> Management consultants cost the NHS £630m in 2014 despite a lack of evidence that their proposals saved money or delivered safer care

NO HOLDS BARRED Margaret McCartney PPA COLUMNIST OF THE YEAR

Save billions without cutting care

The Public Accounts Committee is doing what it does well: counting the pounds and asking where the pennies are. Its reports are worth reading, as examples of cross party truth seeking.

But what of its most recent report, *NHS Treatment for Overseas Patients*. This concluded that the NHS and Department of Health must do "more to promote public confidence that the money due to the NHS is being recovered, and that the system is fair to taxpayers and to patients who are entitled to free care." The committee says that a target of £500m is to be recouped in 2017-18.

Right on cue, Jeremy Hunt announced a crackdown. From 1 April hospitals in England will have a legal duty to charge patients who are not UK residents before any non-urgent, planned treatment.

The planet's power axis is shifting. Donald Trump is unleashing a vitriolic assault on the rights of US citizens on the basis of their birthplace. Unchecked anger and false statements litter his Twitter feed. We in the UK seem to have made friends with Trump while expensively trying to disengage from our European neighbours.

It's worth remembering that people who voted for Brexit were lied to, infamously, with the claim that "£350m a week" could go to the NHS instead of the EU.

The Public Accounts Committee is right in seeking to protect NHS funds. Meanwhile, many sections of the media seize on stories of people coming to the UK to allegedly take advantage of healthcare they can't afford to pay for.

We don't know what the £500m target will cost to recoup. It will be time spent on identity checks, paperwork, a new staff administrative department, debt collectors, and a portion of debt that will be documented, forever unpaid, and written off. This is high value spending: people from other countries get the treatment they need in a crisis. What of the poor value spending in the NHS?

Management consultants cost the NHS £630m in 2014 despite a distinct lack of evidence that many of their proposals saved money or delivered safer care. The seven day services policy has been costed by economists as requiring £1.07bn-£1.43bn to implement—despite a lack of evidence that it will eradicate the "weekend effect." The cost of implementing the Health and Social Care Act 2012 is estimated at around £1.5bn.

Some ways to save money don't rely on not treating people, and for decades mechanisms to recoup money have been available. The focus on charging overseas patients shows a health secretary trying to limit embarrassing press coverage rather than trying to tackle the big problems facing the NHS.

Some other costs are worth counting. About 40% of NHS doctors qualified outside the UK. If the NHS treats only patients who produce a passport, what would the impact be for those doctors we need here, and their families?

Collecting fees owed to the NHS is part of a systemic and global problem, and it can be tackled better at government level. In the meantime, we should be taking better care of billions of pounds at home.

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PERSONAL VIEW Jonathan Glass

Irrational numbers in surgical training

Standing unscrubbed in a theatre so you can say you've seen a procedure should not be a part of surgical training

I enjoy numbers. I enjoy the accuracy they provide and the guidance they give in the practice of clinical medicine. In medicine we should not allow numbers to be arbitrarily bandied about, yet this still happens.

If you were applying for a certificate of completion of training (CCT) in urology in 2015 you had to have seen or assisted in at least 20 radical prostatectomies before being signed off as competent. A year later, for no clear reason, it appears that 10 will do.

Changes to the required numbers of various procedures to which a trainee needs to be exposed are often made year on year, and yet failure to achieve these "indicative numbers" is increasingly a reason for a CCT application to be referred back to the candidate.

I have a problem with urology's indicative numbers. As shown by the arbitrariness of changes to the numbers year on year, the actual numbers seem to be plucked out of the air. On what basis does watching 10 cystectomies (it was 15 in 2014) make you a trained urologist in a way that watching seven wouldn't have done? How do we know that observing 10 is enough? Why were 20 radical prostatectomies necessary if you applied for a CCT in 2015, but now 10 is sufficient? Who's to say that five won't be enough in 2019?

Trying to achieve these arbitrary numbers has a big impact on training. The final year of training should be spent becoming very good both in the area in which you will be marketing yourself when applying for a consultant post, and at the surgical procedures you will be performing. Instead, the final year of training is spent watching—not doing—procedures the trainee won't ever do as a consultant, just to achieve the CCT.

