance placed on such information.

Since 2004, the QOF has variously incentivised the collection of PREMs, the collection of PROMs in people with depression, and the outcomes of patient experience measures, although none are currently used. What do these measures (known within QOF as “indicators”) tell us about what is needed to make use of patient reported information in future? Successful data collection requires clarity on the following four factors:

What is being incentivised?
Incentives can be used to encourage collection of information (process) or to achieve a given response (outcome). Both approaches have been used in QOF. Incentives for data collection and undertaking local experience surveys were included during 2004-10, leading to workload concerns and implementation differences between practices.6

Reliability
Reliability is critical for performance measurement as it quantifies the result’s reproducibility and ensures that any observed differences in practice level scores are attributable to real performance differences rather than random error.7

In 2006, a national GP patient survey was introduced with the incentive payment linked to responses to two questions about access (see table overleaf). Doctors voiced concerns about its fairness, related to sample size, indicator reliability, and incentive structure.8,9 There was also professional discomfort about payment being explicitly linked to patient reported information, which was viewed as outside of practices’ control.

Key messages
• The UK has made many attempts to incentivise the collection and use of patient reported information in general practice with limited success
• Challenges include how best to structure the incentive and how to address professional concerns about data collection and result credibility
• Incentives alone are not enough to increase use
• Organisational commitment and practical support are essential

Incentives alone are not enough to increase use

Reliability
Reliability is critical for performance measurement as it quantifies the result’s reproducibility and ensures that any observed differences in practice level scores are attributable to real performance differences rather than random error.

It requires adequate sample size, sampling frame, and response rates. Indicator reliability was a big concern in the profession when patient survey responses were linked to payment. Analysis at the time suggests that these concerns were largely overstated, with less than 3% and 0.5% of practices having fewer than the number of responses required for 90% and 70% reliability, respectively.

However, the combination of low (38.2%) and variable response rates (<20% for some practices) negatively affected healthcare professionals’ confidence in the results. Healthcare professionals are also
suspicious of patient motivations for providing this feedback. Furthermore, maintaining adequate response rates may be challenging in the face of “survey fatigue” in potential respondents. This is exacerbated through the use of poorly constructed and implemented measures, and incentive design needs to consider how to proceed if minimum samples are not achieved.

How will data be collected?
The first step in deciding what instrument to use to collect data is to determine the concept of interest and review the psychometric properties of available measures.

Patients should be actively engaged to ensure the focus is on outcomes that matter to them and their experience. Many of the available instruments for collating information have not been developed or extensively tested and therefore may not include what patients think is important. Valid and reliable measures of critical concepts, such as coordination, remain elusive despite global research efforts.

The effect of multimorbidity also needs to be considered. With an estimated 23% of the population reporting comorbidities, single disease oriented questionnaires may have limited value in capturing the experiences of these patients, while more generic quality of life measures may not discriminate between providers. New PROMs aimed at people with multimorbidity are being developed.

Interpretation
Interpretation is particularly important when using PROMs to incentivise an outcome rather than data collection.

Within England, outcomes data have been collected before and after surgery from patients having hip or knee replacements, inguinal hernia repair, and varicose vein surgery since April 2009. The aim is to show the health gain from these procedures. However, interpreting changes in health status in the context of long term conditions and, crucially, attributing these changes to primary care providers is more difficult. These scores therefore cannot be used to make meaningful comparisons of quality or outcomes of care between practices. This conclusion may change if PROMs are routinely incorporated into primary care and used to guide clinical decision making.

What should the incentive be?
Once measurement has been dealt with, it is necessary to consider the size and structure of any incentive. It has been suggested that incentives for patient reported measures need to be larger than those for clinical care measures. Studies have reported significant improvements in reported patient experience when the incentive has been structured to emphasise experience rather than productivity and efficiency. However, the question of how much larger the incentive needs to be requires further investigation.

UK experience challenges the assumption that professional reticence about the use of patient reported information for payment purposes can be “bought out.” Between 2006 and 2013 UK GPs were incentivised to use a questionnaire to assess severity in patients with a new diagnosis of depression, with the intention that this would inform discussions about treatment options. A payment of about £2118 for an average sized practice was attached to reaching the target assessment numbers, similar to the amount paid for achieving the threshold for clinical intermediate outcome indicators such as blood pressure control in patients with coronary heart disease and glycaemic control (HbA1c ≤59mmol/mol) in patients with diabetes.

