> Politicians and management must focus on ensuring that staff have the resources to do their jobs safely. This doesn't mean sending them on resilience courses

NO HOLDS BARRED Margaret McCartney

PPA COLUMNIST OF THE YEAR

If NHS staff aren't cared for they can't care for patients

The NHS will not suddenly fail. Instead, it's being made to fail in degrees.

The workplace will become unbearably stressful. Staff will leave or work fewer hours. Patients will be less well cared for as gaps on rotas widen. General practices will go bust. Schoolchildren will read the headlines, see the hours doctors work, and think: maybe medicine's not for me.

The small cracks in the NHS that have been papered over with goodwill and vocation are gaping now, for the stock ingredients are running out. Staff are exhausted and distressed, practising in a toxic culture of fear and impossible efficiency savings, counting down the days to retirement or jobs elsewhere.

Right now, nothing in the NHS is more important than getting it right for staff. If the staff aren't cared for, they can't care for patients. Junior doctors are being pushed into filling rota gaps because of a lack of doctors. One junior recently told me that medical staff couldn't be guaranteed time off to get married despite asking almost a year in advance.

Medical workforce planning has been serially mismanaged, with female part time doctors (me, for example) blamed in the press for many of the woes. The truth is that many part timers work full time hours; for many of us full time is beyond possible.

Spending in the NHS has also been serially mismanaged: short term political policies with no evidence base (health checks, dementia screening, telehealth, seven day working, and—worst of all—the Health and Social Care Act) have been launched on us, distracting and demoralising us and taking us away from the most important thing we need to work well: job satisfaction. Without the feeling that we're doing a good job, and without being able to leave work with satisfaction or pride, the NHS will predictably fail.

What can be done? Politicians and management must immediately focus on ensuring that staff have the resources to do their jobs safely. This doesn't mean sending them on resilience courses. It means safe staffing. It means asking them to do only important and useful work. It means being kind and considerate to juniors, in particular, who must be shown that they're valued and respected through being treated in ways that demonstrate that value and respect.

The NHS is being allowed to fail. This is not simply a matter of underfunding but also of what we spend our money on. The time for short term political populism must be over. It's either evidence based policy making, starting with how we treat the staff, or no more NHS.

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Cite this as: *BMJ* 2016;354:i4690

PERSONAL VIEW Thomas Bak

Language lessons to help protect against dementia

Could learning a second language delay the onset of dementia?

Hardly a month passes without media reports of new wonder drugs offering glimmers of hope to patients with dementia. Unfortunately, most of these stories are misleading: as with internet scams (lottery wins, free iPads, or miraculous princes offering their inheritance), if it sounds too good to be true, it probably isn't true. Words such as "breakthrough" or "game changer" can serve as red flags. Given the modest progress in drug treatments for dementia, much interest has turned to factors that may either accelerate or delay its occurrence. Physical and mental activities have been associated with a later onset of dementia, and a recent study suggests that changes in lifestyle contribute to a decrease in dementia prevalence.[1]

It may surprise many, but one of the mental activities best documented in this context is bilingualism: the ability to speak more than one language.[2] Bilinguals tend to develop dementia four to five years later,[3] and they are twice as likely to recover cognitively from stroke than monolinguals.[4] They show slower cognitive ageing, even controlling for differences in childhood intelligence.[5] And these effects are not confined to people who learnt their languages early in life and mastered them perfectly: a positive effect of language learning on attention switching was already detected after an intensive, one week language course and persisted nine months later in those who practised five hours or more a week.[6]

Why could this be? A possible explanation is that the constant juggling between languages, with their distinct sounds, words, concepts, and grammatical and social rules, offers efficient training for so called executive functions, such as attention switching, inhibition, and monitoring. This may build a higher "cognitive reserve," counteracting the effects of brain diseases.

