

comment

Why worry about declining numbers of hospital beds and rising multimorbidity when we have attachments that turn a smartphone into an otoscope?

NO HOLDS BARRED Margaret McCartney

Technology isn't enough

Social care is imploding, emergency departments are heaving, and GPs are timing their retirements to avoid appraisals. Juniors are striking, applications for references are rising in preparation for Antipodean jobs, and applications to medical school are down.

Every few days we hear that GPs are failing in some new way, and that we are “ideally placed” to act as marriage guidance counsellors, identify terrorists, tackle health inequalities, or solve obesity.

But apparently it's okay: technology will save us.

Why worry about declining numbers of hospital beds and rising multimorbidity when we have self monitoring devices, telehealth, and attachments that turn a smartphone into an otoscope? “With e-prescriptions and home delivery, the problem can be rectified without stepping outside your home,” the health secretary decreed at the annual *Health Service Journal* lecture.¹

Society is now 24/7, and we like using mobile phones and wi-fi, so let's adapt health services to suit new demand. Could we solve the NHS's problems by opening the doors to routine work at the weekend and getting the kit to do Skype and email consultations?

No: this is entirely wrong. We're ruining the NHS because we're not being clear enough about what it's for. Meeting popular demand doesn't solve problems. It simply stokes more demand—and not



all demand is reasonable. The NHS was founded on the basis of need, and that in turn implies fair use. Advocating more use of technology so that parents don't have to leave home when a child has earache is bizarre—but yes, Jeremy Hunt really said that.¹

I've spent the past decade discussing with parents the natural course of minor viral illness, what otitis media is, and why we don't use antibiotics any more. I've explained when review is necessary, what to look out for, and how to get in touch. I try to give knowledge, rarely prescriptions. I offer a relationship, not an “outcome measure.” I want parents to be masters of, and not subservient gatherers of, information.

We are back to front. Technology is useful when it lightens labour; not when it's a replacement for human care or when it creates unnecessary demand through overdiagnosis, overtreatment, and overaction. Until we value sharing knowledge and the importance of human relationships in healthcare we're doomed to repeat the cycle of believing that more and faster is always better—while failing to understand why we get diminishing returns.

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Poor governance in the award of honours and degrees in British medicine

Peter Wilmshurst describes an extreme example of a systemic problem

In 2002 I raised questions about the failure of medical institutions to respond adequately to the decade of reports about the alleged financial and research misconduct of the surgeon Anjan Kumar Banerjee and of concerns about his clinical skills.¹ Banerjee was erased from the Medical Register for more than five years (2002-08), following almost two years suspended, for serious professional misconduct. Yet in the 2014 Queen's birthday honours Banerjee was awarded an MBE "for services to patient safety."² Two months after the award, and after Members of Parliament and the press were made aware of his record of misconduct, Banerjee's MBE was forfeited.³

In the seven years since he has been allowed to return to practise as a doctor three medical royal colleges have honoured Banerjee by making him a fellow. The University of London has also ignored repeated requests to withdraw his Master of Surgery (MS) degree during the 15 years since it was confirmed to be based on fraudulent data. These events raise questions about governance in the award of national and academic honours to doctors.

Banerjee and Peters at the GMC

In November 2000 a hearing of the professional conduct committee (PCC) of the General Medical Council (GMC) found Banerjee guilty of serious professional misconduct for falsifying research, and he was suspended from the Medical Register for one year.⁴

At a separate committee hearing in February 2001 Banerjee's research supervisor, Tim Peters, was also found guilty of serious professional misconduct.⁵ Peters, the committee found, had agreed to be a coauthor with Banerjee of a paper he ought reasonably to have known was fraudulent,⁶ having been warned of the problem by colleagues, and of an abstract he knew Banerjee had falsified.

Peters was the head of the department of clinical biochemistry at King's College School of Medicine and Dentistry in London, director

of pathology services for King's Healthcare (1992-98), and the editor of two medical journals (*Alcohol and Alcoholism*, 1991-93 and *Addiction Biology*, 1995-2000).

The PCC heard in 2001 that Peters and at least one other senior official at King's College London were aware in 1991 of the results of the college's internal investigation that year. This had concluded that "much of the research data produced by Dr Banerjee since 1988 is at best unreliable, and in many cases spurious."