Described at the time as controversial, the implementation of this indicator was
incentives linked to GP patient survey, 2006–11

<table>
<thead>
<tr>
<th>Time in use</th>
<th>Indicator</th>
<th>Incentive framework</th>
<th>Payment threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006–08</td>
<td>% of patients able to get an appointment within 48 hours</td>
<td>Enhanced service</td>
<td>50–90% (qualifying for 50–100% of incentive payment)</td>
</tr>
<tr>
<td>2006–08</td>
<td>% who indicated that they were able to advance book an appointment</td>
<td>Enhanced service</td>
<td>40–90% (qualifying for 40–100% of incentive payment)</td>
</tr>
<tr>
<td>2008–11</td>
<td>% who were able to obtain a consultation with a GP (in England) or appropriate healthcare professional (in Scotland, Wales and Northern Ireland) within 2 working days (within 24 hours in Wales)</td>
<td>QOF</td>
<td>70–90% (qualifying for 0–100% of incentive payment)</td>
</tr>
<tr>
<td>2008–11</td>
<td>% who were able to book an appointment with a GP more than 2 days ahead</td>
<td>QOF</td>
<td>60–90% (qualifying for 0–100% of incentive payment)</td>
</tr>
</tbody>
</table>

QOF=Quality and Outcomes Framework.

challenging because clinicians thought it had limited value, threatened their clinical judgment, risked distorting consultation, and was prone to gaming.27 Given the strength of feeling, and the admission of gaming behaviours, it is uncertain whether merely increasing the value of the incentive would have resolved or exacerbated problems. The value attached to an incentive should be cost effective. In England, cost effectiveness is measured using net benefit analysis whereby net benefit (monetised health benefit–delivery cost)–incentive payment.28 Theoretically, the level of the incentive available could be anything up to the point at which there ceases to be a net benefit, but in reality the amount is capped by the desire to provide incentives across a range of disease domains.

The application, as well as the value, of the incentive affects acceptability. Changes to the incentive applied to the results of the GP patient survey between 2008 and 2009 resulted in a loss of revenue for some practices in the absence of any change in performance.18 This was viewed as unfair and contributed to the measure being removed from the incentive framework in 2011.22

Should patient centred care be incentivised?

Although the technical aspects of designing and implementing incentives are obviously complex, concentrating on these can mask the more important question of whether care should be incentivised at all.

Evidence suggests that the effect of incentives on clinical care is modest, with an associated uncertain but sometimes negative effect on clinician behaviours and motivation. Undesirable negative behaviours include gaming, distortion of patient care through a focus on incentivised activity rather than patients concerns, and less attention being given to non-incentivised care activities.29–31

Patients are also unconvinced about the utility of incentives and are concerned about their effect on medical professionalism.32–33 Despite this, there may be a role for financial incentives in providing additional resources to general practice to focus on areas of care that require improvement.

Making quality improvements

Ultimately, patient reported information should be collected to pinpoint areas for improvement. Financial incentives risk creating a high stakes environment in which debate becomes focused on the performance of selected metrics rather than on how patient feedback, both survey results and patient narratives, can be used to improve care.

Motivators to acting on patient experience data include an organisational emphasis on improving overall performance and the patient experience in particular, with dedicated resources to support quality improvement and a belief that patient experience is integral to high quality care.

Including patient reported data in pay for performance and public reporting also has a role.34–35 Barriers to acting on patient experience information include staff not having time to focus on this area of care, lack of support and physician resistance to using these data.34–35

How patient reported information is presented can also influence its value and acceptability. The following aspects have been identified as helpful: inclusion of narrative comments, recommendation of appropriate responses to results, ease of interpretation, inclusion of benchmarking data, and results reported at the individual clinician level when individual variation may be masked by the organisational score.35 36

In England, legislation and guidance seeks to strengthen the patient voice.37 The current contractual requirement for all general practices to have a patient participation group forms part of this culture change. Although previous attempts to encourage practices to engage patients in discussions about their experiences have had a limited impact,38 a critical difference is that the groups are now a requirement of service rather than an optional extra.

