

# comment

Video recording could flush out poor medical practice. It may also show policy makers the impossibility of practising good medicine without time and resources

**NO HOLDS BARRED** Margaret McCartney

PPA COLUMNIST OF THE YEAR

## Cameras and complaints

**A**n international trial has found that police officers who wore video cameras attracted fewer complaints. Officers were randomly allocated to wear cameras or not; if they did, they told any members of the public they interacted with.

In the year before the study the police received 1539 complaints in the seven experimental sites. This averaged 1.2 complaints per officer before the study, which fell to 0.08 when they were wearing cameras. Importantly, however, no statistically significant difference was seen in the number of complaints between the control and treatment groups, leading the authors to conclude that the decrease in complaints about camera-wearing and non-camera-wearing officers was partly due to “contagious accountability.”

The medical community globally has been asking whether doctors should be doing the same thing. As litigation costs rise, could digital video recording of all clinical encounters reduce complaints against healthcare staff?

Cameras are already used daily by many commuter cyclists, and arguments rage about whether they represent a sartorial act of aggression or a defensive mechanism against a hostile world.

Let's be clear: in most instances recording medical consultations, like having a chaperone present, will aim to protect the doctor, not the patient. General practice, however, has a long history of using cameras to record consultations for training and to improve care. Many out-of-hours services routinely record telephone consultations. And we hear calls for more patients to record their consultations, in the belief that the information will be of use and



patients can listen again. Covert recording is something GPs have been advised to expect—and told that they can't prevent.

But doctors aren't police officers. Complaints about the police are likely to be quite different from those about doctors, including concerns about the use of force. The public will also behave differently. Cameras, which were switched on constantly in the trial, may reduce bad behaviour on the part of the public and the

police. In medicine we expect differences in purposes and outcomes between professionals and patients. Recording consultations has been found to be of great value to patients attending oncology appointments, and it's easy to see why: information about complex choices is distilled into consultations, and it's well known that patients find recall difficult.

I know that the putative aim is to make life easier by protecting myself against an unjustified complaint; but, ironically, I worry about not being perfect. (I suffer recurrently when catching myself on the radio, knowing that I could have phrased something better.)

Video recording could flush out unacceptably poor medical practice. It may also show policy makers the impossibility of practising good enough medicine without enough time and resources.

But it will also place stress on all of us who are imperfect humans in an inhumane system. And it could have unintended effects on the way patients present themselves or disclose or discuss symptoms. Ultimately, is the intention to protect doctors or patients? And who will be harmed while others gain?

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Cite this as: *BMJ* 2016;355:i5674

## Why do we shine lights in the eyes of conscious patients after head injury?

This standard practice is a waste of time and resources

**P**upil examination is a standard part of the neurological assessment of patients after head injury. The internationally recognised Advanced Trauma Life Support course teaches that Glasgow Coma Scale (GCS) score and pupillary responses should be assessed in all patients with head injuries.<sup>1</sup> Similarly, the National Institute for Health and Care Excellence (NICE) recommends that, after initial assessment in the emergency department, a patient who is normally alert (with a GCS score of 15) after head injury should have their GCS and pupils assessed half hourly for two hours, then hourly for four hours, then two hourly thereafter.<sup>2</sup>

The rationale for pupillary assessment is that changes in pupil size and reaction can indicate a rise in intracranial pressure and can help to identify the location of an

intracranial haematoma.<sup>3</sup> This makes sense in patients with a severe head injury (defined as a GCS score of 3-8),<sup>1</sup> but does it also make sense in patients with a GCS score of 15?

For more than 70 years doctors have been taught that pupillary dilatation in the context of severe head injury and rising intracranial pressure is due to ipsilateral compression of the third (oculomotor) cranial nerve.<sup>4</sup> More recently, reduced blood flow in the brain stem has also been implicated.<sup>5</sup>

Nevertheless, and regardless of the underlying pathophysiology, pupillary changes detected by a doctor or nurse using a pen torch are universally recognised as a late sign of injury, when intracranial pressure is raised considerably and consciousness reduced.<sup>4-7</sup>

As intracranial pressure rises the conscious level will fall before any significant change in pupil size or response is detected.



**Serial examination of the pupils in a patient with a normal GCS score of 15 is illogical and unnecessary**

Thus serial examination of the pupils for evidence of raised intracranial pressure in a patient with a normal GCS score of 15 is illogical and unnecessary.