The final year of training is spent watching—not doing—procedures the trainee won't ever do as a consultant

Surgical experience used to be acquired by trainees making themselves available—exposing themselves to as many procedures as possible to become good at their art. Standing in a theatre, unscrubbed, so you can say you've seen a procedure was never a part of surgical training, nor should it be now. It has no value. Unless you are very good at the procedure already and you are learning nuanced techniques from a master surgeon, watching a procedure will never make you a better surgeon. Trainees should spend their training doing the things that they'll be spending their lives doing, not watching procedures they will never perform.

ACUTE PERSPECTIVE David Oliver

Hotel chains are no answer to hospital bed crises

Roy Lilley, the ubiquitous health pundit, wrote in January of the need for radical solutions to current NHS crises rather than medical colleges endlessly campaigning for more resources.

Lilley then set out some big, audacious ideas of his own. One was that, to "get the thousands [of people] marooned in hospital home safely," we should "block-book Premier Inns; create step-down care. It's £45 a night. Include a matron and some care assistants and you'll do it for £150. Hospitals cost £400."

Packing patients off for a bed-to-chair existence, with no equipment or physiotherapy, isn't the smartest move

Does this idea bear scrutiny? Who are these patients stranded in hospital, and will it help them?

Many are awaiting transfer to care homes. They are often still very unwell and dependent on care. Dementia, severe frailty, impaired continence, and mobility are the norm in long term care, along with multiple comorbidities. Median survival time from entering a UK nursing home is only nine months, so end of life care is key, and acute admissions to hospital are frequent. Are budget hotel chains geared up for such needs—even with care assistants?

Then we have those patients waiting for step-down intermediate care, whether at home or in community facilities. They aren't going for convalescence or a rest cure, but for rehabilitation requiring a skilled multidisciplinary approach. Without comprehensive assessment and rehabilitation, long term disability and dependence and the inability to return home are more likely.

We know that bed rest carries a whole range of harms and risks, especially for older, frailer people. Packing patients off for a bed-to-chair existence, with no moving or handling

MARK THOMAS/SPL

Numbers are important to trainees. They should know the numbers of any procedures they have done, how many grams of prostate they resected, how many complications they have had after performing hydrocele repairs or ureteroscopies. They should know the percentage chance of becoming incontinent after radical prostate surgery, and the creatinine of the patient they are looking after on the ward after a cystectomy.

We have lost our way in much of what is important in medicine. It's time that we focused on what really makes a surgeon better and stopped the pointless processes that surround training. Superficial number crunching does nothing to improve the quality of the trainee. Let's abandon indicative numbers and put trainees into the theatres that they want to be in, where their training is hands on, and where they know the patient and can follow them postoperatively.

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equipment or pressure relieving mattresses and no physiotherapy, isn't the smartest move. Soon we'd see "exit block" from the hotel too, when they were so dependent that no facility could take them.

In practice, patients on step-down hospital wards, in community hospitals, or in step-down beds in care homes still require skilled medical input—which is unsurprising in view of their medical complexity and risk of further deterioration.

Given the workforce and workload crises in general practice and community nursing, as well as struggles in providing clinical input to existing facilities, where would clinical input come from for patients decanted into budget hotels? We also have a national recruitment crisis among care assistants. Moving a few of them from home care to hastily commissioned hotel beds will solve nothing.

Lilley's idea doesn't stand up. Sometimes the radical idea was in fact the obvious one all along. We need to resource social and community health services properly to enable patients to leave hospital. And clinicians have a professional imperative to keep saying so, even if those such as Lilley might find it boring.

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BMJ OPINION Tom Nolan

Freeing up some cognitive bandwidth in general practice

How many tabs have you got open on your web browser? I've got 27. It's no mystery then, why my computer is grinding to a halt, suffering petit mal absences every time I click. This is how I feel after a morning surgery. Although I start the day with good intentions to do my referrals and jobs as I go along, things never go to plan. As I run later and later, rather than completing the task straight away, I add it to my list—my brain's equivalent of opening up a new tab.