Unlike most "magic pills," bilingualism is cheap and easily available

Safety and efficacy

So, let's consider bilingualism as if it were a pill. The first question is, undeniably, safety: does it have any side effects? The old myths that bilingualism causes schizophrenia, confusion, or split identity belong to history. But there are downsides: bilinguals have slower lexical access

ACUTE PERSPECTIVE David Oliver

No more broken promises

In clinical practice, trust is paramount. We trust team mates to know their job and to hand over well. Patients and families need to trust that we're competent, compassionate, and acting in good faith.

But sometimes, in trying to reassure patients and with the best of intentions, we make promises we shouldn't. And broken promises damage trust and confidence.

Some promises concern what we as individuals or teams will do for patients. For example, "We'll do our best to get you as well and as close to your usual abilities as we can." "We will refer you for this test or to that team."

Careless talk may not cost lives, but it causes real problems

Expert, evidenced, or educated prognostications about how much better or worse a patient might get or what a test or treatment might achieve—these are, partly, promises: "This treatment might improve your pain control and help your mobility, but in your case there's only a 50/50 chance."

Benign sounding phrases such as, "We'll have you back on your feet in no time" or "We'll have you home in a day or two" can cause disappointment. Or, sometimes pushed by patients and families, we promise exact discharge dates or how many days' life are left. Definite assurances may well cause problems for colleagues who have to reverse the expectation, so they're best avoided.

Then there are promises none of us should ever make: those on behalf of other practitioners or services we don't work in and perhaps don't fully understand. "We're sending you up to the medical assessment unit—they'll do a scan and get you straight home." "They'll admit you to hospital for a few days." "Go and see your GP when you get home, and she'll sort out your blood pressure."

than monolinguals on average—it usually takes them more time to find a word, name a picture, or decide whether a string of letters is a real word or not. It's a clear but small difference, which doesn't affect everyday life outside the laboratory.

The second question, efficacy, is more contested. Not all studies have found the same results,[7] and some of the beneficial effects of bilingualism may be due to confounding variables such as immigration or education.[8] However, evidence from around the world shows clearly that the effects of bilingualism don't depend on immigration,[3] and, if anything, they are stronger in people with less education,[9] including illiterate people.[3] But, in contrast with most pharmacological interventions, we don't know the dose-response curve of bilingualism: recent studies show that positive and negative effects may depend not only on proficiency but also on actual language use.[10] The only study looking specifically at cognitive effects in relation to the amount of time spent learning a new language found a threshold at five hours a week[6]; remarkably close to the current recommendation for physical exercise.

Finally, unlike most "magic pills," bilingualism is cheap and easily available. It's compatible with many other activities and can be combined with music or social interaction. Some may find its taste more palatable than others—but, given the costs, risks, and potential benefits, it's likely to be one of the best deals on the market currently.

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A version of this article originally appeared as a BMJ Blog (bmj.com/blogs)

Cite this as: *BMJ* 2016;354:i5039

Or, "The social worker will organise some home care for you this week."

We should never make promises not in our gift, on behalf of others. It's unfair on colleagues, patients, and families—so it's unprofessional.

Managing expectations

Managing expectations is critical. "We'll refer you to the community hospital but it might take a week for a bed to come up, and you might be well enough to go home before then." Or, "Your dad will have to leave intensive care/the stroke unit for a general ward soon, because these beds are scarce and he's stable enough. They don't have the same nursing and therapy levels as we do, and specialist rehabilitation beds are under a lot of pressure."

There's already enough misunderstanding, even when experienced clinicians carefully choose and properly communicate their words, without further complication. Careless talk may not cost lives, but it causes real problems.

Don't make promises you can't keep. It's less disappointing in the long run to under-promise but over-deliver.

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Cite this as: *BMJ* 2016;354:i4855

BLOG OF THE WEEK

Richard Smith

The difficulty of using evidence to make policy

Doctors commonly complain that they consider evidence before treating a patient but that politicians and policy makers don't use the same rigour when making changes to health services. But they are falling into a common philosophical trap, failing to recognise the "micro-macro problem."