Physiological anisocoria—a minor degree of pupil asymmetry—is a common and harmless finding.<sup>8</sup> But it may be misleading and result in unnecessary reviews, observations, and even computed tomography, particularly when agreement between doctors regarding pupil reactivity is inconsistent.<sup>9</sup>

Moreover, the serial examination of pupil size and response, recorded on each occasion, consumes time

## Let's argue about statistics

In his recent speech to the Conservative Party conference the health secretary, Jeremy Hunt, used statistics enthusiastically.<sup>1</sup> I counted at least 27 times that he mentioned numerical data. And he made several more assertions about numbers, such as, “Safer care doesn't cost more; it costs less.” Not bad for a speech of 23 minutes.<sup>2</sup>

He used statistics to take credit on behalf of his government for purported greater NHS activity. Then he used data to highlight poor or inconsistent NHS performance to justify reforms. And he cited data in support of his commitment to an uncosted “seven day NHS” and



**Hunt ignored the cautions of statistically literate analysts in pushing an uncosted model for seven day services**

changes to doctors' contracts.

But statistics about the huge funding and workforce gaps in our health and social care system and their adverse impact on performance were understandably absent. So were data about services defunded and cut since 2010. But that's OK: “Just writing a cheque doesn't raise standards,” Hunt asserted confidently.

Hunt praised doctors “using hard data” to improve services and announced publication of “Ofsted-style ratings” for performance of cancer services.<sup>3</sup> He promised that hospitals would publish their “preventable mortality estimates.”

This all seems consistent with his previous promises to make transparent use of intelligent data.

Having used selective and contestable statistics to take credit for stated successes, he then shifted the blame for performance gaps away from the Treasury and Department of Health to local clinicians and managers; and, styling himself as the true champion of patient safety, he said something deserving of its very own paragraph:

“So I say . . . to the BMA and to junior doctors, let's not argue about statistics.”

Let's get this straight, Mr Hunt. Academic doctors, statisticians,



PHOTOFLUSSION/REX/SHUTTERSTOCK

responses examined during their first clinical assessment after a head injury. A patient's eyes should be carefully examined to seek evidence of direct injury and to establish a baseline for pupil size and response. Some patients, such as those with previous eye surgery, may have a chronically dilated or unreactive pupil, and it is helpful to record this at the outset.

However, after initial examination of the eyes regular and routine assessment for head injury does not need to include the size or reactivity of the pupils, unless the patient is not normally alert.

In summary, examination of pupil size and response is essential at initial assessment after head injury and routine in head injured patients with reduced consciousness. But it is not necessary, and wastes time and resources, as a regular and repeated observation in patients with a normal GCS score of 15. It can be safely discontinued in this patient group. Clinical training, documentation, and practice guidelines should be updated accordingly.

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Cite this as: *BMJ* 2016;355:i5235

and resources. Nearly 350 000 patients were admitted to hospital with a head injury in the UK in 2013-14,<sup>10</sup> the majority with a GCS score of 15.

If all of those with normal consciousness received the pupillary assessment recommended by NICE over a four hour period, and each assessment took one minute to complete and record, this would represent more than 25 000 hours of healthcare practitioners' time wasted every year in the UK without patient benefit.

This does not mean that patients should not have their eyes and pupil

and health service researchers have produced most of the data that you're using selectively to support your public relations agenda. Yet you're telling them that they shouldn't argue over data, contradicting the principles of their training and the culture of academic peer review.

Perhaps we shouldn't be surprised. You ignored the cautions of statistically literate analysts at the Department of Health in the rush to push an uncoded model for seven day services.<sup>4</sup> Then you refused to heed expert challenges to your assertion, which you repeated at the conference, of "eight independent studies confirming a mortality rate up to 15% higher for those admitted to the weekend."

I know that Mr Justice Green upheld your ministerial right to interpret such studies and their policy implications.<sup>5</sup> But "let's not argue about statistics" conveniently invalidates all objections, and there's no ministerial monopoly on the use or interpretation of peer reviewed data.

The day that trained professionals stop disputing selective use of data by government, lobbyists, think tanks, or the media for their own political and public relations ends will be a nail in democracy's coffin.

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Cite this as: *BMJ* 2016;355:i5649

## BLOG OF THE WEEK Sharon Roman

### I am the girl next door

A Canadian patient describes attitudes to multiple sclerosis

On good days I am able to appear just as "normal" as everyone else, if you don't look too closely. My apparent normalcy does, however, hinder and frustrate me at times, much as I strive for it.

