Winter’s coming, there’s flu in the southern hemisphere, and the canaries have stopped singing in general practice. I have a visceral sense of dread. Jeremy Hunt recently spoke to GPs about “the 26% of GP appointments that GPs themselves say are potentially avoidable.” He talked about 10 “high impact actions” aimed at releasing capacity, which form part of the Releasing Time for Care programme, put together at a cost of £30m.

Essentially, says NHS England, “most common potentially avoidable consultations were amenable to action by the practice, often with the support of the clinical commissioning group.” Some 7% of patients could be diverted elsewhere in the practice, 6% could be seen at a pharmacy or asked to self care, and 3% could be seen by a “care navigator,” it explains.

Hunt’s statistics were based on a survey of “over 50” GPs who gave their own opinion on “almost 5000” consultations. The terminology nags at me: contacts with patients were divided into “avoidable” and “unavoidable.” I’d prefer to think of appointments in terms of whether the patient considers me the best person to help, and whether I agree.

And I’d like to know whether the “problem” being presented should have been a problem at all. I’m thinking, for example, of the mess of medical examinations for welfare benefits, where consequent damage to patients’ mental health is inflicted by private providers and left for patients and primary care to absorb. Or patients who phone the hospital for results of a test organised by secondary care but are told to contact their GP if they don’t want to wait until their outpatient appointment.

The programme of work being embarked on in England is predicated on the belief that some patients don’t need to see the doctor. This may be true, but it’s much easier to know in retrospect. General practice is magnificently complicated, defying clean pathways and templates.

The Department of Health clearly seeks to manage our profession remotely, particularly with online appointment booking. The variety and scope of projects now being rolled out in the name of quality improvement is huge. But searching and reporting of harms is scant, reporting of outcomes is highly variable, and negative projects don’t seem to be reported. And where’s the evidence that working differently will reduce workload or clinical contact time? The situation is too urgent and important to neglect high quality research.

Some proposals—such as for social prescribing—are recommended despite a lack of evidence. Other recommendations for “personal resilience” imply that resilience is in the control of the individual and is little related to environmental strain. Mindfulness training should be “embedded” in organisations, and doctors should have “an annual preventive health assessment” and “make home a sanctuary.”

You may wish to scream. I merely insist, “Citation needed.” For something is missing from this approach: evidence and a mirror. GPs are asked to do screeds of non-clinical contract work, which is time consuming, demoralising, and largely pointless. It’s this that we should class as the “avoidable contact,” and which should be razed.

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The variety and scope of projects now being rolled out in the name of quality improvement is huge

Avoid paperwork, not patients

NO HOLDS BARED Margaret McCartney
Legal uncertainty around abortion harms women

Abortion laws are often vaguely written, breeding uncertainty about what is lawful

In 2012, after being refused an abortion, Savita Halappanavar died in an Irish hospital from complications after a miscarriage. Her physicians believed that as the fetus’s heart was still beating their “hands were tied.”

Under Irish law, abortion is a criminal offence unless necessary to save the woman’s life, yet there is little clarity on this exception. After protests, the government introduced the Protection of Life During Pregnancy Act 2013 to clarify the law and to regulate access under it. Years earlier, the European Court of Human Rights called for precisely such regulation, moved by doctors who “faced criminal charges, on the one hand, and an absence of clear legal, ethical, or medical guidelines, on the other.”

The Irish circumstances are tragic, but not uncommon. Abortion laws are often vague, breeding uncertainty about what is allowed. This creates a “chilling effect” on service providers and women, both cautious about criminal prosecution. A UN human rights report named the lack of access to information—specifically on when and how abortions may be lawfully obtained or provided—as a key public health harm of criminalisation.

Earlier this year WHO and the UN Department of Economic and Social Affairs launched the Global Abortion Policies Database, an open access repository of abortion laws, policies, standards, and guidelines for 197 countries. Designed to strengthen efforts to eliminate unsafe abortion, the database acknowledges and engages law and policy as a social determinant of safe abortion.

The association between restrictive laws and unsafe abortion is well documented, especially among marginalised social groups. Beyond

International comparisons are invidious at a time of such exigent crisis

An argument against more NHS funding? I don’t buy it

The NHS faces an unprecedented financial crisis. A Nuffield Trust report has shown a deficit of £3.7bn in acute trusts, compared with a target of £580m set by NHS England.

The King’s Fund found in June that 43% of NHS finance directors planned to overspend their budget this financial year. It also found that 50% of clinical commissioning group finance leads would have to delay or cancel spending to achieve the set financial “control totals.”

NHS performance is stalling or falling in key areas. Independent analyses of sustainability and transformation partnerships (STPs) have questioned their ability to deliver anything like the scale of savings they promise. The Office for Budget Responsibility forecasts that NHS spending per person will fall by 0.9% by 2020.