However, Banerjee was not reported to the GMC until I reported him in 1998.⁷ The GMC gave Peters only "a severe reprimand."

Rewards for research misconduct

Banerjee had submitted the same fraudulent data for an MS degree from the University of London. The university senate had been forewarned by one of its senior lecturers that the data in the thesis were false, but he was nevertheless awarded the degree in 1991.

It is reasonable to assume that the decision to award the MS was influenced by the fact that Banerjee's supervisor and supporter, Peters, was subdean for research and higher degrees and subdean for postgraduate higher degrees at King's College School of Medicine and Dentistry and was associate dean for the Thames postgraduate medical education department of the University of London.

Banerjee also presented the false data during his prestigious Hunterian professorship lecture at the Royal College of Surgeons of England in 1991.

Around the time in 1990 that senior officials at King's College first learnt about Banerjee's research misconduct, correspondence shows that he was stopped from being on call in the department of surgery on two occasions because of concerns about his clinical skills and flawed decision making.

Banerjee's progress

Instead of reporting concerns about Banerjee's integrity and competence to the



GMC, King's allowed Banerjee to transfer smoothly to a surgical rotation in the West Midlands. Within months he was removed from the rotation because he was reported to be "the worst registrar we had ever had," but he was immediately appointed to the Trent surgical rotation. He was awarded a Doctor of Medicine degree by the

University of Nottingham. In 2014 the university embarked on a review of that thesis. The result is still unknown.

Banerjee was made a fellow of the Royal College of Surgeons (FRCS) of England in 1989 and passed his specialty examination in 1995. By this means he joined those fellows to whom he had presented false data in his earlier Hunterian professorship lecture.

When I first reported Banerjee to the GMC in 1998 he was a consultant colorectal surgeon in Halifax, but by the time he appeared at his first PCC hearing in 2000 he was suspended from his hospital while his clinical skills were investigated by the Royal College of Surgeons.

At that time some fellows proposed him for fellowships of the Royal Colleges of Physicians (RCP) in both London and Edinburgh. I warned the London college about Banerjee's impending PCC hearing and it did not make him a fellow, but the RCP of Edinburgh did.

Banerjee's first PCC hearing in 2000 considered only his research misconduct. The committee found that his fraudulent research included a paper published in *Gut*.⁶ During the hearing, Banerjee's lawyers confirmed that the data in the paper were the same as in his MS thesis, but the PCC issued no finding about the thesis. After the charges were found proved, the editor of *Gut*, Michael Farthing, retracted two of Banerjee's publications.⁷

Farthing, who was then and still is a GMC council member, also reviewed Banerjee's thesis. Farthing confirmed to the university that there was an overlap between the

data in the thesis and those published in Banerjee's fraudulent *Gut* paper. Since then the University of London has been repeatedly requested to withdraw Banerjee's MS qualification, but it has not done so. The GMC, which regulates primary medical qualifications, is aware that Banerjee's MS is based on false data but says that he is entitled to claim the qualification unless the University of London withdraws it.

Banerjee's second GMC hearing

Immediately after Banerjee was allowed back onto the Medical Register in January 2002, I asked the GMC to deal with outstanding concerns. Banerjee was suspended under interim orders on 21 January 2002.

In September 2002 a second PCC hearing again found Banerjee guilty of serious professional misconduct.⁸ The PCC found that he had been dishonest over a sustained period. He misled patients about the lengths of NHS waiting times to induce them to have private treatment. He submitted false and inflated bills to patients and insurers. The GMC also found that in one case he had provided substandard care.

Banerjee was erased from the Medical Register. The evidence suggests that in 2001 there had been concerns about Banerjee's probity and clinical skills for more than a decade but that the senior individuals and organisations that should have reported concerns to the GMC had failed to do so.

Reinstatement on the Medical Register

In November 2007, a GMC fitness to practise committee agreed that Banerjee could return to the register. In January 2008 he was reinstated and began to practise as a surgeon and to conduct pharmaceutical research. In 2011 Banerjee was reinstated as a fellow of the Royal College of Physicians of Edinburgh and was also awarded fellowship of the Royal College of Physicians and Surgeons of Glasgow. In 2013 he was elected to fellowship of the Royal College of Surgeons of Edinburgh.