Nevertheless, further support is required to ensure their effectiveness.

Quality improvement relies heavily on feedback, learning from the best and working in collaboration

Projects such as the Robert Wood Johnson Foundation Aligning Forces for Quality Study make suggestions on how this could be achieved.40 The quest for optimal incentives for patient reported information should not distract policymakers, clinicians, and healthcare organisations from their moral imperative to deliver patient focused quality improvements.

Rachel Foskett-Tharby, honorary research fellow, Institute for Applied Health Research, University of Birmingham; and York Health Economics Consortium, University of York

Nick Hex, associate director, York Health Economics Consortium, University of York

Antony Chuter, lay patient and public representative, Institute for Applied Health Research, University of Birmingham

Paramjit Gill, professor of general practice, Warwick Medical School, University of Warwick, Coventry

Cite this as: BMJ 2017;359:j4532

Quality improvement relies heavily on feedback, learning from the best and working in collaboration

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Peer pressure masquerading as approval

I found the news that NHS England will mandate clinical peer review of GP referrals quite dispiriting (This Week, 9 September). No one doubts that discussion of referrals by GPs is of educational value to the individual GP. But we have yet to discover whether a high referer is a poorer clinician, and we are unlikely to find out, as studies would need to encompass who is being referred to whom for what purpose and with what result, and our referral letters rarely contain such information.

We must not underestimate the powerful effects of peer pressure exerted as “approval.” It might be useful as a first step, with commissioning groups examining referral letters to judge how they could be improved. Then, and when the distraction of cost saving is eliminated, we can move into the complex area of why some GPs need more reassurance and how this might be tackled.

David Brooks, retired GP, Preston
Cite this as: BMJ 2017;359:j4598

No such thing as unnecessary referrals

Nearly 25 years ago, I analysed 600 new patients to assess whether “good” GPs refer less. I found that “excellent” GPs sometimes made referrals that seemed unnecessary.

But how do you define an unnecessary referral? And who should assess necessity?

I concluded that no referrals were unnecessary. If a GP wants to refer a patient, for whatever reason, they should be able to do. Doctors are professionals: demeaning them by cross checking all their work is unprofessional.

We should investigate why some GPs under-refer. Patients are more at risk from that than from being sent to hospital too quickly.

I have often thought, “If only they had been sent up earlier…”

If GPs are, effectively, doing their work twice, the pressure not to refer will become intense, and they will start taking risks. NHS England should think again.

Andrew N Bamji, retired consultant rheumatologist, Rye
Cite this as: BMJ 2017;359:j4606

Outsourcing review of GP referrals: who gains?

We Hackney GPs had compulsory peer review of referrals imposed on us several years ago. Our referral rates are rising, and cost and quality have not noticeably improved. Our practice loses 12 appointment slots a week to fulfil peer review. Time for clinical discussion has all but disappeared.

A third of CCGs have contracted screening referrals to private companies, which reject referrals repeatedly. Who screens these referrals and on what criteria? Are there penalties for missing targets? How many lawsuits from patients for delayed or missed diagnosis would it take to offset any potential savings?

This is not the model of peer learning that referral screening is mooted to encourage. Who ultimately gains?

Most GPs cannot keep taking on more clinical responsibilities. Outsourcing referral screening will add no clinical value, cost more, and might ultimately increase harms to patients.

Nick Mann, GP, London
Cite this as: BMJ 2017;359:j4607

SEVERE ASTHMA

Measuring improvement in quality of life

The review on managing difficult to treat asthma says that studies of novel biological agents failed to detect improvements in quality of life, despite showing marked improvements in other outcomes (From Drug and Therapeutics Bulletin, 2 September). This might be the fault of the quality of life instruments, not the drug.

Current asthma quality of life scales were designed for patients with mild to moderate asthma. In severe asthma, oral corticosteroids impose a high level of adverse effects, which NICE has confirmed were not captured when calculating the quality of life adjusted life years.

The severe asthma questionnaire, developed to meet US Food and Drug Administration standards for designing questionnaires for health related quality of life, is currently undergoing validation but represents a more valid outcome measure for patients with severe asthma. Interventions that improve health related quality of life can only be evaluated accurately if appropriate measures are used.