The micro-macro problem runs through the whole of science. We can't explain the behaviour and functioning of a living cell by reference to amino acids and other chemicals or the workings of the brain in terms of neurones.

Evidence based medicine has severe limitations even within medicine, as all doctors recognise. It's at its simplest when dealing with drugs. Randomised trials can be done to a high standard, testing a drug against a placebo or another drug: nothing is different but the drug. The drug trials can be incorporated into a systematic review, and we have high quality evidence. But we still have problems such as the trials being conducted in ideal conditions, usually in patients with only one condition, and bias regarding which trials are published. Doctors struggle when they try to fit the evidence to patients with multiple conditions and their own idiosyncrasies.

Making policy is fundamentally different from treating patients

The complexity problem increases considerably when we move to health system interventions such as guidelines, training, or use of IT: new methods, such as cluster randomised trials, are needed. But now it becomes harder to maintain both internal and external validity, and we may test simplified interventions that fail to recognise the complexity of the system. People trying to test interventions for obesity have recognised this problem.

But, once you move to whole health systems and changes such as the commissioner-provider split or integrating health and social care, then you have moved up an order and the micro-macro problem kicks in: you cannot use the methods of evidence based medicine. But this is not to argue that evidence is irrelevant. You can gather evidence from other geographies and disciplines, as well as from history. But such evidence doesn't allow for confident conclusions. Evidence should be incorporated into decision making, but it's only one component in decision making—as it is, indeed, in evidence based medicine.

I've heard many talks on evidence in policy making, and the conclusion is always that evidence plays a part but that it's small and that the link with what policies are adopted is often obscure. Making policy is fundamentally different from treating patients.

Richard Smith was the editor of *The BMJ* until 2004.

Read this blog in full and others at bmj.com/blogs

KEY MESSAGES

- Involving patients in medical conferences can help delegates to understand problems that matter most to patients and their caregivers
- Involving patients can spark collaborations with patients in healthcare design, education, research, and clinical care improvements
- Requirements of attending patients, such as facilities for self care and travel expenses, should be considered when planning conferences

ANALYSIS

Patient partnership in medical conferences

Larry Chu and colleagues discuss the benefits of involving patients as partners at medical meetings

The expression "nothing about us without us" was first coined by disability rights activists to convey the idea that no policy should be reached without full participation of representatives of all stakeholders.[1 2] More recently, it has been adopted by patient communities seeking broader involvement with the healthcare system.[3 4] Although the drive for patient involvement has come from patients, the medical community has much to gain.[5]

Patient involvement in health policy, clinical care, and research has gained momentum in recent years.[5 6] In the US, the Patient Protection and Affordable Care Act has stipulated inclusion of patient centred outcomes on the quality and experience of care, including public reporting and performance payments related to this aim.[7] Patients are also involved in medical research, including using patient centred outcomes in comparative effectiveness research. The Patient-Centered Outcomes Research Institute (PCORI) and other bodies were created to help fund these studies and implement the findings.[8] Despite this progress, the role of patients in academic medical conferences has been poorly defined, discussed, and implemented.[9] We describe the benefits of patient partnership in academic medical conferences and how it can be enabled.

Examples of medical conferences that have included patients

International AIDS Conference[11]—Early (1992) conference that included patients and provided initial evidence that physicians valued patient participation as a means to improve discussion

Outcomes Measures in Rheumatology (OMERACT) medical conference[13]—Long term engagement with arthritis patients in the biannual conference has influenced outcome research and contributed to the research agenda by identifying new patient reported outcome measures

Neurological Emergencies Treatment Trial (NETT)[16]—Reports growing interest in including patients and patient advocates in the design of clinical trials for neurological disorders and advocates for their inclusion in medical conferences on the topic

American Medical Informatics Association (AMIA)—Included representatives from patient groups to formulate recommendations on health data use, stewardship, and governance[17]

