> Stopping doing things that waste our time will benefit patients—and if it causes political inconvenience, so much the better

NO HOLDS BARRED Margaret McCartney PPA COLUMNIST OF THE YEAR

Evidence led protest for the NHS

England's junior doctors are planning more strikes. I hope that, in the High Court later this month, the Justice for Health campaign succeeds in finding that the health secretary has no power to impose a contract. If not, the dispute will smoulder. Much public sympathy is still likely, but parts of the media will be predictably hostile.

The new contract is unfair. It relies on misinterpreted statistics surrounding the so called weekend effect. But this is only a part of the current mess in medicine.

Staff are stressed. Services are being cut. The joy of medicine is still there but in scarce supply. Failing to find enough pleasure in work leads to staff cutting their hours or retiring early, leaving more gaps in the system.

The government is not spending enough on the NHS. Much of what is spent is wasted on short term, non-evidenced, political policies that drain resources in the longer term, such as health checks. The founding principle of the NHS—that it is free at the point of use, according to need—is being challenged because of political weakness and repeated non-evidence based policy making, which harms us all.

Junior doctors are right to take action, but they need to keep broad support while being able to explain to the public how it is that the NHS is being allowed to fail. I'm not a medical politician or tactician, and others will have better ideas.

But we need a protest that involves all doctors, which is sustainable, and which will not harm (and may even benefit) patients. It should harm only the political policy making that damages the NHS.

What could our protest be? Appraisal consumes a vast amount of time and adds little value to many doctors' ability to care for patients: could we refuse to do more than is clinically useful? Care Quality Commission inspections cost a fortune and are of questionable value: we should negotiate for inspections based only on evidence and should refuse to take part in wasteful paperwork.

We need better, united action that makes it clear to the public that professionals are still motivated by vocation but that we can't do our jobs well given dwindling and misspent resources. Stopping doing things that waste our time will benefit patients—and if it causes political inconvenience, so much the better. A highly visible, evidence based, online campaign could make the facts known and explain what we need to keep the NHS sustainable.

I'd bet that most of the population would be willing to spend more on front line services in the NHS. We are not being given that option.

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PERSONAL VIEW Michael L Millenson

What "girls" and "queers" can teach patients

It's time to reclaim "patient" to signify a rich, collaborative relationship, says **Michael L Millenson**

It's not surprising that the word "patient" makes some activists uncomfortable. The Latin root "patiens" ("he who suffers") suggests passivity, particularly when paired with "doctore" ("he who teaches"). Small wonder, then, that physicians have traditionally viewed patient centredness as meaning that they provide "caring custody" while acting as "rational agents" on patients' behalf.[1]

Seeking to shake up these old assumptions, we clumsily ask providers to create a relationship centred on the person and family or care giver, with everyone becoming "co-producers" of care.[2] Unfortunately, this mishmash only muddies what should be clear. What patient or doctor, after all, would describe themselves as "co-producers" of chemotherapy?

More importantly, the awkward terminology deflects a focus on the core of the clinician-patient relationship. Etymology notwithstanding, "patient" signifies a personal connection deeply rooted in an ethical framework. At a time when people who are ill can be pigeonholed as "consumers" whose lives comprise but a few bytes of big data, it's time to reclaim "patient" and redefine that term as representing a rich, collaborative relationship.[3]

The history of two other words shows that success is possible. The first is "queer," meant to label homosexuals negatively. The gay rights movement not only turned "queer studies" into an expression of pride, it also made the word more mainstream.

Infantilising women

The popular early-2000s TV show *Queer Eye for the Straight Guy* was built on a premise similar to what happens when a hospital establishes a patient and family advisory council. Apprehensive members of the dominant culture discover that someone whose counsel they never imagined seeking actually gives them highly useful advice. Surprised and grateful, they realise the "other" isn't so "other," after all.

RICHARD YOUNG/REX/SHUTTERSTOCK

Patients can learn from Lauper's anthem of female solidarity

ACUTE PERSPECTIVE David Oliver

Don't undervalue non-clinical work

Remember training? It takes 6-12 years after medical graduation and involves teaching, study, and serial exams. To become an effective consultant, learning through clinical practice isn't sufficient: it increasingly requires grounding in leadership, management, research, appraisal, and quality improvement.

