

comment

Most health apps that promote physical activity tend to get users who want to be healthy. Pokémon Go isn't marketed as a health app

NO HOLDS BARRED Margaret McCartney

PPA COLUMNIST OF THE YEAR

Game on for Pokémon Go

The game Pokémon Go is a “craze,” a “sensation.” You use a smartphone in a virtual scavenger hunt for cartoon characters, but in real locations. It appeals to youngsters and adults. Download the app; start walking.

My youngest child is delighted that his mother willingly accompanies him for miles. The middle child is disgusted with our dedication to the cause, but also (I think) impressed with our plans for domination. My eldest is aghast: the popularity of Pokémon Go leads him to infer, just as Donald Trump ascends to presidential candidacy, that we're at The End of Times.

The media are similarly torn: is Pokémon Go good or bad for you? We've had claims that it can help depression (clue: the reference doesn't lead to a randomised controlled trial but to Twitter anecdotes); that it could solve the US obesity problem (one UK player who caught all of the characters walked 225 km and lost 2 stones); and that it can even “ease the type 2 diabetes burden” (from a press release with no original data but with links to previous research on walking and standing).

In the “bad for you” camp are no end of sorry tales. Pokémon hunters have been rescued by emergency services from sea and caves. The game draws people to real places, making it easy for criminals to spot congregation points. Teenagers in London were robbed of their phones at gunpoint, and US players have been involved in real shoot-outs.

The UK National Society for the Prevention of Cruelty to Children has published a parents' guide. It says that the game lacks adequate protection for children, such as safety reminders when contacting



new users, hiding location by default for under 18s, and clear processes on safeguarding concerns.

Sure: Pokémon Go can and should be made safer. Like most things, playing it has a mix of benefit and risk. In my local park I've received tips from all manner of folk I wouldn't have talked to otherwise. In our modern online lives we all need real life connectivity, and the internet can

facilitate that.

We never hear about the things that didn't happen: heart attacks prevented through more exercise, or vitamin D deficiency that geeks have avoided, blinking in the sunlight while catching a Pikachu monster.

Most health apps that promote physical activity tend to get users who want to be healthy. Pokémon Go isn't marketed as a health app, but players still end up doing a lot of walking. The possibilities for apps to make the streets an active, reclaimed playground in which to have interconnected fun are boundless. Increased physical activity is a tantalising side effect.

Game on.

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com

Follow Margaret on Twitter, @mgmtmccartney

Cite this as: *BMJ* 2016;354:i4306

DON'T MISS MARGARET ON STAGE THIS MONTH

As part of the Edinburgh Fringe Festival, Margaret joins Phil Hammond in *Dr Phil's NHS Revolution* every night until 27 August at 1005 pm at the Symposium Hall of the Royal College of Surgeons of Edinburgh

See THIS WEEK, p 218

Autism is underdiagnosed in prison

More investment is needed for assessment in forensic settings

The UK government strategy on autism spectrum disorder (ASD) now refers to prisoners,¹ an improvement on the previous lack of focus. However, despite over-representation of ASD in forensic settings (0.98% of the general population but 2.3% in secure forensic settings),^{2,3} only five of the 33 action points consider forensic populations.

ASD is of specific concern among prisoners because it can slip through the gap between learning disabilities and mental health diagnoses, for which more formal assessments, in addition to liaison and diversion schemes, are being developed in forensic services. Identification of ASD at the earliest possible stage in the criminal justice system could allow for better assessment and management of challenging presentations, minimise the risk of additional mental ill health developing in this population, highlight the need for specialist support and services, and ultimately reduce the risk of reoffending.

Despite UK legislation that promotes assessment of and support for ASD,^{4,5} a more systematic approach is needed in forensic settings.

The National Institute for Health and Care Excellence (NICE) in England and Wales sets a three month maximum waiting time between referral for diagnostic assessment for ASD and the first appointment. On average, adults wait two years.⁶

Diagnosis crisis

This “diagnosis crisis” is likely to be even worse for prisoners who are vulnerable by nature of incarceration. In the criminal justice system, not only may the waiting time be unacceptably long but diagnosis may be overlooked altogether despite observable clinical indicators.