The later I run, the more frazzled I get, and the more "opening up a new tab" becomes the answer to people's problems—Mrs Jones's headache becomes a neurology referral instead of finding out what's really going on in her life, for example. The more tabs I open, the greater my sense of impending administrative doom. My system runs slower and slower.

Ten minute appointments crammed together is a recipe for overloaded brains

At the end of a clinic my tabs are still all open: complete the physio referral, email the diabetes nurse, write a stroppy response to a discharge letter. The longer they're open, the less important they seem. That's when it becomes a real problem and the errors and complaints pile up.

As soon as waiters hand orders to the kitchen, they immediately forget them. Until that point they remember them perfectly. This is called the Zeigarnik effect. So if you want to remember something, leave it incomplete. If you don't, finish it. I don't want to remember. I don't like missing half an episode of *Game of Thrones* because I'm thinking about Mrs Jones's neurology referral.

So why do we design our workload to leave things unfinished? Ten minute appointments crammed together for a whole morning is a recipe for overloaded brains. If you wanted to create a system that produced unfinished jobs this would be it.

If we can close our tabs—or not open them in the first place—we can free up some bandwidth and focus on the patient in front of us. This doesn't take more money or government intervention, just a change in how we work.

Fifteen minute appointments enable this and help me enormously. Having a reliable, trusted system for sorting and storing our tasks also helps, and GPs are fortunate to have sophisticated systems for task management. Grouping similar tasks to do together can help too: phone calls, referrals, incoming letters.

When planning time, some use the 60:20:20 rule: allocate 60% of time for planned work and 20% for unplanned work. The last 20% is for socialising, which might include a clinical meeting or talking over coffee—all of which free up bandwidth.

Tom Nolan is a GP partner in south London

ANALYSIS

Time for the UK to commit to tackling child obesity

The government missed an opportunity for global leadership on child obesity. Now it's time to act, say **Mark Hanson and colleagues**

KEY MESSAGES

- Preconception, gestational, infancy, and childhood factors contribute towards lifelong health, overweight, and obesity
- The UK government's action plan for childhood obesity is severely limited
- It could be considerably strengthened by incorporating further evidence based interventions recommended in WHO's ECHO report
- Healthcare professionals should use their national and global professional networks to coordinate action between sectors including education, industry, government, and the public

The UK government published its report *Childhood Obesity: a Plan for Action*, after a protracted delay, on 18 August 2016, when parliament was in recess.[1] The plan received very little media coverage or public response. There was, however, an immediate outcry from the medical and public health communities.[2-6] The draft version had been 50 pages, but the published plan ran to just 10; strong actions were conspicuous by their absence, and the desired discussion of anti-obesogenic medicine had been watered down to an emphasis on voluntary actions by industry, consumers, and schools.

One of the most important omissions was reference to the recommendations of the World Health Organization Commission on Ending Childhood Obesity (ECHO).[7] The final ECHO report was presented at the World Health Assembly in May 2016.[8] An implementation plan to guide further action on the recommendations is now available.[9]

Missed opportunity for global leadership

The ECHO report directs specific actions and responsibilities to governments of member states. These include an industry levy on sugar sweetened beverages, nutrient profiling to identify healthy and unhealhty foods, clearer food labelling, and promotion of physical activity in schools.

The UK strategy took up these recommendations but failed to link them back to the ECHO report, an omission which misses the opportunity for the government to show global leadership in child health. Other recommendations, such as stronger controls on advertising, mandatory food reformulation, and nutrition education, were absent from the report.

What's missing from the UK's plan?

The plan notes the short and long term damage to people's health from obesity, but it fails to recognise that overweight and obesity in children and young people are driven by multiple modifiable biological, behavioural, environmental, and commercial factors, some of which operate before conception and birth.[14] Nor does it recognise that the harm extends across generations. This failure represents a major lost opportunity for effective prevention.