Given previous government pronouncements it’s unlikely the chancellor, Philip Hammond, will use his autumn statement to promise a significant funding uplift, let alone one sufficient to cover the trend of rising activity and costs, or the end to pay restraint recently announced by the health secretary, Jeremy Hunt.

Against this backdrop we have individuals or organisations arguing, counterintuitively, that the NHS shouldn’t get a penny more of new money. Tim Briggs, orthopaedic surgeon and director of NHS Improvement’s Getting It Right First Time programme, is one. Briggs has said publicly that no more money should be put in unless the NHS has “put its own house in order.”

Pro-market think tanks such as the Adam Smith Institute, Reform, and the Institute of Economic Affairs (IEA) also tend to argue against further funding. They maintain that services could be better, more person centred, and more affordable if we moved towards the insurance based or multiple provider models seen in some European countries. The IEA’s director, Mark Littlewood, claimed that NHS funding had increased in
prohibiting abortion and forcing women to seek services in clandestine settings, restrictive abortion laws also decrease the availability of, and deter and delay access to, lawful care through burdensome procedures, unnecessary service delivery requirements, and increased costs.

**Comprehensive picture**

The breadth of abortion law captured in the database is one of its key innovations. Other collections tend to focus on legal grounds for abortion, classifying countries on this basis. The database provides a more comprehensive picture, capturing a range of “policy domains” (legal grounds, gestational limits, and service delivery requirements), as well as the complexities of regulation.

Moreover, while abortion was historically addressed in penal codes, these have been increasingly replaced or supplemented by health legislation, constitutional court decisions, and other forms of soft regulation such as medical ethics codes. The database captures these sources, dispelling the myth of a single “abortion law.”

The database endeavours to provide clear and accurate information, suggesting that knowledge is the more critical determinant of safe abortion. Women’s limited or inaccurate legal knowledge influences how they seek services, including in countries with liberal laws. Service providers’ legal knowledge also influences if and how they provide care.

Beyond ECHR, other courts and commissions have recognised the obligation of governments to create regulatory frameworks for lawful abortion, including clear criteria and procedural protections. To support governments, the database links country profiles with human rights standards on abortion law and policy. Moreover, by providing accurate information, the database supports activists to hold governments to account for gaps between entitlement and practice on the ground. Last, comparison across regions raises the standard for government justification. It is harder to defend a restrictive policy in the face of legal alternatives, much less against WHO guidance.

One striking lesson of the database is in the domains the law leaves undecided. The history of abortion decriminalisation is marked by physicians who work the ambiguities of law in the name of evidence based medicine and in the protection of women’s health and human rights.

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**BMJ OPINION** Giles Maskell

**Without context, radiology is a game of Where’s Wally?**

A friend posted a photo on our group chat with the caption: “Where am I?” The photo showed a flower bed, backed by a stone wall. There were no clues. So I guessed, correctly, based largely on what I know about my friend. From that, I could try to work out where she might be visiting, and what she might choose to represent with this photo.

That’s a rather long winded way of pointing out that, when it comes to image interpretation, context is vital, and, of course, the same applies in radiology. Pattern recognition is important, but usually not enough on its own. Accurate interpretation relies on a combination of pattern recognition and the application of contextual information. Radiology without context becomes a game of Where’s Wally?, albeit a version with perverse rules in which Wally is absent most of the time, often wears different outfits, and also lends his stripy jumper to others whose identification is of no interest or value.

**An optimistic view of the future is that computers will help us get it right more often**

Finding the right balance between context and pattern recognition can be challenging. There will be times when they pull in different directions—it has all the features of x, but is that really likely in this particular patient? Or alternatively, patients presenting like this usually have y, but the images look nothing like that.

This has implications for the application of artificial intelligence to radiology. For a computer to interpret the photo described above, it could either employ more sophisticated pattern recognition—the precise shade of the delphiniums—or it could factor in contextual information. My suspicion is that it will need to do both.

Computers will certainly use better pattern recognition—quantification and textual analysis, for example, will extract information which is invisible to the human eye from standard computed tomography and magnetic resonance images. But it is in the application of contextual information, and crucially in balancing the relative importance of that information in a particular patient against the importance of features contained in the images, that real gains may be made.

Radiologists make these judgments all the time and, it has to be said, often come up with the wrong answer. An optimistic view of the future is that computers will help us get it right more often. This, by the way, may help to explain why radiologists can get so fractious when presented with less than the full and accurate clinical picture. Nobody wants to be a Wally-ologist.

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Giles Maskell is a radiologist in Truro. He is past president of the Royal College of Radiologists.

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Real terms every year since 2010 and now received a greater proportion of GDP than at any time during the previous Labour government—an assertion contested by the Nuffield Women’s limited or inaccurate legal knowledge influences how they seek services, including in countries with liberal laws. Service providers’ legal knowledge also influences if and how they provide care.