Several factors contribute to missed diagnoses. ASD may be masked, where the associated rule adherence behaviour creates minimal problems in managing such prisoners. Staff may miss ASD because of poor understanding of its presentations,⁷ resulting from inadequate training.⁸

Even if ASD is suspected, prisoners may not be referred to specialist services for diagnosis because staff are unaware of the benefits or how to refer, or because resources are lacking.

This also applies in police custody, where the Police and Criminal Evidence Act requires that prisoners suspected of having ASD have an appropriate adult present.⁹ Failure to provide statutory assessment means that this population may not be recognised and that their additional needs remain unmet.

Even if a prisoner comes to the attention of healthcare professionals, NICE recommends that diagnosis should be informed by a detailed neurodevelopmental history. This is often difficult to obtain in forensic populations.

Additionally, diagnostic instruments are often time consuming and costly, limiting their use in prison populations in austere times. To overcome this problem with other mental health disorders, quicker (cheaper) screening tools have been used in prisons,¹⁰ but no such tool is employed

Subsequent reoffending may well cost more than ASD assessment and support, financially and in terms of public safety

NHS continuing care is a mess

Early in my training, English hospitals tended to have a ward or two of patients who were staying indefinitely. Some were on site; some were out of sight in a former Poor Law hospital. Local residents often feared them as places you'd never leave alive. Then came large and rapid reductions in hospital bed capacity, including these wards, even as the population aged and demand rose.¹

The NHS and Community Care Act 1990 helped accelerate a shift in England towards commissioning more personalised care outside hospital, and it increased means testing for social care in all but the



Unseemly disputes arise about just how quickly a patient is likely to die

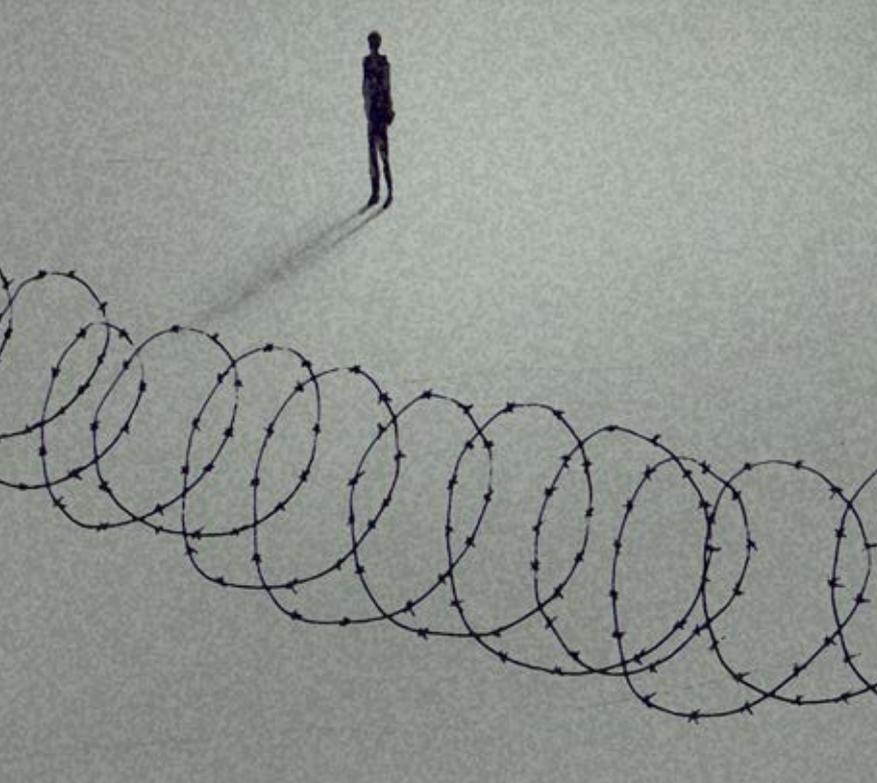
poorest pensioners.^{2,3} Years on, the split between needs classified as healthcare (hence free) or social care (means tested) still fragments services and bewilders users.^{4,5}

An initially small number of patients with complex, unstable, and terminal conditions remained eligible for entirely NHS funded “continuing healthcare” outside hospital. Access was largely determined by local practitioners’ judgment. But, as demand and spending rose, more formal criteria were developed locally, and “light touch” national guidance was issued. Complaints to the ombudsman and landmark legal

challenges concerned fairness, and scrutiny snowballed.^{6,7}

In 2007 the Department of Health published national eligibility criteria for continuing care.⁸ Disputes, delays, and bureaucracy mushroomed as organisations battled to avoid taking on the increased costs. More patients were left waiting in the system, unable to move on.