Many communities typically affected by undernutrition are now experiencing overnutrition through changes in diet, sedentary lifestyles, and a lack of focus on promoting broader health. In these settings, the adverse health effects of poor maternal health and childhood stunting are amplified by the increased risk of later overweight and obesity.[15] Furthermore, the rising prevalence of maternal obesity and gestational diabetes is driving childhood obesity in the next generation.[16] Such problems are particularly acute in lower socioeconomic and educational attainment groups—those least equipped to meet the challenge. The government's plan mentions the marked association between socioeconomic adversity and childhood obesity but not the steps to tackle this growing inequity.

> Voluntary actions have so far been ineffective in halting the rise in obesity

Interventions that might improve unhealthy trajectories that start in early development are largely based on evidence from animal research[17] or observational studies and small randomised controlled trials in humans.[18] This is partly because some interventions can't feasibly be randomised but also because outcomes are difficult to evaluate a long time after the intervention. Reliable markers of obesity risk are scarce. The government's plan does not mention the need to strengthen the evidence base for population interventions. Scientific and political communities should agree on approaches to define interim policies for intervention based on existing evidence, and their robust evaluation, so they can be fully accepted, modified, or rejected as appropriate.

The idea that obesity prevention is predominantly a matter of personal or parental responsibility is unhelpful. Infants and young children are wholly vulnerable to the actions of adults and to the broader societal factors that create an obesogenic environment, including the marketing practices of industry. A sole focus on personal responsibility is likely to result in guilt, resistance, denial, and perpetuation of the problem. Voluntary actions, ranging from people trying to lose weight to industry developing healthier products, have so far been ineffective in halting the rise in obesity, so the government's emphasis on personal choices and voluntary measures by industry is especially disappointing. Fiscal and regulatory measures, such as taxes and regulations on the marketing and packaging of cigarettes, have brought enormous benefits to child and population health; governments should not hold back from taking such actions to protect children.

Healthcare professionals alone are not adequately positioned and do not have the resources to tackle this multifactorial, societal problem that spans government, industry, education, and the public.[19 20] Other professionals such as nursery and school staff, pharmacists, health visitors, social workers, and dentists could assist in generating the wider cultural movement needed, especially in engaging hard-to-reach groups such as migrants and those with lower educational or socioeconomic attainment.

What can we do now?

Measures to tackle factors behind childhood obesity that would benefit individual health, even though a causal relation may be uncertain, should be put in place immediately. The government's plan doesn't mention any of these factors, which include avoiding parental smoking, reducing high pre-pregnancy body mass index, avoiding excessive gestational weight gain, and encouraging breast feeding.[21 22]

Children have different metabolic set points depending, in part, on the intrauterine environment in which they develop. So a focus confined to calorie restriction or physical activity will give variable, and often disappointing, results. Weight and body mass index are easy indices to measure, but people are likely to appreciate a focus on health and fitness rather than just weight, and this may allow more nuanced and positive messages to be conveyed to the public. The government's intention to promote physical activity is excellent, but it will be insufficient in isolation; the public need education to improve nutrition literacy and awareness of the benefits of physical activity regardless of weight.

Constructive discourse with the private sector is essential. The relations between national governments or international agencies and industry have been variable, and some public health communities have resisted such engagement. Multinational corporations operate across national jurisdictions, so we need a wider global approach in which clinical, professional, and scientific organisations have a potentially powerful contribution to make.

Engagement with industry needs to take into consideration trade issues and how to manage conflicts of interest. Engaging with industry may not be possible for organisations such as WHO, but the implementation plan for ECHO commits to developing guidelines for engaging with the private sector in consultation with member states.[9]

Let's create a global alliance

Individual and population health are the fundamental capital of society. We need to recognise this and prioritise the development of evidence informed policies to promote healthy development in infants, children, and young people. This links clearly to the sustainable development goals,[23] which offer an unprecedented opportunity for global collaboration and action. Lack of action to tackle childhood obesity goes against the United Nations Convention on the Rights of the Child (Article 24), which recognises "the right of the child to the enjoyment of the highest attainable standard of health," and, given the substantial economic costs of overweight and obesity, is counter to national economic wellbeing.