Fellowships have to be proposed by several existing college fellows and then considered by the college's council and existing fellows. Because of secrecy in the processes it is impossible to know what those that considered him for these honours were told about Banerjee's history. The Royal College of Surgeons in England, where Banerjee delivered his fraudulent Hunterian professorship lecture, has not allowed him to be a fellow again.

Time to replace the "club culture" in British medicine with a culture that values integrity and transparency

Since he was readmitted to the Medical Register in 2008, Banerjee has held honorary consultant surgeon appointments at the United Lincolnshire Hospitals NHS Trust and at Bedford Hospital. He has also worked as a surgeon at private hospitals.

Fraudulent MS thesis

The PCC hearing in 2000 did not publish a formal finding that Banerjee's MS was based on fraudulent data, even though the evidence and his statements clearly showed that it was. A formal finding would have raised questions about the governance of the award of medical qualifications by King's College London and the University of London, not least because of the senior role of Peters, who was later reprimanded in respect of his supervision of Banerjee, in postgraduate medical education in those organisations.

At the time of Banerjee's first hearing, Graeme Catto was chair of the GMC's education committee, making him one of the five most powerful GMC members. He was also vice-principal of King's College London, dean of Guy's, King's College, and St Thomas' Hospitals' Medical and Dental Schools, and pro-vice chancellor of the University of London. By 2002, when Banerjee had his second PCC hearing, Catto had been knighted and become president of the GMC. In my opinion, the fact that the PCC did not issue a finding about the falsification of Banerjee's MS thesis saved the academic institutions that Catto headed some embarrassment.

Subsequently Catto and other senior officials at King's College tried to persuade *The BMJ* from criticising them and the college over the adequacy of their response to Banerjee's misconduct. Their overtures were coupled with threats of libel action from Roger Williams (a department head), Harry Musselwhite (secretary of the medical school), and Harold Baum (head of the school of life, basic medical, and health sciences). *The BMJ* eventually gave in, agreeing among other things to remove (but not retract) my 2002 article from its website.¹

The award of his MBE

The Cabinet Office informed me that it usually takes about two years from submission of a nomination for a national honour to a successful nomination being announced. This means Banerjee was probably nominated for his MBE "for services to patient

safety" in 2012—four years after he returned to the Medical Register. For honours related to health, the Department of Health and its health honours committee must recommend the award. That committee is supposed to check with the GMC to ensure that there are no concerns about conduct.

The chair of the health honours committee is Lord Kakkar, one of the six medical members of the GMC. Because of secrecy surrounding the process, we do not know who proposed Banerjee for an MBE and whether full information was available to the health honours committee. A check of the GMC website would have shown details of Banerjee's periods of removal from the Medical Register.

The award of honours and medical qualifications to Banerjee is not an isolated case. British medicine has opaque procedures that can be manipulated to gain honours, advancement, and money (for example, clinical excellence awards). When errors occur, the establishment would usually rather close ranks and silence whistleblowers than correct the error.

The imbalanced English libel laws assist in this endeavour. I am aware of other cases in which serious misconduct has been concealed and the culprits have received honours and awards. We need to get rid of the existing "club culture" in British medicine with a culture that values integrity and transparency.

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Anjan Kumar Banerjee



“Schizophrenia” does not exist

Disease classifications should drop this unhelpful description of symptoms

We should drop the “essentially contested”¹ term “schizophrenia,” with its connotation of hopeless chronic brain disease, and replace it with something like “psychosis spectrum syndrome.”²

The website www.schizofreniebestaatniet.nl/english/ aims to inform the public about the nature of psychotic illness and to help patients deal with pervasive, unscientifically pessimistic, organic views of their symptoms. And several recent papers have called for new psychiatric nomenclature, particularly around the term “schizophrenia.”³⁻⁶ Japan and South Korea have already abandoned this term.

The classification of mental disorders, as laid down in ICD-10 (*International Classification of Diseases*, 10th revision) and DSM-5 (*Diagnostic and Statistical*

Japan and South Korea have already abandoned this term

Manual of Mental Disorders, fifth edition), is complicated, particularly psychotic illness.