European Congress for Social Psychiatry (ECSP)[18]—A discussion of use of physical restraint included a patient describing the sense of invasion, humiliation, and fear from being restrained and forcibly injected with medication

National Breast Cancer Coalition (NBCC)[19]—Provides science training to patients to help them engage in a range of local and national conferences where breast cancer decisions are made

Stanford Medicine X (Med X)—Since its founding, patients have been included as delegates (10% of seats), speakers on the main stage, and members of the executive programme committee. Patients also codesign physical spaces at the convening and its educational and mentorship programmes for patients

European Haemophilia Consortium (EHC) Congress[20]—A satellite symposium identified the importance of representing the patient voice in key policy discussions, especially in healthcare technology assessments

What patient involvement can achieve

Medical conferences are convened to spark innovation in healthcare by creating networks of experts, sharing knowledge, forming collaborations, and thoughtful challenging of conventional thinking. Patients can make important contributions in all of these areas by helping everyone understand the problems that matter most to patients, caregivers, and their families.[10]

> Although the drive for patient involvement has come from patients, the medical community has much to gain

The eighth international AIDS conference in 1992[11] was one of the first to integrate patient participation. However, progress since then has been slow, and there is little research into patient engagement.[12] The available evidence shows that including patients widens the focus of research, changes the culture of conferences

Box 2 | Four pillars of patient involvement at academic medical conferences

Accommodation
—Consider the medical, nutritional, and accessibility needs and financial assistance with travel and lodging arrangements as practical. For example, include patients in designing a designated physical space such as a wellness room that provides attendees with an area to rest or attend to personal care.[38] Use of social media and free live streaming should be explored to allow participation by patients unable to travel

Codesign
—Patients should be placed on an equal footing with programme creators to help identify core conference themes, select speakers, and evaluate abstracts that relate to patient centred issues.

Engagement
—Meaningful numbers of patients should be included in the audience and speaking roles. Patients invited to attend or speak should be able to attend all sessions open to others attending the conference.

Education and mentorship
can help patients learn how to collaborate and partner with providers, researchers, and third party stakeholders to fulfil the mission and goals of the conference organiser, hosting society, or institution.[15] They enable patients to participate in creating future conferences and are crucial for a long term, sustainable strategy.

Challenges to involving patients in medical conferences

Challenge	Example	Potential solutions
Terminology	Operational definition of "patient"	The definition of a patient can depend on local customs and cultures. Patients can partner with healthcare professionals to define the term for each conference context
Tokenism	Checklist-type inclusion of patients and co-opting of patient narratives	Meaningfully include patients in the design, implementation, and creation of a conference
Paternalism	Fears that patients are not able to transcend their personal experience, generalise their experience to others, and understand the rigor of scientific discussions[12 14]	Strong leadership, structured patient recruitment, full and equal participation, and multistakeholder design approach with support and training of patients for participation[12 14]
Compensation/ conflicts	Patients receiving payment for their time or having a conflict of interest	Patients should be compensated in the same ways as other conference presenters and held to the same competing interest policies
Financial	Cost of registration and travel scholarships for patients	Many events should be able to afford to fund 1-2 patients. Sponsorship or grant support may be needed for greater numbers[13]

and researchers to use more patient relevant outcomes in clinical trials, and leads to wider patient involvement as partners in research.[12-15] These findings suggest that patient participation is most important in conferences involving research and policy decisions but it can provide meaningful insights at other types of medical conference, such as those with a clinical, quality improvement, or leadership and management focus.