These skills are taught by existing consultants, taking time away from direct patient care. Consultant readiness is also partly acquired when juniors occasionally act as decision maker or team leader, when consultants are working away from the wards.

It probably reduces the risk of burnout and helps keep doctors fresh

I wonder whether one cause of poor morale in trainees is their close-up view of what working life is now like for the senior doctors they will become. Rising demand, worsening finances, targets, bed pressures, and workforce gaps put more strain on consultants, and burnout is a risk.

The expectation that consultants will always be present and review all patients is growing.[1] And, despite the UK's relatively low ratio of doctors to citizens,[2] we hear parliamentarians and commentators talk disparagingly of hospital doctors' declining "productivity."[3 4]

Job planning is becoming more draconian, with doctors expected to account for every hour instead of being respected as senior professionals who get the job done in the time it takes. Job plans sequentially allocate less time for non-clinical activities, including those that support the wider NHS.[5] A failure to reflect the actual time expended is dishonest. Emails alone take hours of non-clinical time.

For doctors responsible for many inpatients, focusing solely on direct clinical care would mean being on the wards for 10 hours a day, reviewing all patients twice, and being available to update every visiting relative. The taxpaying public would understandably welcome more

Apprehensive members of the dominant culture discover that someone whose counsel they never imagined seeking actually gives them highly useful advice

Then there's "girl," often used to infantilise women. In the early 1980s the word was reclaimed by feminists in Cyndi Lauper's *Girls Just Want to Have Fun*, whose lyrics and music were an "anthem of female solidarity."[4] Three decades later, Lena Dunham deliberately called her hit HBO series about her millennial peers *Girls*.

Patients passive no more

As someone who has spent years trying to make medical care more patient centred, I understand that changing clinicians' behaviour is difficult and often frustrating work. All the more reason to jettison jargon and speak, instead, to the heart. As Eric Cassell wrote in *The Healer's Art*, "Medicine must be recognized as a moral profession . . . concerned with the care of persons *by* persons, as simple as that."[5] That type of relationship by its very nature must involve mutual respect, with no need to specifically list respect for family, friends, "values and preferences," and so on.

Moreover, while clinicians should understand a patient's economic and social circumstances, blithely substituting "consumer" for "patient" risks undermining fundamental distinctions between the two terms. Must the patient lying in her hospital bed now keep in mind caveat emptor (buyer beware) as well as primum non nocere (first do no harm)?

The strong ethical (and legal) expectations surrounding "patient" are particularly significant at a time when digitised healthcare data are being hailed as "the new money" and a Google search can reveal someone's health status.[6 7] While we patients are no longer passive, nonetheless we remain your patients (not "customers") even if your paycheck comes from a large organisation. It is you—doctor, nurse, or other care provider—whom we trust not to exploit our vulnerability.

Feminists and gay people refused to be defined by the pejorative intent of "girls" and "queers." Patients can do the same. It's time to reclaim "patient," this time not as a sufferer but as a partner with clinicians in a genuine collaboration.

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of this most visible role—without recognising other vital, unseen work.

On the hospital site we need trainers, educators, researchers, governance and quality leads, and medical managers to provide leadership. Off site we need training programme directors, as well as organisers and speakers for educational events. Doctors contribute to medical societies and colleges; they advise national bodies, guidelines, and audits; and they work with charities, patient groups, and the media. To maintain and update their skills and knowledge doctors need professional education and development. Appraisal and revalidation explicitly require this.[6]

Doing all of this probably also reduces the risk of burnout and helps keep doctors fresh in the final third of a demanding 40 year career. Morale affects care quality and, yes, productivity.[7]

A narrow focus on clinical presenteeism and productivity undervalues all of these other roles. With proposed changes to the consultant contract, which may remove clinical excellence awards for some of these extra contributions,[8] the current generation of trainees are less likely to look forward to being consultants.