Currently, psychotic illness is classified among myriad categories, including schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, depression/bipolar disorder with psychotic features, substance induced psychotic disorder, and psychotic disorder not otherwise classified. Categories such as these do not represent diagnoses of discrete diseases, because these remain unknown; rather, they describe how symptoms can cluster, to allow grouping of patients.

This elegant solution allows clinicians to say, for example, “You have symptoms of psychosis

and mania, and we classify that as schizoaffective disorder. If your psychotic symptoms disappear we may reclassify it as bipolar disorder. If, on the other hand, your mania symptoms disappear and your psychosis becomes chronic, we may re-diagnose it as schizophrenia.

It’s only a classification

“That is how our classification system works. We don’t know enough to diagnose real diseases, so we use a system of symptom based classification. The DSM-5 does this differently than ICD-10—but that does not matter, because it’s only a classification.”

If everybody agreed to use the terminology in ICD-10 and DSM-5 in this fashion, there would be no problem. However, this is not what is generally communicated, particularly



The NHS lacks national clinical leadership

The strike by junior doctors illustrates that the de facto chief executive of the NHS is the health minister, with no advisory or decision making bodies between him and staff at the coalface. The nominal chief, Simon Stevens, is powerless and silent on the strike.

Only four of the 14-strong board of NHS England have a clinical background. Of these, two are political appointees, and one left clinical practice in 2000. They are all admirable individuals, but this board is not structured to scrutinise government policy nor to act as a clinical advisory board.

The chiefs of the several hundred NHS hospitals in England, almost none with a clinical background,

and whose average tenure is less than two years, are equally silent on the strike. The NHS is functioning like a failed state. It is being held together by the goodwill of its 1.3 million staff.

A clinical NHS England Board

The cornerstone of NHS governance should be a clinically strong and democratically legitimate NHS England board (with equivalents in other regions). This could be achieved easily by including in its directors one nominee from each of the medical royal colleges and two from the Royal College of Nursing. The physicians should make a second nomination to cover the Faculty of Public Health.

A link from this board to GPs and consultants could be provided by including two GPs from new regional GP boards, and two senior chief executives of NHS hospitals. Membership could be for a fixed, perhaps five year, term and would probably take one day a week.

Devolution of responsibility

An organisation with 1.3 million staff must devolve responsibility to at least several hundred individuals spread throughout it. Such decentralised points of responsibility are essential for efficient deployment of financial resources but do not exist in the NHS.

It is unusual in business for chief executives not to have a background in their company’s business. But it is



The NHS is functioning like a failed state. It is being held together by the goodwill of its 1.3 million staff

regarding the most important category of psychotic illness: schizophrenia.

The American Psychiatric Association, which publishes the DSM, on its website describes schizophrenia as “a chronic brain disorder,” and academic journals describe it as a “debilitating neurological disorder,”⁷ a “devastating, highly heritable brain disorder,”⁸ or a “brain disorder with predominantly genetic risk factors.”⁹

This language is highly suggestive of a distinct, genetic brain disease. Strangely, no such language is used for other categories of psychotic illness (schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, and so on). In fact, even though they constitute 70% of psychotic illness morbidity (only 30% of people with psychotic illness have symptoms that meet the criteria for schizophrenia),¹⁰ these other categories tend to be ignored in the academic literature (see box on thebmj.com) and on websites of professional bodies. They are certainly not referred to as brain disorders or similar. It’s as if they don’t exist.

What remains is the paradox that 30% of psychotic illness morbidity is portrayed as a discrete brain disease; the other 70% of the morbidity is

communicated only in classification manuals.

Psychosis susceptibility syndrome

Evidence indicates that the different psychotic categories can be viewed as part of the same spectrum syndrome, with a lifetime prevalence of 3.5%,¹⁰ of which “schizophrenia” represents the minority (less than a third) with the poorest outcome, on average. However, people with this psychosis spectrum syndrome—or, as patients have recently suggested, psychosis susceptibility syndrome⁶—display extreme heterogeneity, both between and within people, in psychopathology, treatment response, and outcome.