Rupert C Jones, senior clinical research fellow, Plymouth
Matthew Masoli, consultant physician, Plymouth
Joseph W Lanario, associate research fellow, Plymouth
Michael E Hyland, professor of health psychology, Plymouth
Cite this as: BMJ 2017;359:j4623
OBITUARIES

Jonathan Alper
Associate specialist (anaesthetics) Musgrove Park Hospital, Taunton (b 1956; q South Africa 1985), died from pulmonary fibrosis on 8 August 2017
Jonathan Alper (“Jonny”) left his native South Africa in 1990 and worked briefly on a kibbutz in Israel. He met his wife, Cathy, while working at Maidstone District General Hospital and did his registrar training at Edgware and Barnet hospitals. In 1998 the Alpers moved to New Zealand for two years. Back in the UK they both took up posts at Musgrove Park, and Jonny became active in the BMA. A tireless activist, he was presented with the BMA fellowship at the annual representatives’ meeting in 2017. An avid reader, a traveller, a man interested in so many facets of life, he engaged online with friends on all manner of topics, not least of which his own experiences as a terminally ill patient. Jonny leaves his wife, Cathy.

Cite this as: BMJ 2017;359:j4519

James Michael Butterfield Carr
General practitioner (b 1933; q Edinburgh 1957), died from metastatic bladder cancer on 26 August 2017
James Michael Butterfield Carr (“Mike”) did national service with the Royal Army Medical Corps in Oswestry from 1958 to 1960. From 1960 to 1969 he worked in public health, initially in the Caistor and Market Rasen districts before moving to the Cleethorpes and Grimsby districts in 1966. In 1969 he became a general practitioner and partner in the Roxton Practice, where he quickly progressed to senior partner. He retired in 1994. Mike’s colleagues and patients remember him as a dedicated traditional GP, who was well liked and respected. Outside work, Mike enjoyed a full and varied Masonic career. He was a family man who looked forward to his holidays, enjoyed walking, and completed all of the 214 Wainwright peaks over the years. He leaves his wife, Eileen; three children; and four grandchildren.

Cite this as: BMJ 2017;359:j4477

William JB Cherry
General practitioner Barnard Castle (b 1935; q Durham 1957), died from cardiovascular disease on 17 April 2017
While doing national service William J B Cherry ("Bill") was posted to the market town of Barnard Castle and was offered a post in the local surgery, which he joined in 1966. He encouraged the change to a teaching practice and the addition of a female partner, and he was supportive of all young doctors. He held a healthy scepticism for the professional committee doctor and will be remembered as a well liked, highly competent GP. He retired in 1987 because of ill health, having developed angina in his early 40s. In retirement he was active in the community and became a volunteer driver and a governor of Barnard Castle School, and pursued his love of golf, music, birdwatching, and fine wines. He leaves his wife, Helen; three children; and six grandchildren.

Cite this as: BMJ 2017;359:j4479

Wilhelmina Lockwood
General practitioner (b 1924; q Leiden 1954, MRCS, DObst RCOG), died from bronchopneumonia on 19 April 2017
Wilhelmina Lockwood was born in Indonesia. At the age of 18 she was interred in a Japanese concentration camp (1942-45) and nearly died. She studied medicine at Leiden University in the Netherlands. Wilhelmina met her future husband, David, in Heidelberg in 1950 and moved to Birmingham in 1954 after they got married. Her medical degree was not recognised in the UK, and she qualified by doing her conjoint exams in medicine and surgery. She worked as a rural general practitioner—first in Upton on Severn, then in Kingsland, Hereford—and retired in 1990. She was also a vicar’s wife. She had a direct manner, was well organised, and was popular with trainees. Widowed in 2005 and predeceased by two daughters, she leaves her eldest daughter, who is a professor of tropical medicine.

Diana Lockwood
Cite this as: BMJ 2017;359:j4480

Alan John Sykes
General practitioner and anaesthetist (b 1954; q Dundee 1978), died from a pulmonary embolism on 5 July 2017
Alan John Sykes joined the Leven and Beeford Medical Practice in 1984. He combined his role in general practice with work as an anaesthetist at the Beverley Westwood Hospital. For many years he lived in North Froningham, where he raised his family and worked as a rural family doctor. Alan grew up on the family farm near York but soon realised his vocation was in medicine, not farming. He developed a passion for motorbikes as a boy on the farm, a hobby that he enjoyed throughout his life: he spent some of his best holidays touring Europe on his favourite Honda. Alan died suddenly at home in Beverley, before he could enjoy the retirement he had planned. He leaves his wife, Yvonne; four children; three stepchildren; and two grandchildren.