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ETHICS MAN Daniel Sokol

Medicine's solemn moments

Not so long ago, at the start of a trial I took part in, the opposing barrister was ruffling through his papers while my witness was swearing the oath. The judge, with a frown, told my opponent to stop at once.

I was surprised by this judicial rebuke. Many barristers, for whom the court procedure has become second nature, pay little attention during the swearing of the oath. They arrange their papers, or re-read key documents, or fill a glass of water.

Yet the judge was right. Swearing an oath is a solemn moment, and the lawyers in the courtroom should behave accordingly. Now, during the oath, I keep as still as a statue and look the witness in the eye.

The recent death of the surgeon and writer Richard Selzer[1] prompted me to re-read some of his work. I came across an interview he gave to the writer Peter Josyph: "I was commencement speaker at Boston University a couple of years ago. As we stood to recite the oath, I looked at the graduates, and I saw a couple of them laughing and snickering. I was offended down to my toes by that. I couldn't believe that anyone would be embarking upon this work and not be focused on the words of it."[2]

Signing the consent form is so common that many doctors scarcely give it a thought

There are events whose significance we may not fully appreciate until it is pointed out to us. The significance is lost through familiarity or lack of reflection.

More subtle examples of solemn moments exist in medicine. One is the signing of the consent form, an act so common that many doctors scarcely give it a thought. Yet for the patient it may be as rare as signing the register in a marriage ceremony. It is an expression of trust like no other.

When asking the patient to sign the consent form, the person seeking the consent should act in a way that reflects the significance of the act. In the moments between the invitation to sign and the signing itself there should be no joking, no talking, no fiddling with phones or bleeps. The doctor's demeanour will signify to the patient that this is an important occasion in the sacred relationship between doctor and patient.

Undoubtedly there are other solemn moments in the course of interactions with patients in rounds or clinics that, through habit, gradually lose their significance to become quite ordinary. It may be the giving of a diagnosis or prognosis or a physical examination.

One of Selzer's great contributions to medicine is showing us that these moments are more prevalent than we are aware of.

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OBITUARY: Richard Selzer, p361

OBITUARIES

Sheila Griffiths

Retired general practitioner Newham, east London (b 1927; q Royal Free Hospital 1951; FRCGP), d 30 May 2016.

Sheila Griffiths, with her husband, Ronnie, and her close friend Elizabeth Batson formed the partnership of Batson, Griffiths, and Griffiths in Newham, east London, for almost their entire working lives. Sheila and Ronnie fell in love racing at the United Hospitals Sailing Club. After Ronnie's service in the Royal Air Force the couple settled in Suffolk. In 1959, however, they joined Elizabeth in Newham, where they ran a busy inner city practice, among the first to take part in a formal GP training scheme. Sheila was a member of several committees. Sheila and Ronnie celebrated their 60th wedding anniversary in 2012, and Ronnie died in 2013. Sheila leaves two sons, six grandchildren, and four great grandchildren.

Charlotte Griffiths

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John Reid Kirkpatrick

Retired general practitioner Stockton-on-Tees (b 1934 q Newcastle 1959), died after a cerebrovascular accident on 31 May 2016.

After house jobs at Newcastle's Royal Victoria Infirmary and Middlesbrough Maternity Hospital, John Reid Kirkpatrick entered general practice in Stockton. He stayed in the practice until he retired 35 years later. He also ran an allergy clinic at the North Riding Infirmary for many years. A keen sportsman, he played hockey for Newcastle University and cricket for Northumberland. He also played squash and loved fishing and shooting, as well as playing bridge. His real sporting love, however, was golf, and it was while playing golf that he sustained his fatal cerebrovascular accident. He married Liz in 1962, and together they enjoyed a huge social circle. He leaves Liz, a daughter, a son, and two grandchildren.

Kirkpatrick was a GP in Stockton for 35 years

Colin Mackenzie

Cite this as: *BMJ* 2016;354:i4111

Iris Krass

Medical officer, occupational health, and general practitioner (b 1924; q 1952; MRCS Eng, DObst RCOG), d 20 June 2016.