Beyond ECHR, other courts and commissions have recognised the obligation of governments to create regulatory frameworks for lawful abortion, including clear criteria and procedural protections. To support governments, the database links country profiles with human rights standards on abortion law and policy. Moreover, by providing accurate information, the database supports activists to hold governments to account for gaps between entitlement and practice on the ground. Last, comparison across regions raises the standard for government justification. It is harder to defend a restrictive policy in the face of legal alternatives, much less against WHO guidance.

One striking lesson of the database is in the domains the law leaves undecided. The history of abortion decriminalisation is marked by physicians who work the ambiguities of law in the name of evidence based medicine and in the protection of women’s health and human rights.

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View the full interactive graphic online: http://bit.ly/BMJgapG

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An optimist view of the future is that computers will help us get it right more often

Finding the right balance between context and pattern recognition—quantification and textual analysis, for example, will extract information which is invisible to the human eye from standard computed tomography and magnetic resonance images. But it is in the application of contextual information, and crucially in balancing the relative importance of that information in a particular patient against the importance of features contained in the images, that real gains may be made.

Radiologists make these judgments all the time and, it has to be said, often come up with the wrong answer. An optimistic view of the future is that computers will help us get it right more often. This, by the way, may help to explain why radiologists can get so fractious when presented with less than the full and accurate clinical picture. Nobody wants to be a Wally-ologist.
Healthcare systems globally are facing multiple challenges, with ageing populations, increasing chronic disease, rising multimorbidity, and innovative treatments and technologies all leading to rising costs. With finite resources, and an increasing recognition of the potential harms to patients of overdiagnosis and overtreatment, it is essential resources are used optimally. We explore how the value based healthcare framework can help decisions about how to allocate resources, and the importance of good evidence not only for patient treatment but for the organisation of health services.

What is value in healthcare?
For the past 20 years most of the focus in healthcare has been on quality, safety, efficiency, and cost effectiveness. However, it is clear these four factors alone are not sufficient for the 21st century. Care that fulfills the four in some circumstances, will decrease value when delivered to the wrong patient at the wrong time. Optimality—defined by Donabedian as “balancing of improvements in health against the cost of such improvement”—is important.

As healthcare resources are increased the benefits initially increase but then flatten off. By contrast, the amount of harm done increases in direct proportion to the investment of resources. Consequently, the net benefit rises with increasing investment until a point of optimality, after which it falls off. It is at this point that high value care is achieved. For example, population level reductions in risk factors for cardiovascular disease have led to large improvements in cardiovascular mortality. However expanding indications for treatment to include low risk people takes us beyond the point of optimality; here evidence of benefit is limited and side effects can cause harms.

To achieve value optimality must be considered at the level of the individual (personal value), organisation (technical value), and population (allocative value). Balancing allocation to ensure individual and population needs are met within finite resources is often challenging. For example, drug treatments for hypertension may deliver a large benefit (eg, avoiding stroke) for a small number of people, but the harms (eg, side effects), although relatively small, have not been demonstrated and there is concern they overmedicalise the “worried well” and widen health inequalities.

Pressure to provide better value primary care is growing...

...but change has to be driven by evidence based policy and investment, argue Jessica Watson and colleagues.

Examples of opportunities to improve value in primary care

Things to do less of

Personal value (individual)

Tests not influencing management Tests are often performed for “reassurance,” yet systematic reviews show normal results do not reassure patients.

Polypharmacy By reducing opioid use, for example. Long acting opioids are associated with a significantly higher risk of all cause mortality and are often addictive and ineffective for chronic pain.

Low value risk modification, particularly for multimorbidity Guidelines on single health conditions may not be applicable and aggressive management of risk factors may be an inappropriate treatment burden.

Health checks Benefits have not been demonstrated and there is concern they overmedicalise the “worried well” and widen health inequalities.

Technical value (organisational)

Unnecessary appointments For example, checking blood pressure. Home readings and phone consultations may be appropriate instead.

Administrative workload Delegation of tasks to administrative staff can reduce GP time spent on correspondence.

Low-evidence based technology “solutions” Although technology may improve patient care and reduce pressure on services, many apps and devices have not been evaluated and may have harms or increase demand.

Supplier induced demand resulting from broader routes of access Additional NHS services, such as walk in centres, minor injury units, and 111, are often not substitutive and tend to increase overall service use.

Reorganisations of healthcare These incur costs, both financial and in terms of patient confusion and staff morale.
will affect a very large number of people. Optimality therefore requires evidence and shared decision making with patients.

**Why is value in healthcare important?**

Atlases of variation in health show substantial differences in costs, outcome, and quality. For example, in 2013 there was a 57-fold variation between English primary care trusts in GPs’ use of thyroid function tests and 106-fold variation in the use of serum creatinine tests. This unwarranted variation is likely to reflect both overuse and underuse of healthcare.