Charters and frameworks for patient involvement

Recently, several organisations have created charters or frameworks for patient involvement in medical conferences. The Patients Included charter consists of five clauses that aim to provide conference organisers "with a means of demonstrating that their events are committed to incorporating the experience of patients as experts in living with their condition while ensuring they are neither excluded nor exploited."[31]

Our group has recently published the Stanford Framework for Patient Partnership,[34] which is composed of charter guidelines for including patients as partners in medical convenings[35] as well as leadership principles, implementation aids, design principles, and an Everyone Included declaration intended to nurture respect and trust between patients and delegates.[36] Our Everyone Included ideal aspires to help cultivate the shared values that all stakeholders have an equal seat at the table throughout the design, prototyping, and implementation process.

Based on our work over five years partnering with patients in a large academic medical conference,[37] the framework sets out four pillars of patient involvement for conference organisers (accommodation, codesign, engagement, and education and mentorship). The framework could also be used by prospective delegates to evaluate conferences they are contemplating attending. Our framework was codesigned with patients and has been tested and refined during the organisation of Medicine X over four years. The box above provides advice on how to implement the four pillars, and the table suggests ways to overcome some of the obstacles conference organisers might encounter.

Conclusion

Patient involvement in academic medical conferences is an important step to bring patients closer to the conversations driving the future of healthcare. Current data suggest that meaningful patient inclusion can help drive discussion and knowledge dissemination at academic medical conferences and widen research agendas to include new patient centred domains.[42-44] Conference organisers should work towards patient involvement not only to foster the patient voice in academic medicine but also to realise true partnership and collaboration with patients as a means to drive truly meaningful innovation in health care.

Patient involvement in academic medical conferences is an important step to bring patients closer to the conversations driving the future of healthcare

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Cite this as: *BMJ* 2016;354:i3883

Find this at: http://dx.doi.org/10.1136/bmj.i3883

EDITORIAL, p 431

OBITUARIES

Robert Marshall Milne

General practitioner Perth (b 1922; q St Andrews 1944), d 20 May 2016.

After serving in the Royal Army Medical Corps in India and Japan, Robert Marshall Milne entered general practice in Perth in 1949. He enjoyed his work there until he retired in 1987. In the 1960s he took an active part in local medical politics. One of his main interests was dental anaesthetics. His hobbies included hill climbing (being 65th to complete the Munros), curling, gliding, and Scottish country dancing.

Milne took an active part in local medical politics

He died in Catmoor Nursing Home in Perth after a short illness. Predeceased by his first wife, Betty, he leaves his second wife, Sheila; a son; three grandchildren; a great grandson; and step family.

Robert Marshall Milne

Cite this as: *BMJ* 2016;354:i4397

Geoffrey Donald Wilson

General practitioner Eastbourne (b 1919; q Pembroke College, Oxford/St Thomas' Hospital, London, 1952), d 15 December 2013.

During the war Geoffrey Donald Wilson had appendicitis twice, and on the second occasion he had to walk and hitchhike to the local field hospital and climb on to the table to have the operation. This prompted him to study medicine. Geoffrey initially worked as a house surgeon at St Mary's Hospital in Eastbourne, Sussex, and took a job as a local GP in 1954. He practised for almost 50 years. A fellow of the Royal Society of Medicine, former south east regional representative of the BMA for 12 years, and former medical officer for the Lawn Tennis Association and Davis Cup tennis, he received a special recognition award from the town of Eastbourne for his dedication and contributions. Geoffrey leaves his wife, Anni; two children; and five grandchildren.

Giles Wilson

Cite this as: *BMJ* 2016;354:i4539

Kathleen Mary Perkins

Pathologist and charity volunteer (b 1924; q Liverpool 1948; FRCS), d 26 June 2016.

Kathleen Mary Perkins (née Roby, known as "Kay") studied medicine at the University of Liverpool during the second world war, when attendance was dependent on the scale of overnight bombing, and through the aftermath of war, when the NHS came into being. Then as now the Victoria Building was the heart of the university: then as the place where final examinations were taken, now as a museum and gallery. Kay worked as a house officer at Warrington Hospital before moving to Chester and district hospitals to work in the pathology department. In 1952 she became the registrar in pathology for the Chester Group Laboratory. In 1954 she left this employment to pursue other opportunities. She was a life member of the BMA. Widowed in 2000, she leaves two daughters and four grandchildren.