Born and educated in Hong Kong, Iris Krass was fluent in Mandarin. As a teenager, at the beginning of the second world war, she was interned in a Japanese prisoner of war camp in Manila. She was separated from her mother and siblings, who were each interned separately. Their father survived the war without being interned. After the war, the family travelled to England.

Iris read medicine at the University of London and did her clinical training at Westminster Hospital. She was the first female clinician to head St Thomas' Hospital's casualty department. Later she worked for the civil service and as a popular general practitioner in Edmonton, north London. Predeceased by her siblings, she leaves many fond memories of a unique, determined, and independent woman with those who loved her.

Seeta Siriwardena

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James Riddick Heron

Emeritus professor of neurology University of Keele (b 1932; q Birmingham 1964; MRCS Eng, FRCP Ed, FRCP Lond), d 2 February 2016.

James Riddick Heron ("Jim") was appointed consultant neurologist at the North Staffordshire hospital centre in 1967, a position that he held for the rest of his career. He was also senior lecturer in neurology and then emeritus professor of neurology at the University of Keele. His research resulted in more than 40 papers, largely related to the visual system and how it is affected by multiple sclerosis. In 1982 he was awarded the Medicine-Gilliland fellowship of the Royal College of Physicians. In 1993 he was elected honorary president of the Association of British Neurologists. Outside medicine, Jim was an active patron of the arts in the Stoke-on-Trent community. In retirement, he continued his interest in medical history. Predeceased by his wife, Ann, in 2009, Jim Heron leaves five children and eight grandchildren.

Richard J L Heron

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Neelika Karunaratne

Senior lecturer in anaesthesiology General Sir John Kotalawala Defence University Medical School, Sri Lanka (b 1949; q 1974; FRCA, MD), d 19 February 2016.

Neelika Karunaratne received her higher training in the NHS, lastly at the Farnborough and Orpington Hospitals in Kent, before returning to her native Sri Lanka in 1986, having obtained her royal college membership. She was highly regarded as an anaesthesiologist, and a clinical teacher with a deep commitment to training. Several of her trainees and mentees are currently working as specialist anaesthesiologists in the NHS, in Sri Lanka, and in other parts of the world. Neelika was a former senior consultant in anaesthesiology and head of the department of anaesthesiology and intensive care at Sri Jayewardenepura (Teaching) Hospital. She was also an examiner for the postgraduate institute of medicine of the University of Colombo. She leaves SD, her husband of 40 years, and two children.

Nihal Samarasinghe, Knightly Seneviratne

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John McKessar Duncan

Retired consultant surgeon (b 1919; q Birmingham 1941; FRCS), died at home from infirmity on 26 January 2016.

John McKessar Duncan started his medical career during the blitz in Birmingham. He joined the team led by Archibald McIndoe in East Grinstead and specialised in treating hand contractures. His research into preventing infection from burn injuries played its part in this pioneering work. In 1947 he joined the Royal Army Medical Corps as surgeon aboard HMHS *Oxfordshire*, treating injured servicemen and refugees from Nagasaki. On returning to the UK, he worked at four hospitals in Birmingham and at the Royal Hospital, Wolverhampton, and he lectured in anatomy at the medical school. In 1958 he became consultant surgeon at Dudley Guest and Corbett Hospital, Stourbridge, where he stayed until his retirement. Betty, his wife of 57 years, died in 2000. Predeceased by a son in 2014, he leaves a daughter, three grandchildren, and seven great grandchildren.

Catherine Hamersley

Cite this as: *BMJ* 2016;354:i4261

Richard Selzer

Surgeon who explored medicine through his writings about doctors, patients, illness, death, and life

Richard Selzer (b 1928, q Albany Medical College, New York, 1953), d 15 June 2016.

In the late 1960s, when he was 40 years old, Richard Selzer decided to—as he put it years later—teach himself "the craft of writing." The passion was there. As was the energy. But finding quality time to write would be a problem. Selzer was married with children. He was a practising surgeon in New Haven, Connecticut, where he also taught at Yale University.

He solved the time problem by going to bed each evening between 7.30 and 8 o'clock.