Too much medicine, even if the quality is high, can harm patients. Examples include aggressive treatment to reduce glycated haemoglobin concentrations increasing morbidity and mortality in elderly people with diabetes. Underuse or lack of access to high value services can harm both individuals and populations by increasing inequalities. For example, pulmonary rehabilitation has been shown to improve the health of people with COPD but people living in more deprived areas who enrol in pulmonary rehabilitation are less likely to complete it than those living in less deprived areas.

Tackling wasteful healthcare spending is a priority for governments worldwide. It’s estimated that around a fifth of expenditure makes no or minimal contribution to outcomes, and health systems will be unable to cope with the rises in rates of long term conditions and multimorbidity if value is not optimised. Various initiatives have been developed in response to this challenge such as RightCare, Getting it Right First Time, Choosing Wisely and minimally disruptive medicine. Value based medicine brings these within an overarching framework.

**Things to do more of**

**Personal value (individual)**

- Continuity of care
  - Associated with improved outcomes and lower rates of hospital admission. May require pairing of GPs and shared patients given an increasingly part-time workforce

- Social prescribing (community referral)
  - Means of enabling primary care professionals to refer to local, non-clinical services. It may improve anxiety and could cut the use of services, although evidence is limited

- Patient self care
  - Self monitoring and management of long term conditions may improve health outcomes, improve experience, and reduce costs

**Technical value (organisational)**

- Information enabled peer review to curb variability
  - Such as Clinical Guardian, an electronic platform for routine audit of GP out-of-hours clinicians

- Integration between primary, secondary care, and social care
  - Examples include primary care homes, which provide population based care using an integrated workforce on a larger scale than the traditional practice size. Early evidence shows these improve interprofessional working

**Allocative value (population)**

- Increased allocation of NHS funding into general practice
  - The cost of a hospital stay is estimated at £400/day whereas an average general practice receives £142 per patient a year.

- Allocating more pharmacists and extended scope physiotherapists to primary care to create extra capacity and multiprofessional skill mix

**Things to do less of**

**KEY MESSAGES**

- Value based healthcare involves balancing improvements in health against the cost
- Current changes in UK primary care offer opportunities to increase value at the individual, organisational, and population level
- Change requires adequate investment and better evidence to guide decisions
- Primary care should consider what low value activities to do less of as well as what to do more of
patient contacts occur in primary care. Only 5% of general practice attendances result in referral to another service. Starfield and colleagues found that strong primary care is associated with improved patient outcomes, reduced health inequalities, and improved cost effectiveness. More recent analysis concluded that although countries with comprehensive primary care systems tend to have better outcomes at higher cost, when primary care doctors act as gate keepers to specialists and patients are registered with a primary care doctor (as in the NHS) health spending is lower. Primary care excels at high value preventive care, can lead to decreased disease burden and downstream treatment costs, and may modify demand. However, primary care in England is buckling under rising demand, with clinical workload for general practice rising by 16% in seven years. Little progress has been made to meet the promise of 5000 extra GPs by 2020, and the number of full time GPs in England actually fell in 2016. Pressure on GPs may be partly mitigated by rising numbers of allied health professionals, but if primary care is not strengthened, secondary care could face even greater burdens. As Roland and Everington stated: “If general practice fails, the whole NHS fails.”

Maximising value in primary care
The government response to rising healthcare demands always seems to be to ask primary care to do more. GPs have been asked to do more seven day working, more to take pressure off emergency departments and more to tackle obesity, to name just a few recent examples. But if we are to achieve high value primary care, each additional demand must be weighed up against the opportunity cost. We need to focus on what low value activities primary care should be doing less of.

How could current changes affect value
Primary care in the UK is changing rapidly in response to the pressures described. Many struggling practices are closing or merging, larger practice networks are growing, and integrated models of care linking community and hospital services are developing. By sharing ideas and good practice—for example, through the Royal College of General Practitioners’ Bright Ideas forum—we have an opportunity to rethink or redesign primary care to provide optimal value healthcare for individuals and society.

New models of care such as accountable care systems and sustainability and transformation partnerships mean primary care can influence value throughout the entire system. Evaluation of the National Association for Primary Care’s primary care homes, which integrate primary, secondary, and social care, shows that they have stimulated new ways of working, although data on patient outcomes are still limited. The challenge is to design organisational forms and care processes that decrease waste and demedicalise care whenever possible. These new models must be evidence based and balance benefits against opportunity costs. Some of the recent demands on primary care have not done this. For example, moving towards improving access through seven day working and larger group practices seems laudable, but evidence that better access leads to improved health outcomes is lacking. Furthermore, this could have knock-on effects on continuity of care, which is not only highly valued by patients and GPs but is also associated with improved patient outcomes. Elderly people who see the same GP have fewer hospital admissions, and the rise in hospital admissions in recent years is due almost entirely to patients who had accessed emergency departments directly, without going through their GP.