The best way to inform the public and provide patients with diagnoses, therefore, is to forget about “devastating” schizophrenia as the only category that matters and start doing justice to the broad and heterogeneous psychosis spectrum syndrome that really exists. ICD-11 should remove the term “schizophrenia.”

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Clinical chief executives of district general hospitals and teaching hospitals could answer directly to the NHS England board. Their key brief would be to re-engage with staff and restore morale; to take personal responsibility for the quality of all services, including ambulance services, in their hospitals; and to liaise with regional general practice boards.

General practices could be organised into 210 or so regional boards using existing Clinical Commissioning Group boundaries but focused on primary medical, nursing, and social care. These boards could answer to the NHS England board and could coordinate primary care with hospital services.

John Fabre is professor emeritus, King’s College London

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ACUTE PERSPECTIVE

David Oliver



Why hospitals should challenge inspections

The Care Quality Commission (CQC) last year judged Addenbrooke’s Hospital in Cambridge as “inadequate” and instigated special measures.¹ The hospital’s reputation guaranteed headlines,² as did the resigning chief executive’s self defence.³ Commentators fanned the flames, questioning the value of over-zealous regulation.⁴

The CQC said that inspected hospitals shouldn’t waste time contesting findings but rather should apologise and deliver the changes needed.⁵ I can’t dispute the specifics of the Addenbrooke’s judgment. But I will defend hospitals’ right to challenge or explain. Inspections have statutory force. They can trigger resignations, worsen staff morale and recruitment, and damage public confidence. Does this help patients?

They can worsen staff morale and recruitment and damage public confidence. Does this help patients?

Under newish leadership the CQC has transformed and expanded its approach to inspections. But its journey to infallibility has been tortuous. In leaked minutes its inspectors described an intolerable workload, poor support, and inconsistency.⁶ In the CQC’s own quarterly performance report it rated itself as “requires improvement” across most domains.⁸ An independent review of the hospital inspection process commissioned by the CQC described a steadily improving but still inconsistent process with ratings too dependent on professional judgment.¹⁰

The CQC has used its own growing workload, reorganisation, funding, and staffing to explain its variable performance and delays to hospital reports.^{11 12} But it doesn’t extend such mitigation to the hospitals it inspects.

Addenbrooke’s is but one example of an English hospital struggling to recruit and retain nurses and to staff wards safely. Like most English hospitals, it faces growing urgent demand, funding pressures, and “exit block,” with a lack of capacity and reduced funding in local community and social care. Hospitals have some responsibility in tackling these system issues. But they’re not islands. I’d say they have a positive duty to air them for the good of the whole NHS.

I don’t expect the CQC to reply. Better for it to tackle its problems rather than waste time justifying them.

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rare for the chief of an NHS hospital to have a clinical background. Moreover, overall quality of leadership in NHS hospitals is undoubtedly poor.

Doctors do not want to give up their clinical work for management positions. And few consultants have the appropriate personal qualities. But what if the role was for a set period and retained some clinical work?

John Philip Oakley Chapman

General practitioner Birmingham (b 1951; q Birmingham 1975; MRCP, MRCGP), died from metastatic oesophageal cancer on 9 July 2015.

John Philip Oakley Chapman was a GP in north Birmingham for 30 years. As a young man he had joined the Territorial Army, gained his private pilot licence, and spent a year as a doctor flying the Aussie outback. John could quote tracts of Shakespeare, enjoyed science fiction, and was regularly published in the medical “comics” because of his dry wit. Cooking, motorbikes, dining with GP colleagues, cars, and flying filled his leisure time. He leaves his wife, Ann; two sons; and three grandchildren.

Elizabeth Nyholm

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Maurice Anthony Cowan

Consultant dermatologist (b 1932; q Sheffield University 1954; MD, MRCS), died from thyroid carcinoma on 17 January 2015.

Maurice Anthony Cowan (“Tony”) developed an interest in dermatology during national service. After specialist training in Sheffield and Oxford he did a postdoctoral research fellowship at the University of Oregon Medical School in the US. He returned to the UK as senior registrar at St John’s Hospital for Diseases of the Skin in London before being appointed consultant in Birmingham. This enabled him to do further dermatology research at the Armed Forces Institute of Pathology in Washington, DC. He then served as consultant dermatologist to Birmingham General Hospital, Birmingham Heartlands Hospital, and Birmingham Children’s Hospital until he retired in 1991. Tony leaves his wife, Margaret.