"At 1 am," he later explained. "I would get up, make some tea, and, with the rest of the world sound asleep and all the light in the universe directed on a blank sheet of paper, I wrote. I wrote dozens of horror stories in the dead of night, just as an exercise."

After a few hours of writing, he would return to bed for a bit more sleep before rising at 6 am to prepare for his day job as a surgeon. To preserve energy and time for writing, Selzer gave up most other outside activities. His life focused on three things: medicine, family, and writing.

Success

Selzer's first success came in 1971, when one of his horror stories was published in *Ellery Queen's Mystery Magazine*. His first book was published in 1974: *Rituals of Surgery*, a collection of short stories. He also published essays on medicine in *Esquire* magazine, and in 1975 he won the Columbia University School of Journalism's national magazine award. He gained national attention in 1976 with publication of *Mortal Lessons: Notes on the Art of Surgery*, a collection of essays that showed readers the inside of an operating theatre through the eyes of a surgeon.

Selzer's medical colleagues at Yale, who initially found his writing of horror stories "mystifying," turned cold when Selzer began writing about the "male world" of 1970s surgery. But as his reputation grew, he explained, "the medical profession followed. Now they think of me as their voice."

Mortal Lessons, *Confessions of a Knife* in 1979, and *Letters to a Young Doctor* (1982) helped spark a literature movement within medicine and are now considered by some as required reading for medical students. Selzer, who retired from the practice of medicine and as Yale associate professor in 1985 to focus on writing full time, went on to publish a total of 13 books, with a 14th to be published posthumously.

Daniel Sokol, a London based barrister and medical ethicist, who writes a regular column for *The BMJ*, says *Letters to a Young Doctor* and *Mortal Lessons* are two of Selzer's most important works. Sokol in past years has mentioned Selzer in several of his columns, describing him in one as "a master of both pen and scalpel."

Allen Richard Selzer was born on 24 June 1928 in Troy, New York, the son of parents who had emigrated from Russia as children. His father, a general practitioner who grew up in New York City but studied medicine at McGill University in Montreal, wanted his son to become a surgeon. Selzer, however, was attracted to the arts through the influence of his mother, who had grown up in Montreal and was a singer in nightclubs.

Writing about his life experiences

When Selzer was 12 years old, his father died. There was no longer any doubt about his future: he would become a doctor. After qualifying and two years of surgical training at Yale, he was drafted into the US Army. Selzer later would use his military experience in South Korea and Japan to write his only novel, *Knife Song Korea*, about a young surgeon during the Korean war.

In 1957 Selzer returned to Yale to complete his surgical training. In 1960 he started in private medical practice in New Haven and taught at Yale until he retired in 1985.

Accused of malpractice, Selzer stood trial and testified in court in 1987. In 1990 he wrote in the *New York Times* about the unpleasant experience, which ended when the plaintiff withdrew the case before a verdict was delivered. In 1991 he had a serious illness thought to be Legionnaire's disease and was in a coma for 23 days. He wrote of the experience in the book: *Raising the Dead: a Doctor's Encounter with his own Mortality*.

TERRY DAGRADI

As Selzer's reputation grew, he explained, "the medical profession followed. Now they think of me as their voice"

In a 1991 essay in *New York Times* magazine—"A Question of Mercy"—Selzer describes in diary form the true story of the moral dilemma he faced when asked after he had retired to help in the assisted suicide of a man who had AIDS. The essay inspired playwright and screenwriter David Rabe to write a play with the same title.

In the latter decades of his life, Selzer regularly attended and taught at writing workshops around the US. He lectured at and participated in conferences around the world. He was artist in residence for several years at Yaddo in Saratoga Springs, New York, and a resident scholar at the Rockefeller Foundation's Bellagio Center on Lake Como, Italy.

Selzer leaves Janet, his wife of 61 years; three children; and seven grandchildren.