At the grocery store the elderly woman in front of me is granted patience and helped to her car with her bags. If there is no seat available on the subway, no one steps up to offer me theirs. When I go to use the disabled people's washroom I am eyed with suspicion. Once I had to use the men's toilet to avoid a messy embarrassment, for which I was loudly jeered. Confronted in a parking lot, I have been accused of using my parents' disabled parking permit. I've been accused of not really needing my cane and shunned because it was assumed I had been drinking. These types of incidents are too exhaustive to enumerate here. Unfortunately for everyone involved, ignorance is not bliss. No one, neither others nor I, benefit from narrow mindedness or this inability to conceive of necessities and challenges that are not visibly forthcoming.



### It is difficult for me to deal with something even my doctors have difficulty comprehending

I can make light of things most people would find abhorrent and manage to live with it all, with the help and love of others. I draw the line, however, at thoughtless, hurtful comments and attitudes from total strangers who don't know me or my situation. Worse yet are those who are aware of my disease but behave as though it doesn't always exist. Those who look the other way and don't lend helping hands.

I represent what most of you cannot cope with: the unknown, the ugly. The fear that it might have been you or it might still yet be someone you love. We offer a hand to the elderly person who trips but look away from the young woman stumbling along, slurring; she might be high on drugs, or drunk, or mentally incapacitated. This is my public billboard for multiple sclerosis: Do not dare prejudice, I am the girl next door. It is difficult enough for me, without your ignorance, to deal with something even my doctors have difficulty comprehending.

Thank you to those who have learnt how to be of help. Thank you for all the times you have carried me up or down stairs, helped me laugh at myself, and were not embarrassed by my condition. I wish that everyone had a taste of this kind of love and devotion in their life, though of course not this way.

Sharon Roman is a patient with multiple sclerosis

Read this blog in full and others at [bmj.com/blogs](http://bmj.com/blogs)

# A manifesto to reduce research waste

To avoid waste of research, no new studies should be done without a systematic review of existing evidence, argue

**Hans Lund and colleagues**

**W**hether or not today's medical researchers, like Isaac Newton, see themselves as "standing on the shoulders of giants," they might still be expected to build systematically on previous research when planning new studies. Even though this issue was highlighted as early as 2005,<sup>1,2</sup> numerous studies indicate that researchers do not use a systematic methodology to identify and refer to earlier research when justifying, designing, or discussing new research.<sup>3-11</sup> Rather, medical researchers select studies to cite based primarily on preferences and strategic considerations.<sup>13-18</sup> The term "evidence based research" was coined in 2009 to indicate the approach that is needed to reduce this practice, which is an important source of research waste<sup>19</sup> and risks unnecessary harm for patients and study participants.

Some research funders have already taken action. For example, the National Institute for Health Research in England now requires that applicants for primary research funding justify any proposed research by referencing a current systematic review of relevant existing research to show that they have taken account of the knowledge from previous studies.<sup>20</sup> However, much remains to be done.

It was against this background that a group of researchers decided to initiate an international network (EBRNetwork, <http://ebnetwork.org>) to raise awareness of and confront this problem within health research. The network aims to reduce waste in research by promoting no new studies without systematic review of existing evidence and the efficient production, updating, and dissemination of systematic reviews.

## Proceed with caution

The methodology for systematic reviews requires predefined research questions, inclusion criteria, search methods, selection procedures, quality assessment, data extraction, and data analysis, with no relevant studies excluded without explanation and the results of each study contributing to the review's conclusions.<sup>21,22</sup> Basic scientific training for researchers must include an understanding of the need for a systematic review of the existing evidence<sup>21,23</sup> and the skills to critically assess, interpret, and use these reviews. For scientific, ethical, and economic reasons, current high quality systematic reviews need to be seen as an essential component of decisions about whether further studies are justified, the design of new studies, and the interpretation of new study results.<sup>1-24</sup>

The figure shows the process of evidence based research, from initial research question to the final decision to proceed using an optimal study design. The proposed process aims to support researchers, not to constrain them or pretend to provide all the answers: a systematic analysis is only one of many considerations when framing a research question.