We do not know why the UK government reneged on delivering the promised and much needed strategy, but we do know that the value of investing in long term population health is often compromised by the short term focus of politics. We need ongoing advocacy and leadership by groups independent of governments and the development of approaches that recognise the necessity for a life course approach to achieving health across generations.

We need an initiative comprising relevant legislation, an accountability framework, sustained public engagement, and global advocacy campaigns, underpinned by research and evaluation and led by professional bodies, academic societies, and research institutes. Action is needed across five sectors: education, healthcare, government, industry, and the public. A coordinated approach would involve not only top down provision of resources to assist behaviour change in the sectors of the population most at risk but also bottom up creation of demand. Engaging young people is crucial, as they will be the parents of tomorrow and can be agents of change.[24]

Suggested roles of a global alliance

- Emphasise the need for a life course approach to safeguard the health of individuals, populations, and future generations
- Advocate for a "whole society" approach to wellbeing
- Champion the concept that the preconception period constitutes an important opportunity for engaging future parents
- Push for effective training of a wide range of health and education professionals in how to engage parents, children, and young people with the issue of overweight and obesity
- Formulate a set of key questions around preventive measures and methods of implementation for which a national or international guideline might be justified; approach WHO or other agencies to establish a systematic review group to answer these questions
- Set key research priorities in basic science, healthcare, and societal interventions that target infancy and the preconception period; approach funders to commission research in these areas and catalyse partnerships to deliver studies
- Broker dialogue between industry, policy makers, scientists, educators, professional bodies, and children and young people
- Campaign for government actions on relevant policies, regulation, fiscal actions, and investment

Investing in long term population health is often compromised by the short term focus of politics

Healthcare professionals are respected by the public and other professionals and have direct reporting mechanisms to governments. They have existing, well organised professional bodies that routinely cooperate within and across nations. We therefore propose a new initiative to coordinate between these sectors: a global alliance against child obesity led by an international alliance of healthcare organisations (box). This alliance would be ideally placed to liaise with other bodies for which this area is a priority, such as WHO,[7 9] FIGO,[25] and the Lancet Early Child Development Series group.[26] We hope that the government would work with the alliance to build on their plan for action and develop it into a strategy for childhood and future societal health.

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OBITUARIES

Elsa Mary Bradshaw

General practitioner (b 1927; q Manchester 1951), died from Alzheimer's dementia on 20 November 2016

Elsa Mary Bradshaw moved with her husband to Leicester Royal Infirmary in 1964 and became a clinical assistant in the radiotherapy department. She subsequently worked for the local authority, involved in child development and educational psychology. In the late 1960s she became a general practitioner in Syston, Leicestershire. After moving to Sheffield with her husband in 1977, she continued to work as a GP on a large council estate in the east of the city. She became a partner and then principal partner in this practice. After retiring in 1988, Elsa was a reader in the Anglican church and a Methodist local preacher. For 15 years she undertook assistant lay chaplain duties at Harrogate and District Hospital, for one day each week. She died after a short stay in a nursing home in Ripon.

J David Bradshaw

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Peter Gordon Gaskell

Generalist (b 1924; q Glasgow 1949; MD 1967, FRCGP), died with rectal cancer on 5 September 2016

Peter Gordon Gaskell was a singlehanded GP in Law, Lanarkshire, for seven years before being appointed lecturer at Edinburgh University. Five years later he reverted to full time singlehanded general practice in north central Edinburgh and subsequently formed a group of small practices (Eyre Medical Practice) with two other singlehanded practitioners. He worked there for 18 years and continued as a GP trainer. He retired in 1984. An elder in the Church of Scotland, he was Boys Brigade officer and vice president of the Edinburgh Battalion. In retirement, he chaired the Edinburgh Council for Single Homeless and was honorary secretary of the Scottish Council of the Royal College of GPs for three years. Predeceased by one son and by his wife, Margaret, he leaves three children, seven grandchildren, and a great grandson.