We therefore need a public debate about the relative importance of convenient timely access versus continuity of care. Making a change that is not underpinned by a clear rationale and evidence is wasteful.

Pressure on GPs may be partly mitigated by rising numbers of allied health professions

Effective change
Fundamental questions about how to organise and deliver primary healthcare require better evidence to guide decisions. Primary care measurement systems need to be developed to generate data that can assist with the identification of optimality. Innovative examples include OpenPrescribing.net, which allows GP prescribing rates to be compared at a regional and practice level. Data on rates of consultation, diagnostic testing, referral, and patient outcomes could help identify outliers, explore trends, and measure the impact of policy interventions.

Evidence based medicine has changed the way medicine is practised; now it is time for politicians to follow suit with evidence based policy. This means interventions should be trialled or piloted before implementation and evidence of benefits must be weighed against the opportunity costs and potential harms.

We must also remember that change itself requires adequate investment of time and money. Many primary care organisations are introducing multiprofessional roles or bringing in physician assistants, extended scope specialists, and mental health workers. These new roles and relationships may take years to reach full potential and require substantial input from senior practice staff. Extra resources will therefore be needed initially and staff retention is crucial to allow the benefits of these roles to be realised.

Finally, although it is important to maximise value through decisions about how resources are used, this is inextricably linked to the total resources made available, which is ultimately a political choice. The proportion of GDP spent on healthcare is reducing in the UK compared with other developed countries, and added value can only partially mitigate the effects. Given limited resource and unending demand we also need a wider dialogue and debate about what we want from the NHS and what we choose to afford.

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Anant Jani, honorary research fellow, Value Based Healthcare Programme, Nuffield Department of Primary Care Health Sciences, University of Oxford
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Bhan McKinstry, professor of primary care e-health, Usher Institute of Population Health Sciences and Informatics, University of Edinburgh

Cite this as: BMJ 2017;359:j4944
How are junior doctors supposed to learn?

I wonder whether Glass’s colleagues did anything to change the training of their juniors (Personal View, 30 September). Did they give their medical students and foundation year doctors enough hands-on experience? Many juniors are keen to practise clinical procedures but are declined.

Ironically, NHS doctors, paid to be in teaching hospitals, do not take the responsibility to improve medical training. Rather, they complain about how their juniors were not well trained before starting. I have seen senior doctors prevent juniors from joining ward rounds, because they think students can slow the workflow and that only foundation doctors should insert cannulas and write discharge letters. How are juniors supposed to learn?

Glass calls for open forums, which do exist but eventually become checkbox exercises to show that workplaces tackle trainees’ concerns. An open discussion is not enough. We need to change the attitude of the stakeholders in medical training.

Eugene Y H Yeung, medical doctor, Lancaster

Cite this as: BMJ 2017;359:j5057

FALTERING CHILD GROWTH

Improving early detection of cleft palate

Gonzalez-Viana and colleagues summarise NICE guidelines on faltering growth in children (NICE Guidance, 7 October). Ineffective suckling, clicking sounds, or nasal regurgitation while feeding might indicate a cleft palate or submucous cleft palate undetected at newborn assessment. The Royal College of Paediatrics and Child Health recently made six recommendations to ensure early detection of a cleft palate, including using a torch and depressing the tongue to see the whole palate, making another attempt within 24 hours if the first attempt is unsuccessful, and providing training to all healthcare professionals who carry out newborn examinations.

The Cleft Registry and Audit Network found that 28.3% of children born with a cleft palate in 2015 had a late diagnosis and that diagnosis times have not improved over the past five years. This delays referral to specialist cleft centres and valuable input from specialist cleft nurses.

Sophie Butterworth, junior cleft fellow
David Sainsbury, consultant cleft and plastic surgeon
Peter Hodgkinson, consultant cleft and plastic surgeon
Newcastle upon Tyne

Cite this as: BMJ 2017;359:j5082

GUIDANCE AFTER OPERATIONS

Local guidance can have better results

McCarty asks when she can start running again after a microdiscectomy (No Holds Barred, 7 October). I think she missed an alternative approach to finding the best advice.

Following guidance based on evidence from randomised controlled trials results in suboptimal treatment and recovery in almost all patients. Looking at what produces the best outcomes locally can have better results. This might seem counterintuitive, but evidence shows that well informed deviation from national guidance is probably better for patients than treating them all identically. It improves population outcomes despite the differences between centres.

I disagree that nationally standardised leaflets are a good solution. Both staff and patients benefit from a local approach, with savings in the medium term.

Unless the one size fits all approach is abandoned, we are condemned to increasing costs, poorer outcomes, lower staff morale and productivity, and widening inequity in outcomes.