The number of published systematic reviews has increased steeply over recent years<sup>26</sup> so (in principle) researchers in most areas should be able to identify at least one relevant review. However, even if systematic reviews are available, researchers still face several challenges. For example, the identified systematic reviews may be out of date or of inadequate quality, necessitating additional work (requiring relevant skills, time, and resources) before the primary study.



**Research waste can be prevented by granting approval only to proposals informed by a current systematic review**

Alternatively, a lack of common measures and definitions in included studies may preclude a statistical synthesis of results, making it difficult to integrate new results.

Taking account of relevant ongoing studies when preparing systematic reviews and planning new studies presents a further challenge for evidence based research. Although registration of new trials has now become standard,<sup>27</sup> there has been less progress in the registration of other types of study.

## Be efficient

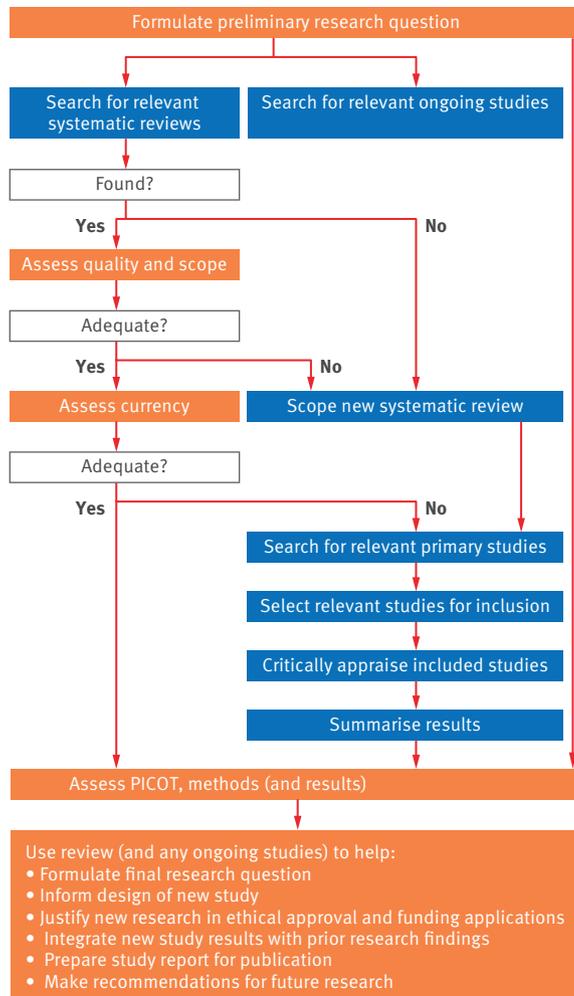
Conducting systematic reviews is resource and time consuming, and many clinical researchers are not trained to do it. Integration of systematic reviews within the research context not only challenges researchers to acquire the required skills but to make sure that any attempts to accelerate the underlying processes do not impair quality. This necessitates changes to training curriculums; close collaboration between researchers and librarians, information specialists, and IT experts; and focused investment to optimise and automate the processes.

Various initiatives in recent years have started to tackle the problem. Most prominently, a series of articles dealing with how to avoid waste in research,<sup>28-34</sup> led to the REWARD (Reduce Waste and Reward Diligence) initiative (<http://researchwaste.net/>). Other important initiatives have been launched to prepare, update, and disseminate systematic reviews more efficiently, such as the Cochrane Collaboration.<sup>35</sup> The realisation that many of the tasks of preparing a systematic review could be automated led to the International Collaboration for the Automation of



## KEY MESSAGES

- Embarking on research without reviewing systematically what is already known, particularly when the research involves people or animals, is unethical, unscientific, and wasteful
- A systematic review of relevant evidence can establish whether the proposed research is truly needed
- Some research funders now require applicants to refer to a systematic review of existing research
- Research waste can also be reduced by efficient production, updating, and dissemination of systematic reviews



Orange boxes = researcher's own responsibility

Blue boxes = step could be outsourced or performed by researcher, depending on skill set

PICOT = Details about included patient population, intervention(s) and comparison(s), outcomes, and associated timeframes

### Flow chart for evidence based research

Systematic Reviews being established in 2015. New ways to prepare and update systematic reviews have been developed, such as “living systematic reviews.”<sup>36,37</sup> Cumulative meta-analyses and other methods have been used to identify whether new research is needed.<sup>38-41</sup> Of particular interest to researchers planning to conduct a systematic review are

new user friendly software solutions (<http://systematicreviewtools.com/>). To avoid duplication of effort and ensure all reviews are published, it is now possible to register systematic reviews in PROSPERO,<sup>42</sup> with another registry dedicated to systematic reviews of animal studies (<http://www.syrclle.nl/>).