Philip Gaskell

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Robert Hope Mackay

General practitioner Churchdown, Gloucestershire (b 1947; q Guy's Hospital, London, 1971; MRCS Eng, FRCGP), died from metastatic melanoma on 20 October 2016

Robert Hope Mackay ("Rob") trained at Guy's, later working in London, where he met and married Fran, a nurse. Rob became a GP in Churchdown, Gloucestershire. During 30 years in practice, Rob epitomised the very best qualities of personal family doctoring. Rob made major contributions to GP education, for 18 years as a trainer and later as course organiser. Rob was passionate about rugby and was Gloucester rugby club's official doctor for 16 years. Despite being diagnosed with stage 4 malignant melanoma in 2010, he was helped by emerging treatments. During the next six years he achieved a BA in history with distinction and enjoyed more time with the family he lived for. Rob leaves his wife, Fran; four children; and eight grandchildren.

William Foster

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Swati Karmarkar

Consultant anaesthetist with a special interest in transplant and regional anaesthesia Manchester Royal Infirmary (b 1968; q Tver State Medical Academy, Russia, 1994; MD, FRCA), died from lung cancer on 12 November 2016

Swati Karmarkar started her training in anaesthesia in Mumbai in 1996. She married Amar in 1998, and their daughter, Sejal, was born in Delhi the following year. The family moved to the UK in 2000. Swati did her specialty training in anaesthesia in the North West Region in 2003 and was appointed as a consultant at the Manchester Royal Infirmary in 2008. An educationalist, researcher, and clinical governance lead, she remained in contact with colleagues during her cancer treatment and maintained a keen interest in developments within the anaesthetic department and at Central Manchester University Hospital. She leaves Amar and Sejal.

Chandran Jepegnanam, Sian Jones, Adam Pichel

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Timothy Daniel Heymann

Consultant physician and gastroenterologist Kingston Hospital (b 1961; q Christ's College, Cambridge/St Thomas' Hospital, London, 1986), died from a glioblastoma on 18 October 2016

Timothy Daniel ("Tim") Heymann became a doctor, notwithstanding an MBA at INSEAD, time with McKinsey management consultants, and a lifelong love of flying. He worked at Kingston Hospital for all but three years of his career. He delivered health management programmes at Imperial College Business School, hosted examinations for the Royal College of Physicians, and chaired the information group of the British Society of Gastroenterology. Tim was a member of the UK government's Risk and Regulation Advisory Council, and a non-executive director of NHS Direct and Monitor. His main satisfaction came from adding pleasure to patients' lives, opening career opportunities for students, and spending time with his wife and children.

Timothy Daniel Heymann

Cite this as: *BMJ* 2017;356:j290

James Cyprian Swann

Consultant radiologist Bromley Hospitals NHS Trust (b Madagascar 1931; q London Hospital Hospital 1959; FFR, FRCR), d 28 December 2016

James Cyprian Swann ("Jim") was born in Madagascar to missionary parents and had a strong Christian faith. He completed two years' national service in the Royal Artillery and then worked as a consultant at the London Hospital for nearly a decade, before moving to the Bromley group of hospitals. Alongside David Rickard, Jim raised nearly half a million pounds to purchase a computed tomography scanner, which was installed at Farnborough Hospital, to which he introduced cross sectional imaging. He helped to set up the symptomatic breast clinic at Farnborough Hospital, working with two breast surgeons, an oncologist, a pathologist, and a radiologist. He leaves his wife, Josephine; three daughters; seven grandchildren; and a great grandson.

Clare Humber

Cite this as: *BMJ* 2017;356:j293

Rosamund Snow

Researcher and campaigner for patients' involvement in healthcare

Rosamund Snow (b 1971; PhD, MReS), died by suicide on 2 February 2017

On her first day as *The BMJ*'s patient editor in 2014 Rosamund Snow disclosed that a favourite pastime of hers was watching classic episodes of *Coronation Street*. Early storylines in the long running ITV soap were a particular draw, she said, especially rows between Ena Sharples, the street's self appointed moral guardian, and Elsie Tanner, the middle aged single mother looking for Mr Right. Snow admired Elsie's struggles to gain understanding and respect and her resilience in the face of censorious neighbours.