Maria McDiarmid
Jaap Vermeijden
Cite this as: BMJ 2017;359:j4481

Frances Mary White
Assistant surgeon Bromsgrove (b 1925; q Leeds 1949; DRCOG, MBE), died from old age on 30 March 2017
After qualifying, Frances Mary White moved to Bromsgrove with her husband, Max, who entered general practice. She became an assistant surgeon at Bromsgrove General Hospital and Droitwich Private Hospital, specialising in treatment of varicose veins. She was one of the earliest women involved in medical politics and served on BMA Council and many BMA committees, centrally and regionally. She was chair of the Worcestershire division and was, like her husband, a fellow of the BMA. Mary was very active outside medicine and was awarded an MBE for her outstanding work in developing the Bromsgrove Music Festival. She also found time to serve as a magistrate and school governor, in addition to running her family farm in south Yorkshire. She leaves her son, John; daughter, Sara; and several grandchildren.

David Brownridge
Cite this as: BMJ 2017;359:j4495
Shigeaki Hinohara

Oslerian scholar who was one of Japan’s most famous doctors

Shigeaki Hinohara (b 1911; q Kyoto University, Japan, 1937), died from respiratory failure on 18 July 2017

Shigeaki Hinohara started his medical career at St Luke’s International Hospital in Tokyo in 1941. A devout Christian, he remained at the hospital for the rest of his life. At the time of his death he was honorary president of the hospital and chairman emeritus of the board of trustees of St Luke’s International University (previously St Luke’s College of Nursing).

Discovering William Osler

Hinohara fell under the spell of legendary Canadian physician and humanist William Osler in August 1945 when, shortly after the end of the second world war, US Army chief surgeon Warner Bowers gave him a gift of Osler’s book Aequanimitas: With Other Addresses to Medical Students, Nurses, and Practitioners of Medicine. The book became Hinohara’s “companion on the journey.” In 1983 he cofounded the Japan Osler Society and was an honorary member of the Osler Club of London and of the American Osler Society.

In 1983 he and Shakespeare scholar Hisae Niki published a book of 20 of Osler’s lectures translated into Japanese. In 2001 they published an expanded annotated version in the original English, under the title Osler’s “A Way of Life” and Other Addresses, with Commentary and Annotations.

Innovator and writer

Hinohara’s contributions to improving medical care in Japan included pioneering comprehensive medical check-ups and advocating patient-first medical care in the 1950s. Under his guidance St Luke’s established Japan’s first department of palliative care medicine, the first department of psychosocial medicine, and the first residency training programme for young doctors.

At the age of 75 Hinohara began a prolific writing career. He was the author of nearly 150 books on a wide range of health, cultural, self help, and societal topics. His 2001 book, Living Long, Living Good, with advice on staying healthy and happy in old age, was a bestseller and stemmed from his advocacy for what he called the “new elderly.” He argued that the global definition of old age beginning at 65 was no longer valid and decreed that the new threshold would be 75. In 2000 he founded the Association for the New Elderly. He encouraged older people to remain active, keep learning, seek new challenges, and, as he put it, simply have fun like you did as a child.

Life and career

Hinohara was born on 4 October 1911 in Yamaguchi Prefecture in western Japan. His father, a Methodist pastor, had studied at Duke University in North Carolina. Hinohara started studying medicine at Kyoto University, but in his second year he contracted tuberculosis.

After recovering, Hinohara resumed his medical studies, graduating in 1937. He trained at Kyoto for two years and then worked in cardiology, receiving a PhD for his study on atrial heart sounds detected through the oesophagus by means of a tiny microphone that he had devised.

He remained at St Luke’s in Tokyo during the second world war. In 1943 he married Shizuko, who was to be his wife of nearly 70 years. They would become parents of three sons and grandparents of six. In March 1945 Hinohara treated victims of the firebombing of Tokyo, considered the deadliest and most destructive in history. Later in life he became an outspoken peace advocate and spoke regularly to children at schools across Japan about the beauty of life.