### It's everyone's problem

It is crucial that not only researchers but all other key stakeholders in the scientific process—such as patients, research funders and regulators, ethical committees, and publishers—acknowledge their responsibility for evidence based research. Research waste and unnecessary harm to patients can be prevented by granting approval only to proposals informed by a current systematic review. Demanding references to systematic reviews that synthesise all relevant earlier studies needs to become a guiding principle for all those safeguarding the research process up to publication.

Senior researchers and educators need to ensure that new researchers are taught how to conduct research that is evidence based.<sup>23</sup> Information specialists and librarians have a crucial role in teaching students to perform a systematic search for systematic reviews, and in preparing and publishing research about improved ways to perform literature searches.

Last but not least, research and adequate investment in the automation of systematic reviewing are crucial to achieving and maintaining evidence based research, as the growing size of the healthcare literature and increasing complexity of studied interventions<sup>26</sup> make it impossible to keep up with

the workload using traditional manual methods of reviewing.

### Invitation to action

The task of identifying and addressing the challenges for all stakeholders can only be confronted efficiently through international collaboration. The EBRNetwork has prepared a road map for publications (including a systematic review into the current status and effects of evidence based research itself) to raise awareness of the challenges for different stakeholder groups (implication papers) and to suggest how to deal with the tasks identified in or implied by the evidence based research statement (how-to papers). For more details, see [ebrnetwork.org](http://ebrnetwork.org).

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Cite this as: *BMJ* 2016;**355**:i5440

Find this at: <http://dx.doi.org/10.1136/bmj.i5440>

## OBITUARIES

### Harold Hillman

Neurobiologist (b 1930; q Middlesex Hospital Medical School, 1956), died from heart failure on 5 August 2016.

Harold Hillman was the second of three sons of David Hillman, a stained glass artist, and of Annie, an Edinburgh University trained GP in practice in north west London for 40 years. After qualifying Harold worked in general practice while obtaining degrees in physiology at University College London and a PhD in biochemistry at the London Institute of Psychiatry. His professional life was based at Surrey University, where he set up the Unity Laboratory. His research focused on biochemistry, physiology, neurochemistry, and, particularly, the limits of electron microscopy. He wrote six books and published more than 150 papers on various related subjects. He was a founding member of Amnesty International and active in many other organisations and societies. He leaves his wife, Elizabeth; four children; and four grandchildren.

Mayer Hillman

Cite this as: *BMJ* 2016;355:i5463



### Desmond Edward Sharland

Consultant physician in geriatric medicine Whittington Hospital; clinical teacher of anatomy University College London (b 1929, q London Hospital Medical College 1953, BSc, MD, FRCP Lon), d 12 August 2016.

Desmond Edward Sharland was appointed consultant in geriatric medicine at the Whittington Hospital in 1966. He singlehandedly looked after five acute and rehabilitation wards on the acute hospital site and more than 75 long term patients on three community sites until 1980. Between 1978 and 1993 he was an examiner in anatomy for the Royal College of Surgeons. Locally he was director of the academic centre for six years between 1967 and 1973. After retiring he continued to teach anatomy and pursue his passion for ballroom dancing and cruising, until he developed Alzheimer's disease. He leaves two children, two granddaughters, three stepchildren, and stepgrandchildren. Gurcharan S Rai

Cite this as: *BMJ* 2016;355:i5465

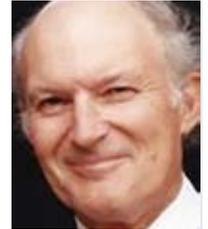


### Nicholas Dudley

Consultant surgeon (b 1938; q St Bartholomew's Hospital, London, 1964; FRCS), died from motor neurone disease on 20 March 2016.