By 2012 a new national framework standardised screening, decision and support tools, and maximum waiting times, including for “fast track” (end of life) funding and for performance reporting.⁹ Still, tens of thousands of bed



GARY WATERS/GETTY IMAGES

systematically for ASD. Although general mental health screening has helped prison staff,¹⁰ they need specialist training in ASD and in the pathway for referral and assessment.

Psychiatric comorbidity

A lack of diagnosis affects analysis of offences and the development of risk management plans, as well as awareness of prisoners' increased vulnerability to bullying or exploitation, their heightened risk of psychiatric comorbidity, and the management of challenging behaviour resulting from deficits in

social and communication skills.

More ringfenced investment is needed for diagnostic assessment in forensic settings. The hidden population of prisoners with ASD deserve our attention, for their own care and for public safety. Future harm may be avoided if an offender receives the specialist ASD support required to help manage the risk of reoffending.

Sarah Ashworth is forensic psychologist in training, Centre for Forensic and Family Psychology, University of Nottingham; and Derbyshire Autism Services, Ripley lwxsash@nottingham.ac.uk

Cite this as: *BMJ* 2016;353:i3028

days are lost each year to people awaiting assessment and funding, through delayed transfers of care.¹⁰

If funding for continuing healthcare is refused and social care is required, patients' families may reasonably contest professional assessments and decisions before agreeing to pay substantial costs. Many patients are technically eligible for continuing care but don't currently receive it.¹¹ Websites and helplines have proliferated to help people appeal.^{12,13} Some families appeal even when their loved one blatantly won't meet the criteria—meaning more delay, misery, and frozen acute beds.

Unseemly disputes arise about just how quickly a patient is

likely to die and whether it's soon enough to access funding. Huge variation remains in the time taken to make assessments and decisions.^{14,15} I've witnessed plenty of gaming and the retreat to organisational interests.

The NHS in England now spends over £2.7bn a year on continuing care,² supporting more than 60 000 people.⁴ Politicians should simplify the arbitrary rules around funding between health and social care. We've gone from people never leaving hospital to some leaving only if someone can put up bail.

David Oliver is a consultant in geriatrics and acute general medicine, Berkshire davidoliver372@googlemail.com

Cite this as: *BMJ* 2016;354:i4214

THEBMJ.COM BLOGS Tessa Richards

Therapeutic relationships—prized but hard to deliver

I hate to think of what I've cost the NHS since I was diagnosed with cancer in 2004 but I'm grateful to be alive and kicking, and having opportunities to observe how health professionals' behaviour affects patient wellbeing.

My interactions range from good, bad, to indifferent, but one stands out: a new one-to-one appointment with a consultant radiotherapist.

As a rule, one sits and waits for the retinue to arrive and conduct a "team meets the patient" event—a mode of communication I find disquieting. One is never quite sure which member of the (often changing) team one is supposed to relate to.

Refreshingly, she did not start the conversation with the conclusions of the last multidisciplinary team who discussed my case. She simply asked, "Well, with all this going on, how are you feeling? How is it affecting your life and that of your family?"

For the first and only time since my recurrent inoperable cancer was detected, I was moved to tears. I was being seen as a person first, rather than another case with interesting pathology (although that has its upsides).

She has continued to be there for me and we "talk" by email if needed—a mode of exchange I am careful not to abuse.

I was being seen as a person first, rather than a case with interesting pathology

Her wise, kind, and timely counsel, brief and to the point, is beyond rubies to me. It's helping me steer a course through a choppy sea of multi centre, multi disciplinary management.

We know that empathy and support from a doctor with whom one has a trusting, ongoing relationship is important to patients. We also know that healthcare organisations don't or can't prioritise it.