Mark Temple, retired public health physician, Penarth

Cite this as: BMJ 2017;359:j5083

FLU VACCINE

Pharmacist vaccination affects data integrity

Pharmacist vaccination (This Week, 14 October) leads to problems with data integrity, because the communication from pharmacist to GP is suboptimal.

It is often on paper and states only that the vaccination has occurred, without the vaccine manufacturer or batch number. This makes monitoring of adverse events—recommended by the European Medicines Agency—more challenging and reduces the chance of linking any severe adverse event to brand or batch.

In contrast to many other communications, it does not include a recommendation for coding key data into computerised medical record systems. This can cause inconsistencies and make it invisible when searching to identify unvaccinated people or monitor vaccine effectiveness.

In a system where patients increasingly enjoy the benefits of electronic prescribing and data are shared electronically, we must find a better way of passing more complete information about pharmacist vaccination to records in general practice.

Simon de Lusignan, professor of primary care, Guildford
Matthew Houghton, medical director, London
Imran Rafi, chair, London

Cite this as: BMJ 2017;359:j5084

Reducing our plastic footprint

I disagree with Wright and Kelly’s conclusion that we need to establish safe thresholds for exposure to environmental plastics (Editorial, 7 October)—the urgent need is to stem the tide of plastic entering the environment in the first place. We must all challenge ourselves, our communities, and our leaders to transition from a linear “chuck it away” economy to a circular one, where every item is manufactured with its ultimate disposal in mind—be it recycling or reusing.

Let’s start by ending single use plastics—the classic example of convenience over common sense. As well as being a GP, I work with Surfers Against Sewage, above. We have just launched our Plastic Free Coastline campaign working with local communities to reduce usage of plastics. The response has been overwhelmingly positive, with a real desire to be part of the solution. As doctors, we have a responsibility to reduce our own plastic footprint and to work with our employers to look at usage on a larger scale. We have a powerful voice—we should use it to support initiatives such as the proposed deposit return scheme for plastic bottles. We should lobby the government to make manufacturers responsible for the final destination of their product.

What you decide to do after reading this letter will determine whether you become part of the solution or part of the problem.

James Szymankiewicz, GP and regional representative, Surfers Against Sewage, Ilfracombe

Cite this as: BMJ 2017;359:j5056
OBITUARIES

John Percival Barham
General practitioner (b 1920; q King’s College Hospital, 1944; MRCS), died from a chest infection on 20 September 2017

John Percival Barham qualified just before the end of the second world war and, after a casualty officer appointment at King’s, received his call up papers on VE day. He joined the Royal Navy and set off on his “world cruise on the grey funnel line” to the Far East. After a time back at King’s, John entered general practice in Hythe, Kent, where he joined the St John Ambulance Foundation and later received the Hythe Civic Society award for services to the town. After retiring from general practice in 1982, John continued to work as a doctor’s friend for members of the profession undergoing legal prosecution, and carrying out assessments for disability allowance. He leaves his wife, Joy; two children; three grandchildren; and four great grandchildren.

Christopher Barham
Cite this as: BMJ 2017;359:j4824

David McGechie Duncan
General practitioner Welligington, Northamptonshire (b 1936; q St Andrews 1960; MBE), died from prostate cancer on 27 May 2017

After qualifying and house jobs in Dumfries, my father, David McGechie Duncan, moved to England, where he spent most of his working life as a GP in Welligborough. The energy and enthusiasm that he put into his job were extraordinary, and as a result he was awarded an MBE for services to medicine just before he retired. He was committed to the local church, to Round Table, and to Rotary, which awarded him the Paul Harris fellowship as recognition of his invaluable service. In retirement, he and my mother retired to southwest Scotland, where he became involved in the local community. He was diagnosed with an undifferentiated prostatic cancer, which was resistant to both radiotherapy and chemotherapy. He leaves my mother, my brother, me, and four grandchildren.

Roderick Duncan
Cite this as: BMJ 2017;359:j4818

Linda Carol New
Associate specialist in microbiology Epsom and St Helier hospitals, Surrey (b 1958; q St George’s, 1983; BSc, MRCP, MSc), died from cancer on 6 July 2017

At medical school, Linda Carol New achieved a first and won several awards. She also did research on Toxoplasma, setting her on her career path. After a spell in the Public Health Laboratory Service in Tooting, she joined Epsom Hospital, where, apart from an eight year break to have a family, she spent her career. She was an approachable, dedicated doctor, popular as a reliable, friendly source of advice. As an undergraduate, Linda had been a successful athlete and enjoyed ballroom dancing and singing in the choir. She had a tremendous sense of fun and loved all of the social functions connected with work, especially if the opportunity for some disco dancing presented itself. She leaves her husband, Alan Williams, and their two daughters.