Nicholas Dudley ("Nick") trained in London, Oxford, and Melbourne and was appointed consultant paediatric and general surgeon (with an interest in endocrine disease) to the Radcliffe Infirmary, Oxford, in 1974. In 2001, while examining at Al Quds University in the West Bank, Nick was struck by the challenges faced by the medical students. He raised funds for the group of visiting surgeons, physicians, and paediatricians who now deliver teaching for one week a year at hospitals in Bethlehem, Hebron, Ramallah, East Jerusalem, and Gaza City. Nick was a longstanding member of the Surgical Sixty Travelling Club, had a passion for underwater photography, and was a skilled restorer of antique clocks. He leaves Dawn, his wife of 51 years; four children; and 10 grandchildren. Barney Harrison

Cite this as: *BMJ* 2016;355:i5461



### Geoffrey Arthur Evelyn Baker

General practitioner Englefield Green, Surrey (b 1928; q Guy's Hospital, London, 1951), died from pulmonary fibrosis on 20 May 2016.

Soon after qualifying Geoffrey Arthur Evelyn Baker ("Geoff") met and married Margaret and remained married for 62 years. They lived in Germany for two years, for his national service in the Royal Air Force. They developed a passion for skiing, which he continued until age 86. He entered general practice in Englefield Green in 1956 and remained in the same practice for 35 years, helping to develop it into a thriving training practice. He retired from general practice at the age of 62 but continued working as medical adviser to an insurance company until the age of 86. Geoff was an active member of the Windsor and District Medical Society and was its president in 1984-85. He died three months before Margaret. He leaves four children and eight grandchildren.

Tim Baker

Cite this as: *BMJ* 2016;355:i5466



### Margaret Anne Evelyn Baker

Paediatrician Ashford Hospital, Middlesex (b 1926; q London Hospital 1952; DCH), died with dementia on 11 August 2016.

Margaret Anne Evelyn Baker (née Stuart) was born to a third generation Singapore family. She spent much of her childhood in several countries in Africa. Soon after qualifying, she met and married Geoff. They spent their first two married years in Germany. On returning to England, the family settled in Englefield Green. Margaret brought up four children and studied. She worked in community and school clinics, and as a clinical assistant at Ashford Hospital, until the late 1980s. She always kept active, playing regular tennis and golf, as well as skiing, gardening, and playing the piano. Margaret's and Geoff's health declined rapidly over 12 months, and they died three months apart. She leaves four children and eight grandchildren.

Tim Baker

Cite this as: *BMJ* 2016;355:i5467



### Thomas Bowman Madden

General practitioner and anaesthetist (b 1924, q Trinity College Dublin, 1948, MA, MD, DCH), d 23 March 2016.

Thomas Bowman Madden ("Tom") worked in hospitals in Dublin for three years in accident and emergency medicine, obstetrics, and paediatrics. During this time he met his future wife, Daphne Laughlin. He then worked in Chichester and Banbury hospitals and Denbigh Sanatorium. In 1953 he joined a general practice in Oswestry, Shropshire, and assisted in the Oswestry and District Hospital as an anaesthetist. He remained in this general practitioner post until he retired in 1987 and continued to work at the hospital. He kept up to date with medical journals and courses with particular interests in cardiology and diabetes. Throughout his life, he enjoyed pheasant shooting and fishing. For the last four years these activities were restricted because he developed renal failure and required haemodialysis. He leaves his wife, three daughters, and seven grandchildren.

Shelagh Watts

Cite this as: *BMJ* 2016;355:i5464

# Fons Sips

Helped forge a single voice for general practice in Europe

AJBI (Fons) Sips, general practitioner and senior lecturer in general practice medicine at Maastricht University (b 1940; q 1970), d 22 July 2016.

Fons Sips perhaps knew he was dying when the clinician treating him invited him to attend a presentation on liver disease, which Sips had been recently diagnosed as having. He readily accepted and, on the day, soon had the microphone, explaining his own x rays to the students. Sips knew his literature, accurately describing his treatment and prognosis, and, characteristic of a life promoting medical knowledge, it was Sips who ended up giving the lecture.

## An internationally renowned GP

In Sips's background, there was little to suggest that he would become that rare breed: an internationally renowned general practitioner. However, in 1941 the Ziekenfonds law for compulsory health insurance—which would form the bedrock of social medicine—was imposed; the obligation to register with a GP followed in 1949; the Dutch College of General Practitioners was formed in 1956; and in 1968 obligatory specialist GP training was instituted.

The elements were in place for Sips, who had spent the 1960s studying medicine and psychology at Nijmegen's Radboud University, to join a generation of family doctors that would ensure a dominant place for general practice in Dutch healthcare.

Sips was primarily a "valued and passionate" local GP who singlehandedly ran a practice in Vught, a small town in Brabant, for 34 years.