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ANALYSIS

Institutional ageism in global health policy

Peter G Lloyd-Sherlock and colleagues argue that a focus on premature mortality is discriminating against the needs of a growing older population

The sustainable development goals agreed in March 2016 by the United Nations General Assembly set the global development agenda for the next 15 years. They include an ambitious target to reduce premature mortality from non-communicable diseases by a third by 2030. Premature mortality, defined by the World Health Organization as deaths occurring between the ages of 15 and 70, has gained broad acceptance in health research and policy over the past decade. We argue that it is explicitly ageist, reflecting institutional ageism in global health policy.

Institutional ageism

Institutional ageism involves the inclusion of ageist principles in formal rules and procedures and in wider institutional cultures. It is characterised by language consistently depicting older people in negative terms.[2]

Several arguments have been used to justify age discrimination in health policy. The "fair innings" argument posits that everyone is entitled to a certain quality adjusted life expectancy and so policies should prioritise interventions that deliver this, even if they often favour younger people.[5] Accordingly, ageism may be fundamentally different to discrimination based on gender or race since it redresses existing disadvantage. Of course, there is the vexed question of how many years might be considered a "fair innings": something that would require informed debate and social consensus among people of all ages before being adopted. More generally, these justifications for age discrimination contradict the universal principle of health as a fundamental right for all.

Other arguments for age discrimination draw on concepts of human capital and efficiency. These claim that older people make fewer contributions to society than younger adults and thus have less social and economic value.[6] This links to stereotypes equating old age with frailty, weakness, and dependency, which are contradicted by evidence that many older adults make substantial economic and social contributions.[7,8] It is sometimes observed that older people's health problems are relatively expensive to treat and that interventions generate few returns.[9,10] Yet many conditions affecting older people can be treated cheaply, substantially extending healthy life expectancy.[11]

Global policy priorities have remained heavily focused on other issues, such as infectious disease and reproductive health

KEY MESSAGES

- Despite growing numbers of people aged over 60 in low and middle income countries, health priorities remain focused elsewhere
- The target in the sustainable development goals to reduce premature mortality from non-communicable diseases reflects wider ageism in global health policy
- Policy makers should consider how the choice of measure affects the priority given to each age group

Epidemiological roots of ageism

Simple measures of overall mortality are skewed towards conditions that disproportionately kill older people, since most deaths occur in later life.[12] This could unfairly understate conditions affecting younger age groups. To take account of this, the years of potential life lost (YLL) approach to measuring mortality was developed in the 1980s.[13] YLL weight the burden of mortality according to the number of years between the age at which death occurs and an arbitrary age threshold in later life, typically somewhere between 65 and 80. Averting the death of a person over

that age is given a value of zero.

In 1993 the World Bank and WHO launched disability adjusted life years (DALYs) as a tool for studying patterns of disease and assessing health priorities.[14] DALYs apply a disability weight to remaining years of life, up to a fixed YLL age threshold. It was argued: "The young, and often the elderly, depend on the rest of society for physical, emotional and financial support. Given different roles and changing levels of dependency with age, it may be appropriate to consider valuing the time lived at a particular age unequally."[6]

Several studies noted that DALY age weighting and the Global Burden of Disease unfairly undervalued conditions mainly affecting older people.[15-17] Yet age weighting continued in the Global Burden of Disease studies until 2010.

Global priorities and older people

By 1960 roughly half the global population aged 60 or over lived in low and middle income countries, rising to two thirds by 2015. Despite this shift, until the 1990s research and policy discussion about older people's health took place almost exclusively in high income countries.[18] There has been some growth in geriatric research and practice in low and middle income countries since, but global policy priorities have remained heavily focused on other issues, such as infectious disease and reproductive health. In the case of HIV/AIDS, WHO

EDUCATION IMAGES/UIG/GETTY IMAGES

and UNAIDS supported the collection of prevalence data only for people aged 15-49.

The slow response of the global health community to demographic change reflects several factors, including the influence of UN agencies and non-governmental organisations interested in specific issues and other population groups.