Patients hoping for continuity of care are increasingly likely to encounter health professionals who are suffering from "burnout." The knock-on effect on them, their patients, and the healthcare economy is significant and warrants exploration. Organisations that don't provide a supportive workplace for staff can't expect them to provide compassionate, patient centred care.

Burnout must be acknowledged as a pervasive and "wicked" problem in health systems, and patients should be aware of it and seek to play their part in reducing its frequency.

Tessa Richards is senior editor/patient partnership, *The BMJ*

Read this blog in full and others at bmj.co/burnout

OBITUARIES

Ann Ward

Surgeon and nun who helped pioneer the surgical repair of obstetric fistula

Ann Ward (b 1929; q University College Dublin 1957; FRCOG), had been in declining health and died on 28 May 2016.

Ann Ward was a devoted and a humble Roman Catholic nun. She was a dedicated, kind hearted, and skilful gynaecologist, obstetrician, and surgeon. And—according to those who knew and loved her—she was also very tough.

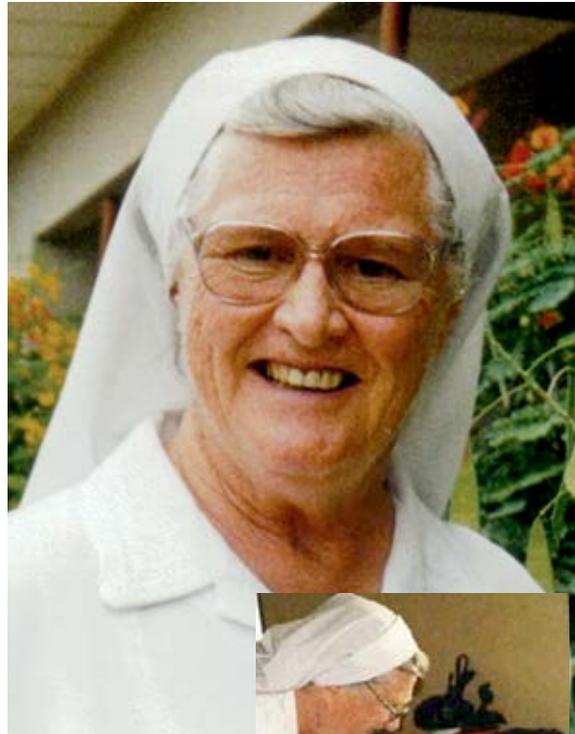
For nearly half a century, starting in 1959 as a member of the Medical Missionaries of Mary, Sister Ann cared for thousands of teenage girls and women in Nigeria. She helped pioneer surgery to repair the debilitating condition of obstetric fistula. Women with the condition are often young—some are barely teenagers—and are presented by their families to older men as third or fourth wives when their bodies are not yet fully developed for childbirth.

“The worst thing that could happen to a woman”

In a 2001 interview in the *Irish Times*, Sister Ann said that the global health community focused more on ending female circumcision than on obstetric fistula. She felt that the latter was the bigger of the two problems, saying that it was “the worst thing that could happen to a woman.” She added, “It’s wonderful to be able to return women to their dignity, because it is such an injustice, the way these women are pushed around like cattle.”

By the time Sister Ann retired in late 2006, she had successfully performed surgical obstetric fistula repair procedures on more than 3000 women. She then directed their postoperative care and rehabilitation—a slow process that can last up to a year and sometimes requires a second operation. “You have to be able to stay with these patients and you have to be there for the long haul,” she said.

Dom Colbert, a classmate of Sister Ann’s during their medical studies at



Sister Anne felt that obstetric fistula was “the worst thing that could happen to a woman”



University College Dublin, and now retired as senior lecturer in applied physiology at University College Galway, says that Sister Ann was “a pioneer of the surgery of repair of vesicovaginal fistula long before the fistula hospital started in Addis Ababa. She taught me how to operate on these women, who were almost always disowned by their husbands and families, and outcast from society.”

He added that Sister Ann helped Birmingham obstetrician John Kelly in surgical procedures to repair obstetric fistula. Kelly went on to become “a renowned world authority” on the procedure.