Celia Moss, Elizabeth Margaret Cowan

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David Charles Gould

General practitioner Keith, Moray (b 1962; q Edinburgh 1985; DRCOG, MRCGP), died from metastatic prostate cancer on 17 August 2015.



David Charles Gould spent three years on a general practice training scheme at Borders General Hospital, including a registrar year in Hawick. During this period he became passionate about rural general practice and

met and married Louise. Soon after completing his training he joined the five partner practice in Keith in 1992. He adjusted well to life in the north and soon became the respiratory diseases expert of the practice and also had a lifelong interest in end of life care. Sadly in early 2014 his working life came to an abrupt end, when he was diagnosed with advanced cancer. He leaves Louise and three daughters.

Janie Thomason

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Karenza James

Consultant surgeon Heart of England NHS Foundation Trust, Birmingham (b 1971; q Guy’s, King’s, and St Thomas’ Medical School, University of London, 2001; PhD, FRCS), died from lung cancer on 15 October 2015.



Karenza James did a degree in applied and human biology with industrial training and a PhD, examining melatonin and its receptors in the eye, before qualifying in medicine. After basic surgical training at Norfolk and Norwich University Hospital and specialist training with the South West Deanery she worked as a consultant surgeon at the Heart of England NHS Foundation Trust, Birmingham. Karenza was a true perfectionist and thrived on hard work. She enjoyed teaching undergraduate and postgraduate students as well as audit and research. Diagnosed with terminal lung cancer in April 2015, she leaves her family, friends, colleagues, and patients.

Alison James

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David Antony Long

Professor of microbiology (b 1917; q St Bartholomew’s Hospital 1941; MD, MRCP, DSc, FRCPath, FInstBiol), d 29 November 2015.



David Antony Long’s career began with a series of papers on the clinical effects of penicillin in humans. He worked in the US, Paris, and the UK; he drew up immunological guidelines for the World Health Organization and was instrumental in introducing new international standards for tuberculin and scarlet fever antitoxin after the second world war. Throughout his professional life Long was involved in the work of many institutions and committees. After the death of his first

wife, he married Annette Picton in 1979 and with her established a beautiful two acre garden at their home in Sedlescombe, East Sussex. He leaves Annette and a daughter from his first marriage.

S Charles Gallannaugh

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George Hockley Pagdin

General practitioner (b 1926; q Sheffield University 1949; MD, FRCGP), died from Alzheimer’s disease and vascular dementia on 26 November 2014.



George Hockley Pagdin did national service with the Royal Army Medical Corps. Stationed in Malaya and Singapore for two years as an army doctor, he also acted as general practitioner to military families. After returning to a Sheffield practice as an assistant, he was offered a junior partnership in 1955 and became a senior partner in 1958, working from a domestic surgery that gave 24 hour cover and midwifery. He retired in 1988 at age 62 and enjoyed painting, fell walking, and writing articles. George donated his body to the University of Sheffield Medical School. He leaves Joan, his wife of 59 years; three children; and five grandchildren.

Joan Pagdin

Cite this as: *BMJ* 2015;351:h6688

J H Woolf

Former general practitioner Bermuda (b 1928; q Queen’s University Belfast, 1952), died from leukaemia on 27 September 2015.



J H Woolf (“Paddy”) went to Bermuda in 1955 during national service with the Royal Army Medical Corps. Subsequently he joined the local public health department and later joined a group in private general practice. This was in the early 1960s, before there were many specialists in Bermuda, and his practice included obstetrics, minor surgery, and anything else that came along. In the days before government legislation made health insurance mandatory, a general practitioner had 30% bad debts, which were irrecoverable, and Paddy accepted this readily because of job satisfaction. He leaves his wife, Heather; two sons; two stepchildren; and six grandchildren.