David Ward, Justin Bendig
Cite this as: BMJ 2017;359:j4821

Bruce Campbell Ogilvie
Consultant cardiothoracic radiologist Southampton (b 1941; q Edinburgh 1965; FRCP Ed, FRCR), died from metastatic colorectal cancer on 14 July 2017

As medical registrar in Kirkcaldy, Bruce Campbell Ogilvie helped establish one of the first coronary care units in a UK district general hospital. During his subsequent radiology training in Edinburgh he developed expertise in cardiac catheterisation and coronary angiography. In 1976 he took up a consultant post at the Wessex cardiothoracic unit in Southampton, where he was lead cardiothoracic radiologist for 20 years and clinical services director for radiology for three years. By the end of his career, cardiothoracic radiology had become a service of great importance in the acute setting. On his retirement in 2006 Bruce moved with his second wife, Rosemary, to the Scottish Borders. He leaves Rosemary, two sons, two stepsons, and six grandchildren.

David Ogilvie
Cite this as: BMJ 2017;359:j4883

James William Lawson Holmes
Anaesthetist (b 1946; q University College Hospital, London, 1969; FRCA), died from prostate cancer on 25 July 2017

James William Lawson Holmes ("Jim") initially wanted to become an orthopaedic surgeon as he thought that this would marry his love of science and family craft of carpentry. However, his passion shifted to anaesthesia. He trained in Plymouth, Cardiff, and Cambridge, and in 1975 he accepted a one year locum consultant post in Tromsø (northern Norway) that focused on the then super-specialist skill of regional anaesthesia. In 1977 he took up a consultant post in Swindon’s Princess Margaret Hospital, where he introduced regional anaesthesia. He retired from anaesthetics in 2002 and took up a palliative care doctor post at the Prospect Hospice in Wroughton, where he worked for four years. He described this period of his career as an absolute privilege. He leaves his wife, four children, and 10 grandchildren.

Tom Holmes
Cite this as: BMJ 2017;359:j4820

Henry Francis Valentine Riddle
Consultant anaesthetist (b 1928; q Liverpool 1959; PhD, FFOM, RCP, MRCGP, MD), died suddenly from complications after day case surgery on 17 September 2017

Henry Francis Valentine Riddle ("Val") was a GP principal in Dysart, Fife, from 1962 to 1974. Having obtained a grant from the Scottish Health Department, he completed his MD thesis in 1970, on the topic of allergic alveolitis and respiratory disease among malt workers—a condition that became known as malt worker’s lung. In 1975 Val moved to Edinburgh to be senior regional medical officer in the Civil Service Medical Advisory Service and completed several reviews of the causes of ill health in the workplace. Finally he was appointed the first director of occupational medicine for Scotland. Val leaves his wife, Ann; four children; eight grandchildren; and his much loved dog, Boris.

Pippa Riddle
Cite this as: BMJ 2017;359:j4882
David Todd

Haematologist and head of medicine at Hong Kong University

David Todd (b 1928; q University of Hong Kong 1952; MD, FRCP, FRACP, OBE, KB), died on 16 August 2017

The fate of a newborn placed in an orphanage in Canton (now Guangzhou) unexpectedly changed when he attracted the attention of Paul and Margaret Todd, Presbyterian missionaries from the United States. They adopted the Chinese baby in 1929, christened him David, and took him home to live with their other adopted children, Lois and Jonathan. Paul Todd was a doctor and his wife, Margaret, a nurse. Together they established the Kung Yee Medical College in Guangzhou in 1909, and the Todd Clinic and Hospital in 1931 (now the Second People’s Children Hospital). The family lived in the shadow of the hospital, and from an early age David Todd was inspired to follow his parents into medicine.

In 1937 family life was disrupted when Japan invaded mainland China. Todd was sent to Hong Kong, then a British colony, where he boarded at the Diocesan Boys’ School. During the second world war, Japan laid siege to Hong Kong, and Britain surrendered the colony on Christmas Day in 1941. Fleeing the Japanese for a second time, Todd returned to China to Shaoguan, to study at Lingnan Middle School. At the age of 14 he had to make a solitary, dangerous journey through northern Guangdong, and according to a colleague, Gabriel Leung, he witnessed several atrocities. Colleagues later said that his characteristic resilience and sense of purpose were probably rooted in his early experiences.

Early medical career

Todd’s multicultural background meant that he was open to change and opportunity. In 1947, in what his colleague and friend TK Chan described as “a great loss for Guangzhou but an enormous gain for Hong Kong,” he chose to read medicine at the University of Hong Kong. He excelled, coming first in his exams, and winning prizes for anatomy and public health.

In 1953 the young doctor joined the teaching staff at the university department of medicine at Hong Kong’s Queen Mary Hospital. Here he built his career for more than 40 years. He left Queen Mary’s only for a two year period to study at Glasgow’s Royal Infirmary from 1956.