Paul Hilton, a retired consultant gynaecologist and urogynaecologist in Newcastle upon Tyne, spent time with Sister Ann in Nigeria on the advice of John Lawson, a mentor to both of

them who was a former vice president of the Royal College of Obstetrics and Gynaecology and a professor in Ibadan, Nigeria. In the late 1990s Hilton and Sister Ann co-authored two papers on obstetric fistula surgical repair.

Ann Ward was born on 8 April 1929 in Lifford, County Donegal, Ireland, the youngest of three children. Her father, Peter Ward, represented South Donegal in the first Dáil (the first independent Irish parliament). She completed secondary education at St Louis Convent, Monaghan, and in 1947 joined the Medical Missionaries of Mary. In 1951, after formation for religious missionary life, she began studying medicine at University College Dublin and qualified in 1957. She then trained at the National Maternity Hospital in Dublin’s Holles Street, and received a masters in obstetrics in 1959.

She was assigned to St Luke’s Hospital in the village of Anua in Akwa Ibom state in Nigeria. In 1965 she moved to London for additional training at Hammersmith Hospital, where in 1967 she received a masters degree in obstetrics and gynaecology, and her royal college membership.

Tough, professional, compassionate

When she returned to Nigeria, the civil war, often called the Biafran war, was raging. After two years of temporary postings, she returned in 1970 to her beloved Anua to resume her work at St Luke’s Hospital. She remained there as chief consultant obstetrician and gynaecologist until 1997, when she established, and became director of, the specialist unit for surgical repair of obstetric fistula a few miles away, in the village of Itam.

Robert Walley, founder of MaterCare, an international group of Catholic obstetricians and gynaecologists, describes Sister Ann as “the consummate professional,” who demanded excellence from all. “She had seen it all in obstetrics and gynaecology,” he says. But Walley,

who has written in *The BMJ* about being a Catholic doctor, also knew Sister Ann's soft side. On one of his visits to Nigeria he accompanied her on an emergency call to the bedside of a young mother in extremis, at term. Her distraught husband was at her side. Sister Ann and Walley began desperate attempts to save her life, but she died. And her baby died too. After trying to console the grieving husband, the two doctors sadly and silently left the hospital. As they walked through the gloomy evening, Walley noticed that the tough lady beside him "was in tears."

Sister Ann spent her final years being cared for at the Motherhouse of the Medical Missionaries of Mary at Drogheda, Ireland. "Sister Ann was a person of great faith and great determination," says Mary Molloy, a nun and general surgeon who has also worked in Nigeria, including at Itam during the final years before Sister Ann's retirement. "Sister Ann had a heart full of compassion for every woman and girl who came to her with a fistula from a difficult childbirth."

Over the years Sister Ann lectured at university hospitals and before professional groups on her surgical techniques to repair obstetric fistula. She was an active force at international meetings on prevention and treatment of the condition. Her honours include an Outstanding Professional Work award from the International Federation of Obstetrics and Gynaecology, and honorary fellowship of the Royal College of Surgeons in Ireland for her work, which included helping to train Nigerian doctors.

Colbert says, though, that Sister Ann neither sought honours, nor was she impressed with them. "But she was proud of the fact," he says, "that she rescued countless women in west Africa from a life worse than death."

Sister Ann leaves a sister in law and nieces and nephews.

Ned Stafford, Hamburg ns@europfn.de

[Cite this as: BMJ 2016;354:i3765](#)

Shaikh Ali Hossain

Consultant psychiatrist (b 1933; q Dow Medical School, University of Karachi, Pakistan; DPM, MRCPsych), died from pulmonary oedema on 9 July 2015.



Shaikh Ali Hossain ("Ali") worked at South Ockendon Psychiatric Hospital, Essex, from 1974 to 1994. He specialised in learning disabilities. He took over this post after a major inquiry at the hospital, the findings of which led to nationwide reappraisal of mental care in the country. He worked to implement the inquiry's recommendation. Later he also had to implement new initiatives for "care in the community," enabling the transition of institutionalised patients either to live in smaller units of care or to return to their families in the community. South Ockendon Hospital closed in 1994. Hossain continued to work with his psychiatric teams, for his designated catchment population living in east London, helping his patients and their families to adjust to their new environment. He leaves his wife and four children.