While at *The BMJ*, Rosamund Snow challenged internal systems and processes if she felt they weren't helpful to patients

Placing patients centre stage

Perhaps Snow drew parallels between Elsie's battle for recognition and a similar one waged by patients. Like Elsie, patients are often misunderstood and excluded from conversations. Snow fought to place patients centre stage in debates about service quality improvement and medical education.

Hers was a portfolio career that at the time of her death at the age of 46 straddled *The BMJ*, an academic research post at Oxford University's Nuffield Department of Primary Care Health Sciences, and a collaboration with DeepMind, Google's artificial intelligence research venture, advising on its patient and public involvement strategy.

Snow had been diagnosed with type 1 diabetes as a teenager, and among her first forays into service user research was in 2008, when a consultant at her outpatient clinic in Oxford asked if she would help to investigate its 15.7% DNA (did not attend) rate. Her audit showed that in 61% of cases patients had either not been told of the appointment (often because a change of address had not been recorded) or they had spent up to 20 minutes trying to get through by telephone, often without success.

"Lightbulb" moment

Snow's "lightbulb" career moment was in 2009, when her partner, Stephen Barton, noticed a newspaper advertisement for paid PhD programmes at King's College London. At the time she was part of Transport for London's research team. She secured funding for both a masters degree in research and a PhD, which she gained in 2013.

In her role at Oxford, she helped to develop patient involvement in curriculum design and taught communication skills to medical students, working alongside GP principal Helen Salisbury.

Despite being an Oxford academic, Snow was decidedly "town," not "gown," with spiky bleached hair and a penchant for wearing high heels. An only child, she grew up in the Oxfordshire village of Finstock, where she learnt the trombone, acting, and performing at local venues with her musical mother, Mary, a psychiatrist. After graduating with a politics degree from Sheffield University in 1993 and completing a postgraduate diploma in publishing at Oxford Brookes University, she settled in east Oxford.

The BMJ provided a return to academic publishing (her first job was at Blackwell). At the journal she assertively challenged internal systems and processes if she thought they weren't helpful to patients and actively championed *The BMJ*'s patient partnership strategy (www.bmj.com/campaign/patient-partnership). With a skilled mix of advocacy, innovation, and good humoured support she worked tirelessly alongside fellow editors and authors to help them understand what patient involvement really meant and how to advance it in research and medical education, by involving patients as peer reviewers and coauthors. She also spearheaded a move to include patients on the judging panel for the annual BMJ Awards and advocated for other journals to take up the "patients included" baton.

In January 2015 she launched a new article type, "What your patient is thinking." Unlike "Patient journeys," which they replaced, WYPITs (as they have come to be known) were not coauthored and did not include a clinician's view. Instead they are "owned, led, and edited by patients," with titles such as "Before I kick the bucket, I want to say thank you," "Why there's no point telling me to lose weight," and "Excuse me, doctor: I can still hear you."

Snow leaves Stephen; her parents, Mary and Gordon; two stepdaughters; and three step grandchildren.

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bmj.com

Read a tribute by Paul Buchanan at http://bmj.co/paul_on_rosamund

LETTER OF THE WEEK

Post-Ebola reforms

We at the World Health Organization agree that most of the 11 000 Ebola deaths in west Africa could have been prevented had the world been better prepared (Analysis, 28 January). Affected countries had broken health systems, rudimentary capacities for research and logistics, and no early warning systems. Clinicians had unsafe treatment centres, no vaccines, and too little protective equipment. We have a long way to go.

But substantial reforms are under way. WHO's new emergencies programme is using procedures established during humanitarian crises to tackle disease outbreaks and helping to strengthen early warning and rapid detection systems. A formal process for vetting emergency medical teams assures a quality controlled workforce with surge capacity.

WHO's Pandemic Influenza Preparedness Framework has secured access to around 350 million doses of vaccine to prepare for the next pandemic and has enabled investment of more than $110m to build capacities in developing countries.