Kit Syder

Cite this as: *BMJ* 2016;354:i4563

Paul Haydon Rogers

Psychiatrist Northampton (b 1919; q Cambridge/London Hospital, London, 1943; FRCP, FRCPsych, DPM), died from a chest infection on 11 February 2016.

In 1955 Paul Haydon Rogers was appointed consultant psychiatrist and deputy physician superintendent to St Crispin Hospital, Northampton, and director of the local child guidance clinic. Paul had experienced psychiatric hospital care before the advent of major psychotropic drugs and open door policy. As medical director, from 1969, he was involved in the planning and commissioning of a new hospital for people with learning difficulties. After retiring from the NHS in 1979 he worked with the health advisory service and the Mental Health Review Tribunal. For the last 10 years of his life he lived in a complex in the grounds of his old hospital, St Crispin. Predeceased by his wife, Marjorie, and a daughter, he leaves two children, five grandchildren, and seven great grandchildren.

D D R Williams

Cite this as: *BMJ* 2016;354:i4564

David Graeme Sinclair

Consultant chest physician (b 1958; q Birmingham 1981; MD, FRCP), died from a glioblastoma on 15 May 2016.

David Graeme Sinclair joined the Royal Army Medical Corps in 1978. His army career took him to Germany, Northern Ireland, Saudi Arabia during the first Gulf war and Angola. At home he specialised in respiratory and intensive care medicine. He left the army to take up his consultant post in Torbay in 1996. An interest in HIV medicine prompted him to build a large clinical service in Torbay and Exeter. He took on leadership roles within the acute trust (including being deputy medical director) and in the developing Peninsula Medical School. David combined his career with a joy of life that extended to a love of good food, wine, whisky, ballroom dancing, rugby, and a serious interest in cars. He leaves his second wife, Mel Hearn; three stepchildren; and two children from his first marriage.

Melanie Hearn

Cite this as: *BMJ* 2016;354:i4566

Bernard Nchewa Nwulu

Consultant psychiatrist (b 1944; q University of Lovanium, Kinshasa, Zaire, 1972; FRCPsych), died from septicaemia on 26 May 2016.

In 1984 Bernard Nchewa Nwulu was appointed as a consultant psychiatrist specialising in learning disabilities at Rotherham District General Hospital. Ten years later he became medical director of Rotherham's mental health and community health services. In 1998 he left to work as a consultant at Rampton Hospital. He enjoyed the medicolegal perspectives of this role and was appointed as a medical member of the Mental Health Review Tribunal in England and Wales. He ran medical clinics during his yearly trips back to Nigeria. Along with other doctors he donated medical journals to the libraries of Nigeria's teaching hospitals. He took early retirement in 2006 in order to build a science based secondary school in his home village in Nigeria. Bernard leaves his wife, Sabinah; five daughters; and two sons.

Ugochi Nwulu

Cite this as: *BMJ* 2016;354:i4398

DA Henderson

Smallpox slayer

Donald Ainsley Henderson (b 1928; q Rochester University School of Medicine, 1954), died from complications associated with a broken hip on 19 August 2016.

DA Henderson—he was always DA, no one remembers quite how or why, but the moniker stuck early—became the man most identified with eradication of smallpox. He had initially planned on becoming a cardiologist. But completion of his schooling also meant the end of deferment from military service, and he faced the option of being drafted into the army as a private, or enlisting as an officer. The least boring option to him seemed to be the Public Health Service under the direction of the surgeon general.

He enlisted in 1955, and after a month of training he was certified as an epidemiologist in the Epidemic Intelligence Service, then in its fourth year of existence. He was immediately immersed in the introduction of the groundbreaking polio vaccine. In 1957 an assignment took him to Argentina, where he asked to see a smallpox outbreak in the interior of the country. It was the first time he had seen a case, and it left a deep impression. Soon he was in charge of the tiny smallpox bureau at the US Centers for Disease Control and Prevention (CDC).