Yet he did not simply accept general practice as it was. His first target was GP checks for the contraceptive pill. GPs were required to physically examine female patients although there was little evidence of any benefit, and many simply found the consultations embarrassing. A gradual consensus developed

into professional guidance based on giving information, advice, and checking blood pressure before issuing a prescription. Sips became "the man who abolished pill check-ups in the Netherlands"—one of the first achievements of evidence based medicine.

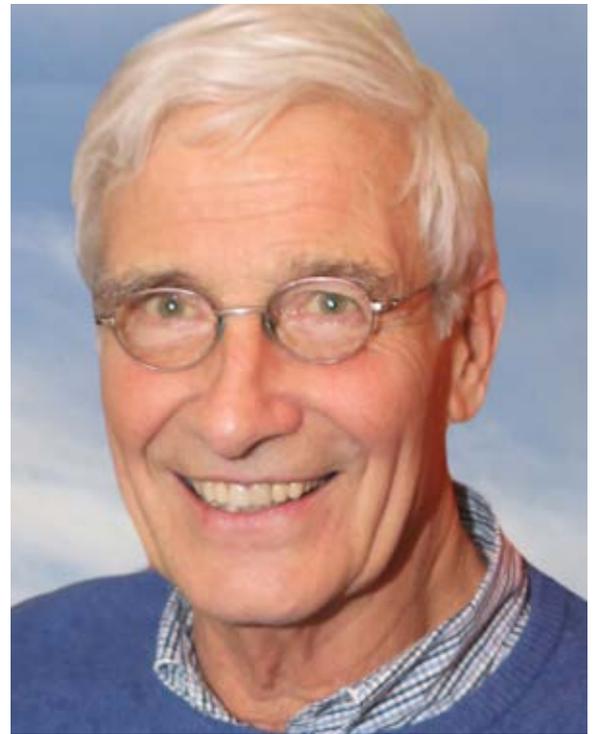
## Evidence based practice

Meanwhile awareness was increasing among GPs that evidence, rational prescribing, and guidelines were needed to make general practice more professional. Prescribing and referrals had been subject to enormous unexplained variations. Sips was in his element. By 1985 he was leading the "protocol project" for the college of general practitioners, where a team examined the existing medical literature for everything from osteoporosis to sinusitis in children. From 1987 to 1993 Sips sat on the college's coordinating committee on standards and was responsible for chairing its second guideline on hormonal contraception. Once all the guidelines were published, the numbers of GPs belonging to the college rose dramatically, and now nearly all GPs are members.

Sips's passion was illustrated by the controversy that surrounded the college's 1999 guidance on treating osteoporosis, which advised a very circumspect use of oestrogen, vitamin D supplements, and bisphosphonates. One university hospital consultant endocrinologist slammed it as "navel gazing." But for Sips, evidence for medication to treat what was, for most, a natural symptom of ageing was inconclusive. The guideline first recommended information on diet and lifestyle. It would, he argued, "offer GPs a possibility of resisting an industry that has a great interest in a large group of people taking medication in the long term."

## SIMG and WONCA

By the end of the 1980s Sips's work went beyond the Netherlands as he helped to forge a single voice for general practice in Europe.



Fons Sips's last act on the international stage was to encourage the next generation of GPs

Since 1987 he had been a member and president of the Societas Internationalis Medicinae Generalis (SIMG) or International Society of General Practitioners. Now, working together with Lotte Newman, a former president of the Royal College of General Practitioners, he negotiated a merger with a rival: the World Organisation of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians (WONCA).

In 1995 WONCA Europe was launched at the European parliament in Strasbourg. It was soon followed by the launch of the *European Journal of General Practice*—one of Sips's initiatives.

Sips's last act on the international stage was to encourage the next generation. He arranged a preconference workshop for trainees at WONCA's 2005 regional conference in Amsterdam, where Europe's GPs of the future could find their own voice. Known as the Vasco da Gama Movement, the group honoured him by creating the Fons Sips Outstanding Achievement Award.

He leaves four children; their mother, Dorothé; and his second wife, Marie Louise.

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Cite this as: *BMJ* 2016;354:i4892

## ALL HOME GROWN DOCTORS

**Non-home grown NHS staff feel insecure and unwelcome**

The aim to expand “home grown” doctors (This week, 8 October) prompts Toynbee to write in the *Guardian*, “The puzzle is why anyone would insult the one third of NHS doctors born abroad by suggesting they are only ‘interim,’ as [Theresa] May said.”