WHO's blueprint for research and development has been applied to expedite the development of new products for Zika virus disease. The Coalition for Epidemic Preparedness Innovations, which draws on the blueprint and WHO's list of priority pathogens, holds great promise for developing vaccines ahead of epidemics.

We stand at a critical moment. The international community must seize the opportunity to build on lessons learnt during Ebola, to ensure a cohesive, adequately funded approach to global health security.

Margaret F C Chan (chanm@who.int)

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FETAL MONITORING

Intrapartum cardiotocography and cerebral palsy

Nelson et al call for a task force to consider whether electronic fetal monitoring in labour reduces the risk of cerebral palsy (Analysis, 10 December). But that isn't the issue. Cardiotocography detects hypoxia and acidaemia. Most cases of cerebral palsy are associated with antenatal, not intrapartum events, and are unlikely to be associated with fetal hypoxia and acidaemia in labour.

The authors don't mention that cardiotocography use is associated with an approximate 50% reduction in neonatal seizures, most of which are hypoxic in origin and due to intrapartum events. The long term motor and cognitive outcomes of hypoxic seizures are guarded at best. Paradoxically, hypoxic seizures may disproportionately affect low risk pregnancies, as these women undergo intermittent fetal heart auscultation rather than continuous cardiotocography.

Whether an increased caesarean rate is an acceptable trade-off is a decision for the mother, informed by carefully weighed professional opinion.

Christoph Lees (christoph.lees@imperial.nhs.uk)

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Authors' reply

As Lees mentions, children whose births were monitored electronically had significantly fewer neonatal seizures (Analysis, 10 December). But the meaning of this association is unclear; in the large Dublin study incidence of cerebral palsy did not differ according to method of monitoring in labour among those with neonatal seizures or the total.

Neonatal seizures have many potential causes, including infection, toxins, and perinatal stroke. We cannot accept Lees' assumption that most seizures in the fetal monitoring trials were "hypoxic in origin and due to intrapartum events" because neonatal seizures that are due to acute intrapartum hypoxia-ischaemia are usually accompanied by low Apgar scores, cord blood acidosis, and need for special care. None of which occurred more often in the auscultation group.

The long term effects of preventable neonatal seizures remain unknown, while the effects of electronic fetal monitoring—more surgical deliveries, higher costs, and more litigation—are well established.

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THE BMJ CHRISTMAS APPEAL

Exorbitant cost of lenses used by Orbis

I am a great supporter of charity work overseas, especially for cataract surgery, which transform people's lives. But I am aghast at the quoted cost of £25 per intraocular lens (*The BMJ* Christmas Appeal 2016, 28 January).

I know of good quality implants that are much cheaper—£150 could buy 150 implants. How does Orbis justify the cost of the lenses it uses?

Jennifer A Watts (jenpalwatts@hotmail.com)

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Reply from Orbis

Orbis says that "£150 could buy six intraocular lenses for cataract surgery." Laura Burnell, Orbis UK's head of communications, told me that this price is given in the International Agency for the Prevention of Blindness's standard list of recommended equipment and consumables.

"The lens was chosen as it is suitable for the type of cataract surgery that Orbis's volunteers typically teach to local partner staff. We work with our partners to identify the right lens for the site, based on what they are used to working with and cost effectiveness. These costs can fluctuate from centre to centre. All the costs are a guide for what supporters' donations could be spent on."

Richard Hurley (rhurley@bmj.com)

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VITAMIN D SUPPLEMENTS

Neglect or good practice?

Rhein accuses us of "condescending neglect" of northern Britain (Letters, 7 January). She says that the evidence for vitamin D supplements is good enough for her, citing meta-analyses with substantial limitations and studies with surrogate endpoints, which are insufficient to inform clinical practice.

Arguably the best evidence for whether people in northern Britain should take vitamin D is from the RECORD trial, which showed that daily vitamin D had no effect on total fractures or hip fractures, falls, cardiovascular or cancer mortality, infections, preventing diabetes, or the need for more diabetic medication. No evidence was found for a differential effect according to latitude, with 1636 of 5292 participants recruited in Scotland.

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