The neglect of older people was paralleled by the low priority given to non-communicable diseases (NCDs). This resulted from a misperception that these diseases mainly affect wealthy people and sustained resistance from related industries.[21] Ageism may have contributed to this neglect, inasmuch as NCDs are viewed as primarily "conditions of older age." From 2000, when WHO published its first global strategy for prevention and control of NCDs, an influential global network began to promote them as a development concern.[22 23] Potentially, this represented an opportunity to improve recognition of older people's health, but the network took a different line. Many WHO documents and publications on NCDs make no reference to older people, or merely identify population ageing as a "driver" of NCD pandemics.[24] They emphasise the effect of these diseases on younger adults to justify giving them a higher priority than conditions mainly affecting older people. For example, WHO's 2008-13 Action Plan for the Prevention and Control of NCDs refers to gender, race, and people with disabilities but not to older people.[24] Six of the 27 key NCD indicators that WHO advocates member states should prioritise, including tobacco use and raised blood pressure, are limited to people aged 25 to 64. No reasons are provided for these age limits.

Justifications for age discrimination contradict the universal principle of health as a fundamental right for all

Premature mortality: a new form of institutional ageism?

From 2008 the concept of premature mortality started to gain widespread acceptance among global agencies. In part, this was driven by concerns about the economic effects of disease, especially on people of "working age" and the view that scarce resources should focus on preventing death at younger ages. The foreword of WHO's 2008-13 action plan claims that reducing premature mortality from NCDs could save millions of lives, but the term is not defined and is not mentioned in the rest of the plan.[24] By contrast, premature mortality took centre stage in the 2010 global status report on NCDs. It is defined as mortality below the age of 70.[25]

The 2010 WHO report was the reference document for the 2011 UN high level meeting on NCDs, a political declaration, and a plan ratified by the 2013 World Health Assembly. The plan commits to reducing premature mortality from cardiovascular disease, diabetes, cancers, and respiratory disease by 25% between 2010 and 2025 and has already influenced national policies.[26] A modified version of the premature mortality target was included in the sustainable development goals: "by 2030 reduce by one-third premature mortality from NCDs through prevention and treatment." The goals do not define premature mortality but presumably refer to WHO's under 70 threshold.

The potential effect on research and data collection is shown by the earlier exclusion of older people from HIV targets. In 2010, fewer than half UNAIDS national HIV progress reports included data on people aged over 50.[28] A review of clinical trials on reducing the risk of sexually transmitted diseases found that over two thirds excluded people aged 50 or over.[29] There is already evidence that older people are also excluded from studies of NCDs and from randomised controlled trials, making findings potentially inapplicable to them.[30] A growing number of epidemiological studies apply the 70 and over premature mortality threshold.[31-33]

The challenges of reducing premature mortality from NCDs by a third are substantial, requiring a large reallocation of resources away from older people. Advocates of premature mortality argue early life interventions ultimately benefit people of all ages, but this approach excludes people currently aged 70 or over.[34]

Use of the term premature mortality exacerbates and justifies existing age discrimination in healthcare[11 35] by implying that survival after the age of 70 is fundamentally less important than survival at younger ages. It also distracts attention from major challenges that especially affect older people, including multimorbidity and palliative care.[36]

Redressing the balance

The prominent role given to premature mortality thresholds shows that ageism is becoming increasingly blatant. It is inconceivable that global targets would similarly discriminate against other groups, such as women or people with disabilities.

Engaging with ageism in health policy does not mean throwing the baby out with the bathwater. We still need mortality indicators such as YLL, but they must be interpreted with care. Additionally, policy makers should explicitly assess how the choice of measure affects the priority given to each age group.

In 2015 WHO published a major report on ageing and health,[36] indicating that it is ready to jettison ageist concepts and champion a more ethical approach. Such progress must not be undermined by poorly considered global targets.

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HEALTH LEGACY OF IRAQ WAR

Outcomes show quality trauma care and rehab

Greenberg et al highlight health outcomes of the Iraq war (Editorial, 16 July). Headley Court Rehabilitation Centre has worked to enhance outcomes for severely injured British battle casualties. Enhanced survivability has resulted in considerable challenges.

At discharge, 95% of complex trauma patients are independent in daily living with an aid or adaptation. Over 90% of amputees walk independently over all terrains, and 75% of triple amputees do not require a wheelchair for daily activities.