Parwez Hossain

[Cite this as: BMJ 2016;354:i3904](#)

John Marks

Pathologist, pharmaceutical physician, and life fellow Girton College, University of Cambridge (b 1924; q London 1946; MA, MD, FRCP, FRCPath, FRCPsych), d 27 April 2016.



While at medical school, John Marks won several prizes and was involved in college sports. He married Vera Joan Twinberrow ("Twin") and the couple lived in the same house in Duxford with their children for almost 60 years. John went to Cambridge, where his early research focused on haematology and he started teaching medical students. In 1955 he became medical director, then managing director, at Roche. He had various roles in the company for 20 years, while continuing to teach students. Girton College admitted him as its first male fellow in 1977. John was heavily involved in university as well as college sports and published widely. Throughout his retirement he was always busy with projects. Predeceased by Twin and their daughter, he leaves a son and three grandchildren.

Fiona Cooke

[Cite this as: BMJ 2016;354:i3897](#)

Stuart Ingram

Consultant anaesthetist (b 1943; q St Thomas' Hospital, London, 1967; FRCA), died from head injuries after an accidental fall on 19 May 2016.



Stuart Ingram was appointed consultant anaesthetist at University College Hospital and the National Hospital for Neurology and Neurosurgery in 1976. He was a member of the organisation then known as the National Institute for Clinical Excellence (NICE), president of the Neuroanaesthesia Society, and vice-president of the Royal College of Anaesthetists. He published extensively on neuroanaesthesia related topics and on the findings of NCEPOD investigations. His honours included the Dudley-Buxton prize of the Royal College of Anaesthetists. Stuart needed treatment for carcinoma of the thyroid. He took early retirement, designed a yacht, and sailed around the world with his wife, Annabelle. He excelled at practical tasks, but vigorous conversation was his principal talent. His fatal accident occurred when he climbed aboard his boat in darkness and bad weather. He leaves Annabelle, two sons, and four grandchildren.

Ian Calder, John Lytle

[Cite this as: BMJ 2016;354:i3922](#)

John Watt Robertson

General practitioner Isle of Harris (b 1923; q Aberdeen 1959; FRCGP), d 9 February 2016.



John Watt Robertson left school at 14, following the family tradition of fishing. He became a skipper but left the sea after sustaining a compound fracture when his arm was pulled through the winch. He returned to studying and gained his entrance qualification to Aberdeen University. John worked as a GP for 22 years—many of them singlehanded—in Tarbert on the island of Harris, where his workload was immense. Initially he had patients living on four separate islands and tirelessly attended calls at all hours, totally committed to the welfare of his patients. After retiring from general practice he worked as a prescribing adviser for five years. A committed Christian, in his later years he gained a degree in theology. He published his memoir, *Leaving the Nets, Trusting Him*, in 2014. He leaves a wife and three children.

James D Finlayson

[Cite this as: BMJ 2016;354:i3819](#)

BIG HEALTH DATA

Opt-in method is vital for data sharing

We agree with van Staa et al that “The ultimate solution [for health data] must combine new technologies with clear accountability, transparent operations, and public trust” (Analysis, 16 July). One method is an opt-in mechanism for identifiable data.

Building on the Scottish SHIP governance mechanisms and registry based systems, we created the SHARE register in 2012. People consent to use of their NHS data to determine suitability for research. Participants can consent to storage of “spare blood” for future studies. More than 120 000 have volunteered.

Researchers can use SHARE for recruitment at the grant application stage to assess suitability and then to approach potential participants. Once potential participants are identified they are contacted with details. Only if they agree to consider participation are their contact details passed to researchers. To avoid excessive demands, participants are temporarily withdrawn from the register until their participation in the project is scheduled to finish.