Under the tutelage of AJS McFadzean, Todd became an internationally respected haematologist, known for his interest in the demographic distribution, clinical features, and molecular characteristics of thalassaemia in Asia. In the 1970s he was able to apply the newly emerging knowledge of genetics and molecular biology to improve understanding of the type of thalassaemia found in south China, and Queen Mary’s became the first centre in south east Asia to offer prenatal diagnosis using DNA technology.

AJS McFadzean Library

When McFadzean retired in 1974, Todd became head of department. As well as doing clinical work, he wrote over 100 publications and set up the AJS McFadzean Library. He brought in new specialisms, such as clinical pharmacology and neurology, and he taught generations of medical practitioners. Todd also worked hard to put Hong Kong on the international map. From 1980 he was an examiner for membership of the Royal College of Physicians, and built a partnership with the college that allowed the exam to be held in Hong Kong. He became a council member of the Royal College of Australasian Physicians, and through numerous visiting professorships he brought many prominent international physicians to Hong Kong to participate in teaching and research. He founded the Hong Kong College of Physicians in 1986 and became a trustee of the Croucher Foundation, which supports young Hong Kong scientists and doctors.

In 1995 Todd was knighted for his services to medicine. An Anglophile, he came to Cambridge in 1997 (after retiring in 1994) for a complete change of scene. Here he spent 12 years enjoying classical music, among other things. He regularly attended concerts and operas in London, Germany, and Italy.

In 2009 Todd moved back to Hong Kong to be near his brother. And exactly 70 years after he first arrived at Queen Mary’s Hospital as an undergraduate he completed the circle. He died in his own hospital on 16 August 2017, after a short illness. He was not married and had no children, but he is warmly remembered by his many close friends.

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When I use a word: A medical Blade Runner

A reader on Twitter (Stuart Feltham @sfparamedic) recently wondered: “Is this the geekiest @bmj_latest blog that has ever been written? Top marks for citing Blade Runner *and* Star Trek.”

Here is an extract of the article from Jeffrey Aronson, a clinical pharmacologist at Oxford’s Nuffield Department of Primary Care Health Sciences, so others can consider the question:

“Blade Runner 2049, recently released, 35 years after the cult movie Blade Runner, features androids called replicants. “Android” comes from the Greek word νήρ, a man—although ever since Fritz Lang’s Metropolis, androids have been both male and female.

“Various fictions feature different distinctions between humans and androids. In Philip K Dick’s novel, Do Androids Dream of Electric Sheep, and the Blade Runner films based on it, empathy is the key. The Voigt-Kampff test, which androids fail, tests empathy through physiological differences. But were empathy so readily detectable, the specific effects would be easily installed in an android; “compassion” would be a better term.

“The title Blade Runner, introduced by the movie’s director, Ridley Scott, has a medical connection. It comes—via a novella by William Burroughs, Blade Runner (a movie)—from a novel by Alan E Nourse, called The Blade Runner. Nourse’s novel is about an overpopulated healthcare system, in which only those who have been sterilised qualify for medical care and to offer it to others is a crime. The blade runner of the title is a boy called Billy Gimp who illegally provides surgical instruments to a surgeon willing to operate on those who are denied care by the system: “At least the Doc had got away—no telling what the cops would have done to him for taking out a kid’s tonsils!”

Read this in full and more articles in Jeffrey Aronson’s “When I Use a Word” series at blogs.bmj.com/bmj/category/columnists/jeff-aronsons-words

**TWEET OF THE WEEK**

“A substantial percentage of US journal editors received personal payments from industry and these payments were often large, finds #BMJResearch”

Last week, this conclusion of a BMJ research paper (BMJ 2017; 359:j4619) made for our most popular tweet. Some on Twitter took the findings with a kind of weary resignation: “Big surprise there,” said John @JohnLakeshow, while Iván D Flórez @IvanD_Florez observed that it was “not surprising at all but still disappointing.”

Other readers expressed more shock and dismay. “Journal editors wield enormous power… eerie,” summed up JLH (Hans) Evers @EversJlh; while Dr Jason Fung @drjasonfung took it further, seeing in these findings “the rotten heart of evidence based medicine… everybody on the take.” Many were also disturbed by the study’s real world implications for doctors, such as Dr Sameer Gupta @SGuptaMD who commented: “Research in journals drives clinical care and such potential conflicts can compromise care.”

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**LATEST PODCAST**

An education round up

“The kind of information that the GP needs might be quite different from the way that information should be framed for a patient.” Clinical editors at The BMJ discuss discharge letters in a conversation about handovers in the hospital setting, between hospitals and community settings, and between medical teams and patients.

Listen to our latest education round up podcast—which also covers postpartum haemorrhage, anticoagulant and antiplatelet combined therapy, and ward rounds.