Of 91 patients with moderate to severe brain injury, 79 were living independently and 84 were in employment four months after discharge.

These outcomes indicate high quality trauma care, including specialist rehabilitation, and have significant implications for the lifelong outcomes of these patients. This is also relevant to the NHS: the lack of investment in rehabilitation has major implications for the economy and patients' health and wellbeing.

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SURGEON SPECIALISATION

Training must support specialist surgeons

Sahni et al show the importance of surgeon specialisation and volume in reducing mortality (Research, 23 July). The Association of Surgeons in Training (ASiT) advocates excellence in surgical training, and is concerned by proposals for a more generalist and less specialised curriculum after the Shape of Training report.

Sahni et al add weight to the argument that a shift towards generalism is not in surgical patients' interests. The outcome measure is 30 day mortality, and differences in relative risk are significant. Training to the highest level and operating in a specialist sphere of knowledge equip surgeons to achieve the best possible outcomes.

Clear evidence shows that specialists achieve better outcomes. This must be considered when redesigning the surgical curriculum.

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LETTER OF THE WEEK

Quality improvement is vital to NHS finances

The editorial by Dixon and Warburton on NHS finances is timely (Editorial, 13 August), but an even stronger case could be made for the solutions offered by quality improvement. Without increased clinical effectiveness, efficiency, and productivity, health services are doomed to continue implementing reactive, short term policies to balance the books.

Beyond involving more clinicians, a lot more could be done:

- Reduce non-financial barriers to measuring and improving quality. Many promising initiatives waste time tackling information governance rules for accessing data.
- Focus capacity on high impact problems. Small scale, low value, and low impact improvement projects waste talent and resources.
- Make improving productivity a key goal. This includes helping to understand and measure financial impact.
- Avoid wasteful reinvention: scale up and replicate what has worked elsewhere.
- Ask hard questions about the value of existing initiatives. For example, does the Friends and Family Test offer enough value to justify the resources invested? Why do we invest so much more in regulation than in improvement?
- Make much more sophisticated use of data to understand where and how services could be improved.

Improvement is not a "nice to have if we could afford it"—it is central to preventing the NHS from entering a death spiral of simultaneously deteriorating finances and quality.

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MISCONDUCT UNSANCTIONED

Being above the law

The Medical Practitioners Tribunal Service's hearing on John Brookes (Seven days in medicine, 13 August) ruled that "his unique surgical skills made him too important to patients' welfare to suspend."

No matter how valuable and inspiring a doctor's work is, those who have committed misconduct should be subject to the same sanctions as any other. How can the public or the profession have confidence in a system that applies one standard to "ordinary" doctors and another to those deemed particularly eminent?

The tribunal chair decided that it would not be in the public interest to interrupt the continuity and level of care provided. Surely the same would apply to any doctor.

No one is so important that he or she should be above the law.

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CONTRACEPTIVE PILLS

Oestrogen or progesterone?

Oestrogen-containing contraceptives were illustrated with a picture of Cerazette, a progesterone-only pill (Seven days in medicine, 13 August).

This common confusion can lead to unintended pregnancy if women who are used to taking oestrogen-containing contraceptive pills in a 21/7 pattern (taking pills for 21 days, then stopping for seven) then take a progesterone-only pill in the same pattern. Progesterone-only pills should be taken on a continuous daily basis (28/28) with no seven day break.

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GAME ON FOR POKÉMON GO

Pokémon no

A member of the public recently walked into our emergency department resuscitation room looking for one of the Pokémon Go characters (No holds barred, 13 August). Also, a crab-like Pokémon was seen in the notes room of our Medical Admissions Unit, by one of our foundation year doctors. And one of my consultant colleagues had a character seen on a chair in his outpatients department.

I understand that these characters are placed by the game's designers or summoned by users and are placed according to GPS location, so they may appear on multiple floors of a building.

To my mind, this may breach confidentiality and raise issues with clinical governance. If characters are placed in medical areas I worry that they're also in areas such as schools, care homes, changing areas, etc.

Shouldn't these areas be out of bounds?

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