In the early 1950s Hinohara spent a year in the US at Emory University in Atlanta for advanced studies in general internal medicine under Paul Beeson. On his return to Japan, he focused on cardiology, psychosomatic medicine, water and electrolyte metabolism, and preventive medicine.

“A new life”

In 1970 he was on a domestic flight that was hijacked by Japanese Red Army members and ended up landing in South Korea. Hinohara and his fellow passengers were handcuffed and spent a “scary” three days and nights in the plane before being released. “I was nearly 60 then,” Hinohara later said, “and I felt that my life had ended once, and that I was given a new life—a life that I was determined to devote to selfless love for the social good.”

During the 1990s his focus turned to ageing, hospice care, and alternative approaches to healing, including music therapy. A newspaper article in 2009 outlined some of his thoughts on medical care, which included: “Science alone can’t cure or help people. Science lumps us all together, but illness is individual. Each person is unique, and diseases are connected to their hearts.”

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The old war on drugs rhetoric

On this day in 1982, US president Ronald Reagan announced federal initiatives to tackle drug trafficking, saying that America needed to “end the drug menace.”

A few months later in January 1983 (Br Med J 1983;286:129), The BMJ’s correspondent George Dunea, a US physician, reported how “in the Chicago area, drug related deaths have increased by 60% in four years” and that “in response to this problem President Reagan recently vowed to expand the government’s war on drug abuse by increasing the number of judges, prosecutors, and law enforcement officers, and by using military intelligence to detect drug traffickers.” Already, said Dunea, “official figures indicate that arrests have increased and more marijuana is being confiscated,” yet he ends by cautiously noting that “the war on drug abuse, clearly, is far from being won.”

Seven years later and with a recent change of president, the journal carried an article (BMJ 1989;299:1275) prompted by the “recent declaration by President George Bush of a war on drugs,” which came “on the heels of identical but ultimately impotent Reaganist rhetoric.” The author, R J Epstein, observed that “paradoxically, the most visible effect of the announcement has been to make many people confront the failure of traditional Prohibition style policies.”

The same conclusion was reached last year by The BMJ’s editor in chief Fiona Godlee and Richard Hurley, features and debates editor, who penned an editorial (BMJ 2016;355:i6067) headlined, “The war on drugs has failed.” They said that “too often the war on drugs plays out as a war on the millions of people who use drugs,” and that with growing calls for reform, evidence and ethics should be the guiding principles of new policies.

FROM THE ARCHIVE

BMJ OPINION Michael Farquhar

The health effects of shift working

The 2017 Nobel prize in physiology or medicine was recently awarded to Jeffrey Hall, Michael Rosbash, and Michael Young for “discoveries of molecular mechanisms controlling the circadian rhythm.” Their work illuminates the genetic and molecular workings of our body clocks, which allow our physiology to respond to different needs at different times of the day and night.

Increasingly, we are realising how intimately every aspect of our physical and mental health is tied to our circadian rhythms. When our lives are not in synchrony with our body clocks, there are consequences.

For many, the most obvious example is when we shift time zones and experience jet lag. Jet lag makes us feel awake and sleepy at the wrong times, we feel disorientated, sluggish, find it difficult to concentrate, are more likely to become anxious or irritable, have aches and upset stomachs. We feel out of phase with the world around us. It can take days for our internal clocks to reset and, until they do, we can struggle to function.

More than three million people in Britain—more than one in eight of the workforce—regularly work at night, many providing essential services on which Britain’s smooth running depends. They are doctors, nurses, police, firefighters, paramedics, transport and maintenance crews, cleaners, bakers, security guards, factory workers … all ensuring your life runs like clockwork in the daytime. For them, the experience of working against their body clocks isn’t an occasional annoyance due to travel—it’s a regular fact of life.

When we ask people to work at night there are consequences. As well as the increased risks of long term health problems associated with shiftworking, night workers are vulnerable in other ways, including a significantly increased risk of death by accident just trying to get home to their beds in the morning.

We must support those who work at night, both by giving them advice to help manage working at night better, but also by employers and organisations recognising that night time work is physiologically unnatural.

Michael Farquhar is a consultant in sleep medicine at Evelina London Children’s Hospital

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