Gordon Black

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Jane Wardle

Prolific health psychologist and director of Cancer Research UK Health Behaviour Research Centre

Frances Jane Wardle, professor of clinical psychology (b 1950; graduated University of Oxford 1973), died from complications due to chronic lymphocytic leukaemia on 20 October 2015.

Jane Wardle was a clinical psychologist whose research had a profound impact on cancer prevention. In 1991 she was persuaded by a colleague to join the nascent health behaviour unit at King's College London's Institute of Psychiatry. The unit was funded by the Imperial Cancer Research Fund (ICRF) and had a brief to look at cancer prevention.

Before joining the unit Wardle had been a practising clinical psychologist and lecturer at the institute, but she had also undertaken research on obesity, binge eating, and dietary preferences. She studied the eating behaviour of infant twins, observing them in the clinic and asking their parents to record their eating behaviour at home. Eventually she and her coauthors were able to show the influence of the FTO gene, and that those children who carried the obese type variant were less likely to stop eating when they were full.¹

“Ten Top Tips”

The study of obesity in both adults and children was an interest throughout Wardle's life, and she came up with the “Ten Top Tips” campaign—a list of helpful and easy to understand messages aimed at promoting a healthy attitude to food and eating over the course of a lifetime.² She also set up the charity Weight Concern, whose aims are to promote healthy eating and weight in both adults and children.

When Wardle became director of the health behaviour unit in 1996 it moved to University College London and, under her tutelage, flourished. Now, as Cancer UK Health Behaviour Research Centre, it has become one of the most important research centres of its type in the world. The unit has more than 70 staff members, and Wardle personally supervised more than 40 PhD students during her career.



She had an important role in the introduction of the human papillomavirus vaccination to prevent cervical cancer

In the early days of her stewardship, however, not all those at ICRF (which would later become Cancer Research UK) were convinced of the value of the unit, with some in the charity's hierarchy dismissing its work as not “proper” science.

In the early 2000s, budget constraints meant that all the charity's research centres were under review. Two of ICRF's most eminent scientists—future Nobel prize winning molecular biologists for whom behavioural psychology was probably pretty airy fairy stuff—were members of a panel that visited the unit to assess whether its grant should continue. A colleague remembers the scientists being “dazzled” by Wardle and the unit's rigour and evidence based research.

In fact, airy fairy was the last thing that Wardle's research could be described as. With Wendy Atkins she worked on the UK flexible sigmoidoscopy trial, a randomised controlled trial of 170 000 people that showed that a single screening test could reduce incidence of bowel cancer by 23% and mortality by 31%.³ Wardle's work was focused on how to encourage people to take up screening.

She had an important role in the introduction of the human

papillomavirus vaccination to prevent cervical cancer, conducting a trial that showed that 75% of mothers surveyed would accept the vaccination for their daughters despite media hysteria over the vaccine's potential to increase promiscuity.⁴

She attended 13 different schools but showed early determination by asking Mary Warnock (later to become Baroness Warnock and mistress of Girton College, Cambridge) if she could attend Oxford High, where Warnock was headmistress. Warnock gave Wardle a place at the school, where she did well, winning a place at Oxford University to study psychology and physiology. Wardle then went to the Institute of Psychiatry, where she did a masters and then a PhD.

She met her first husband, Nick Stirling, while at Oxford, and the couple had a daughter, Lucy. In 1982 she met and later married Andrew Steptoe, now British Heart Foundation professor of psychology and director of the Institute of Epidemiology and Health Care at University College, London. The couple had a son, Matt.

Wardle loved her work and was astonishingly productive as author and coauthor of more than 700 papers, 100 of which were written in the last two years. She was a supportive mentor and teacher, inspiring great loyalty among her students and colleagues. But she was also fun—she loved to gossip and was witty and irreverent.

In 1996, just three months after being appointed director of the health behaviour unit, Wardle was diagnosed with chronic lymphocytic leukaemia. She wrote in the *Observer*⁵ about her shock at receiving the diagnosis and how she and those around her adjusted and reacted to the news. She hid the diagnosis from her children for a year, thinking she was protecting them from the shock.

She leaves her husband, and two children.