Eradicating smallpox

In the mid-1960s Henderson was asked to put together a proposal to eradicate smallpox in 18 central west African countries. He estimated the cost to be about $35m (£27m)—many times the budget that others had been considering—and the project did not go ahead.

Somehow the White House learnt of the proposal and latched on to it. President Lyndon Johnson wanted to see a peaceful American international initiative in the middle of the cold war and an increasingly "hot" war in Vietnam, Henderson recounted in a 2008 interview. He was put in charge.

The Soviet Union had eradicated polio within its borders in the 1930s and had been pushing for a worldwide effort. But the World Health Organization (WHO) had tried and failed to eradicate yellow fever and malaria, and was not keen on taking on a third daunting challenge.

News that the US was planning a major smallpox eradication effort in Africa was enough to tip the balance and in May 1966 the World Health Assembly voted by the slimmest margin to take on a worldwide eradication effort.

WHO's director general, Marcolino Gomes Candau, wanted an American in charge of what he felt would be the eventual failure of the effort; he wanted Henderson.

Henderson agreed to go to Geneva for 18 months and stayed for more than a decade. He made a decision not to buy any additional vaccines but to improve the production facilities that existed. By 1972 about 80% of the vaccine produced in countries where smallpox was endemic was of good quality.

Technological innovation

The Soviet Union had pledged 25 million vaccine doses a year, but it became clear that that would not be enough. And then Wyeth, the vaccine manufacturer, came up with the bifurcated needle. The needle used only a quarter of the vaccine of older procedures, it was inexpensive, and it could be easily maintained and sterilised in the field.

Ring vaccination was another concept that helped make eradication work. William Foege seized on this when he implemented the US supported programme in Africa. He believes that putting Henderson in charge of the WHO smallpox eradication programme was absolutely critical to its success. Henderson had the freedom "to make courageous decisions. If he needed to be a bull in a china shop, he could do that."

India was a major reservoir of smallpox, where only limited progress was being made towards eradication. The turning point came in May 1974, when India detonated its first nuclear device, and international press coverage focused on the dichotomy of advanced technology and continued endemic smallpox. Government support materialised, eradication took only a year.

Henderson examines vaccination scars in children in Ethiopia

Henderson had the freedom "to make courageous decisions. If he needed to be a bull in a china shop, he could do that"

Ethiopia was the last major challenge, a combination of poor infrastructure and a civil war. But finally the last case of smallpox was recorded in neighbouring Somalia in 1977. Victory was declared a few years later.

After leaving WHO and the CDC, Henderson served for more than a decade as dean of the Johns Hopkins University School of Public Health in Baltimore. He continued to serve as an adviser to agencies of the US government, international health organisations, and the Bill and Melinda Gates Foundation until his death and received many honours and awards.

Donald Ainsley Henderson leaves his wife, Nana Irene Bragg, and three children.

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Cite this as: *BMJ* 2016;354:i4742

HEALTHCARE FOR PEOPLE

Designing healthcare to fit real people

It's helpful to see designers' knowledge applied to make the most effective use of resources in response to the clinical needs of individuals and populations (Editorial, 3 September).

The early development of geriatric and psychogeriatric medicine demonstrated the massive advantages of taking clinical skills to people in their own homes. More recently we've found that taking specialists into primary care augments its capabilities and minimises the need for secondary care.

These initiatives didn't have the advantage of academic designers but evolved directly from clinical observations and an awareness of population characteristics. It's encouraging to find that approaches from differing backgrounds come to similar conclusions.

We now need to apply this knowledge widely: let the distribution and application of resources be tailored flexibly to the needs of individual patients and populations rather than dictated by the self image and desire for power that we see among trusts and other mega-organisations.