Frank Sullivan
(frank.sullivan@nygh.on.ca)
Brian McKinstry
Colin Palmer

Cite this as: *BMJ* 2016;354:i4293

REDUCED ANTIBIOTIC SAFETY

Procalcitonin can guide antibiotics for RTIs

Gulliford et al recommend avoiding antibiotics in patients with self limiting respiratory tract infections (RTIs) in primary care who lack clinical features suggesting bacterial infections (Research, 9 July). Distinguishing bacterial infections on the basis of clinical features is inaccurate, and



LETTER OF THE WEEK

Learn from care.data mistakes

Care.data’s massive potential was wasted. It failed because of our poor regard for data accountability beyond distribution, such as in assessing insurability.

The aim to exploit the commercial value of datasets was clear in care.data’s structure. Patients’ fears about privacy were well founded (Analysis, 16 July). The benefits of data sharing were adequately emphasised; the risks were underplayed.

New models for data modelling and sharing should relegate commercial value to secondary importance and learn from safety measures inherent in the Welsh (SAIL) and Scottish (SHIP) models.

In the burgeoning health apps and wearables market, personal health data remain vulnerable to exploitation. Some 80% of diabetes apps studied had no privacy policy, and 90% of these permitted sharing or selling personal data without users’ permission. And 33% of companies sent data over the internet without encryption.

Selling personal data is integral to apps’ business models, with no proposed regulation. Care Quality Commission proposals will not over-ride the terms and conditions of private companies’ individual apps. Letting courts set legal precedents will favour large corporate developers.

As the NHS plans to distribute free wearables in 2017 and insurance companies offer health insurance discounts to wearables users, public confidence in health apps could be rapidly undermined. This hands-off approach to commercialisation of data privacy is shoddy: it indicates that we’ve not learnt from the mistakes of care.data.

Nick Mann (drnickmann@gmail.com)

Cite this as: *BMJ* 2016;354:i4289

alternative strategies should be investigated.

Procalcitonin is released in different tissues in response to bacterial but not viral infections. In a Cochrane review of 14 trials, which assessed procalcitonin guided protocols to initiate antibiotics in RTIs, procalcitonin significantly decreased initial prescription rates without affecting rates of treatment failure, mortality, or recurrent infection. Furthermore, diagnostic guidance by NICE supports procalcitonin as a promising, cost effective biomarker for use in clinical practice to differentiate bacterial

from non-bacterial infections.

Point-of-care procalcitonin assays are now available, and their use to guide antibiotic administration for RTIs in primary care should be further assessed, as they could contribute to safe and significant reduction of antibiotic prescribing.

Alexander G Mathioudakis
(a.mathioudakis@nhs.net)
Victoria Chatzimavridou-Grigoriadou
Efstathia Evangelopoulou
George A Mathioudakis

Cite this as: *BMJ* 2016;354:i4245

Author’s reply

Mathioudakis et al draw attention to the potential role of

point-of-care testing in the early diagnosis of bacterial infections. This is consistent with the O’Neill review on antimicrobial resistance, which identified the use of rapid diagnostic tests to confirm whether antibiotics are needed—one of seven strategies to reduce the overall demand for antibiotic treatment. However, as forecast diagnostics have shown, there are practical obstacles to introducing these testing methods into clinical practice, and, like all new health technologies, these testing methods require careful evaluation to ensure that the intended benefits are realised.

Martin C Gulliford
(martin.gulliford@kcl.ac.uk)
Cite this as: *BMJ* 2016;354:i4256

PHE ON PSA TESTING

PHE guidance warns about PSA testing

In response to Kole (Letters, 16 July), Public Health England is in step with the evidence on PSA testing. The partial quotes don’t fully reflect our guidance, as our GP and patient advice clearly doesn’t promote a test: it says GPs “should not proactively raise the issue of PSA testing with asymptomatic men.”

It outlines potential risks and benefits: “Men who have a PSA test increase their chance of a prostate cancer diagnosis. The PSA test provides the opportunity for clinically relevant prostate cancer to be diagnosed at a stage when treatment options and outcome may be improved. However, the PSA test may lead to investigations which can diagnose clinically insignificant cancers which would not have become evident in a man’s lifetime.”

The guidance is based on the recent UK NSC evidence review, including NICE recommendations, and was reviewed by GPs and the PCRMP scientific reference group. Kevin Fenton (Kevin.Fenton@phe.gov.uk)
Anne Mackie

Cite this as: *BMJ* 2016;354:i4238