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MERIT OF DRY JANUARY

Evidence that Dry January does more good than harm

Our evaluation of the short and longer term effects of Dry January (Head to head, 16 January) found that participants managed temptation and the pressure to drink better, and that six months later they were drinking less than before. Even a failed attempt was associated with these benefits.

“Rebound effects”—drinking more after a period of abstinence—were seen in only a small proportion of participants.

The fact that people self select to participate in Dry January does not invalidate our results, which are applicable to all who are motivated to take part in abstinence challenges.

Dry January is a relatively inexpensive way to reduce excessive alcohol consumption in people who are already motivated to change their behaviour, and side effects (rebound effects) seem to be uncommon.

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Evidence that Dry January changes behaviour for good

Since we launched Dry January (Head to head, 16 January), its long term effects have been evaluated.

Surveys were taken before and after Dry January, with follow-up at six months: 67% of participants reported reduced alcohol consumption six months after completion and 8% stayed dry after January.

Alcohol is linked to more than 60 medical conditions and research from the Royal Free Hospital, to be published shortly, has shown the physiological benefits of a booze-free month.

Research in 2015 looked at the effect of one month abstinence on insulin resistance and other

LETTER OF THE WEEK

Alcohol consumption—the importance of context

The new drinking guidelines (This week, 16 January) do not adequately account for the complex interactions of alcohol with other factors in the diet. For example, low to moderate alcohol consumption during a meal is an integral part of the Mediterranean diet, one of the healthiest diets in the world, which protects against cancer mortality even in the presence of alcohol.

There is no evidence of increased breast cancer with a Mediterranean diet, and this may, at least in part, be linked to the protective effects against alcohol of folates in the diet. In addition, a Mediterranean diet with low to moderate alcohol consumption reduced the incidence of cancers of the upper aerodigestive tract, and low alcohol consumption was not a risk factor for these cancers in non-smokers in the Million Women Study.

The Mediterranean diet is renowned for its cardioprotective effects, and alcohol seems to be an important part of this. Recent epidemiological studies support the cardioprotective effects of low to moderate alcohol consumption and have compensated for possible confounding by heterogeneity among non-drinkers.

Many epidemiological studies on alcohol do not take drinking patterns into consideration. Failing to adequately emphasise the importance of the context of alcohol consumption risks unnecessarily stigmatising responsible drinking with a healthy meal, an activity that brings pleasure and stress relief for many people.

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markers of non-alcoholic fatty liver disease in moderate drinkers. It found that short term abstinence improved insulin resistance and fatty liver phenotype in moderate drinkers. It also had a positive impact on blood pressure and cholesterol.

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WHO ANALGESIC LADDER

WHO analgesic ladder gone astray: wider implications

Opioids are essential drugs that must be used appropriately.

The WHO analgesic ladder was developed to treat terminal cancer (Editorial, 16 January), and its extension has caused problems. Many guidelines rely on the ladder for the blanket treatment of cancer pain. Treatment advances and increasing cancer survival have led to a rise in chronic complications that cause pain.

In our experience, widespread use of the ladder for cancer pain has led to serious problems in a small group of patients. Moreover, palliative care doctors have extended their role in the management of chronic

conditions that are associated with pain. Opioids are the cornerstone of their therapeutic armamentarium. Lessons learnt by pain clinicians and GPs about the WHO ladder need to be disseminated widely, including to oncologists and palliative care doctors. All doctors have a duty to prevent harm, especially when the harm is iatrogenic.

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Search for treatable causes of chronic pain

The message on opioids in chronic pain—that they are usually ineffective and have major potential complications—is long overdue (Editorial, 16 January). Their use may blur the distinction between symptoms of complications, particularly addiction, and those related to the underlying illness.

The problem has another important dimension. Chronic pain is not a diagnosis. Following a treatment paradigm without investigating and understanding the cause of the pain means that specific and remediable causes may be neglected. Establishing the cause of chronic pain often allows targeted treatment. In the case of neuropathic pain, we find that the diagnostic yield of neurological examination, electrophysiology, imaging, and other tests in establishing the site and cause of pain, including treatable conditions, is similar to neurological conditions without neuropathic pain.

Establishing the cause of chronic pain is not simply an intellectual exercise—it may lead to successful treatment of the pain by specifically tackling its causes.

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