As ministers refuse to guarantee EU staff’s right to stay, workers feel insecure and may slip away. Simon Stevens of NHS England wrote, “It should be completely uncontroversial to provide early reassurance to international NHS employees about their continued welcome in this country.”

There’s nothing wrong with increasing new doctors’ training, but underneath these promises of self sufficiency lies thinly disguised blame on outsiders for the country’s ills. This was a theme at the Tory conference, in which the home secretary said that she wanted to “name and shame” businesses that fail to take on British workers.

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Cite this as: *BMJ* 2016;355:i5687

## CANCER DRUGS FUND REFORM

**Cancer Drugs Fund: the bigger picture**

We welcome the authors’ creative ideas on the appraisal of cancer drugs (Editorial, 1 October). But they are wrong to imply that the Cancer Drugs Fund exists only to support observational data collection.

When a treatment is recommended through the fund, a formal data collection arrangement is drawn up, outlining the key areas of uncertainty and explaining how they will be tackled. Longer term overall survival data from ongoing randomised clinical trials can be included. Companies receive reimbursement that reflects the decision uncertainty:



JAMES GOURLEY/REX

## LETTER OF THE WEEK

**Medicine thrives on experience from abroad**

It’s taken the health secretary four years to concede that the NHS is not self sufficient in producing the correct number of doctors (This week, 8 October).

A fully home grown doctor workforce won’t mean more “domestic” doctors if the removal of the cap also applies to international students wishing to study here. An additional levy from these students would make them more attractive to universities, which would have the opposite effect to the policy’s aim.

Medicine is an international learning community that thrives on the interchange of experience and knowledge. It thrives on British doctors being able to go abroad and serve communities—and, more importantly for NHS patients, on overseas doctors being able to bring their experience from abroad.

Training more doctors is a welcome move, but it shouldn’t be seen as an alternative to recruiting highly skilled and expert overseas staff. To simply close our borders would be terrible for patient care. Without international doctors the NHS can’t cope.

The GMC must now ask whether the significant increase in medical students on wards and in theatres is safe. Clinical placements remain saturated in the context of the current cap, so this difficulty can’t be ignored.

Retaining the current workforce must be the priority. We can have more doctors if we make the NHS attractive for those who currently work in it.

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Cite this as: *BMJ* 2016;355:i5699

greater uncertainty means lower reimbursement during the data collection period.

Concerns about NICE’s rigour are also misplaced. The fund offers patients rapid access to the most promising treatments when key clinical uncertainties remain. Regardless of whether the evidence is from clinical trials, observational data, or a combination of the two, NICE’s appraisal is driven by its robustness and quality and whether it is fit for purpose.

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Cite this as: *BMJ* 2016;355:i5644

**New Cancer Drugs Fund solves the wrong problem**

I agree with the proposal from Grieve et al (Editorial, 1 October) to allocate money from the Cancer Drugs Fund to randomised studies, though for different reasons.

The collection of observational data by the new fund will not tackle key uncertainties related to long term outcomes. If observational data are collected from the time of a NICE decision, they are unlikely to arrive before the patent on the drug expires or the drug is replaced by a more effective treatment.

The revised fund solves the wrong problem. At the point of NICE assessment we generally have information on how the drug will perform over the first few years. But we lack data on the long term outcomes, which would be better collected in extension studies to the original clinical trials.

The fund will rarely aid decision making and is unlikely to improve the health of the population.

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Cite this as: *BMJ* 2016;355:i5619

## LEADING ON CLIMATE CHANGE

**We must “think globally, act locally” on climate change**

We agree with Ramanathan and Haines that climate change poses a grave threat to global public health (Editorial, 8 October).

We concur that healthcare professionals should be active participants in the climate change debate and sometimes lobbyists. But we should be realistic about how much influence they have. Strategic policies affecting climate change are driven primarily by economics and politics, not health. And few, if any, healthcare professionals can match the scale, sophistication, and determination of professional lobbyists.

The environmental movement gave us the slogan, “Think globally, act locally.” This is relevant to healthcare professionals, who should combat climate change locally, with a view to global benefits.

Climate change attributable to healthcare should be minimised by improving public health. Through improved interventions, our population can become healthier for longer, which implies less ill health and a reduction in healthcare related climate change effects. This could be a rare win-win scenario.

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Cite this as: *BMJ* 2016;355:i5686