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Cite this as: *BMJ* 2016;354:i5016

LETTER OF THE WEEK

Directors of public health are pivotal

The government has plans to tackle health inequalities (This week, 3 September).

The health select committee's report is clear about why public health is important and the NHS's key roles. However, many doctors and nurses will need training and time to deliver additional preventive advice.

It also highlights the needs assessment skills that public health specialists can bring to commissioning. We believe that each clinical commissioning group must include a public health specialist on its board.

The report focuses on data, but positive indicators are needed instead of negative indicators, such as deaths, for planning, evaluation, and promoting health.

We agree that "cuts to public health are a false economy," and we think that funding should increase to be commensurate with the issues facing the country. We previously mentioned that directors of public health are pivotal to the health of communities. However, to have a substantial level of influence, they will need both the power and the resources.

When the government responds to this report, it should be ambitious and should develop an evidence based, long term public health strategy that not only focuses on priorities including smoking, sensible drinking, and mental health but also prioritises the reduction of inequalities. Coordinated action in hospitals, primary care, workplaces, schools, and other settings is required. Well resourced and robust public health departments will be vital to effective action.

Michael Craig Watson (Michael.Watson@nottingham.ac.uk), Sylvia Tilford

Cite this as: *BMJ* 2016;354:i5013

TRANSITION TO A NEW EHR

Patient involvement in electronic health records

Health providers pay attention to the use of electronic health records but less to patient safety. Barnett et al found no general correlation between EHR implementation and short term inpatient mortality, adverse events, or readmissions in 17 US hospitals (Research, 30 July).

One rationale is that clinicians or researchers often focus more on treatment outcomes in defining patient safety, whereas patients focus on processes and interpersonal relations. Patients hold a pivotal role in safety schemes, since they can help in monitoring and reporting adverse events.

A US survey found that clinicians tend not to report errors, leading to under-reported adverse events in records. Many EHR improvements focus on collecting objective information rather than capturing patients' concerns and preferences. EHRs could be used as a standardised instrument for performing clinical protocols to reduce clinical carelessness. In terms of patient safety, patients should be involved in EHR design to maximise the technology's potential.

Windu Kusumo (kusumowindu@gmail.com)

Cite this as: *BMJ* 2016;354:i5035

PATIENT SOCIAL NETWORKING

Addison's forum helps to support and engage patients

Social media allow people with rare conditions to connect and share experiences (Patient groups, 20 August).

Our members-only forum has over 27 000 posts and 3000 subscribers, equivalent to a third of the estimated 9000 UK Addison's patients.

Patients can vent frustrations in a safe environment. A "no blame" rule allows only positive clinician recommendations. Many new patients experience anger or anxiety before developing self management skills.

Medication can be discussed in more detail than in a face to face medical appointment. Members can pool insights into UK and international endocrine practice: patients can know more than their clinician about clinical practices in other hospitals.

We also raise awareness through Facebook, but our website and forum remain central to providing information and support.

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Cite this as: *BMJ* 2016;354:i4998

GHOSTWRITING

Medical literature is becoming more transparent

The International Society for Medical Publication Professionals, a not-for-profit society involved in publishing medical research, has serious concerns with the assertion of a "rebranding of ghostwriting" (Analysis, 3 September). Rather, we see a positive evolution of transparency and completeness in medical publications reporting research.

We believe that ghostwriting is unacceptable. We support the role of professional medical writers and the complete and transparent disclosure of their involvement in medical publications, as well as the source of their funding.

Over more than a decade, disclosure of medical writers' roles and funding in medical publications has become standard practice. The involvement of medical writers, statisticians, and others is made fully transparent to editors and peer reviewers and, ultimately, to readers, along with authors' disclosures and potential conflicts of interest.

We challenge the suggestion that current disclosure practices "compromise" medical literature, particularly when they have improved transparency.

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Cite this as: *BMJ* 2016;354:i5043