

comment

Above all, what is the effect of presuming donation?
A forced, presumed, or expected gift is not a gift

NO HOLDS BARRED Margaret McCartney

PPA COLUMNIST OF THE YEAR

When a donation isn't a donation

“Soft opt-out boosts donation in Wales,” wrote the BMA. “‘Dozens saved’ in six months by Welsh deemed consent organ donation system,” said the *Guardian*. Should the rest of the UK follow what Wales started in December 2015: a system of opt-out organ donation?

The rest of the UK requires consent for organ donation, either by the dead person having pre-empted the decision by joining the donor register or by family consent.

Wales uses a “soft” opt-out, meaning that it’s not intended to be legally enforced and that potential situations where doctors remove organs for transplant directly against the surviving family’s wishes will not occur.

Has it been effective? The most recent available figures, from the first three quarters of 2016-17, show a small decrease in deceased donors since the same period the previous year. Although variability is to be expected, they don’t show the obvious increase in donations the headlines suggest.

In fact, opt-out legislation may do more harm than good. This law is present but not enforced, so the point of it must be debated. Will it make people think more about organ donation? Possibly: certainly, it’s triggered a small avalanche of people who heard the publicity about the new law and chose to opt out.

One in 20 Welsh adults has opted out after the new process, compared with none before. I consider this a potential harm, because some or many of those opting out may have been willing to donate freely but not



under uncertain legislation. It means that the number of potential donors has shrunk by 5%. It may mean unease with doctors, donation, or death. Trust may decrease as a result.

Discussions hover in England and Scotland about passing new laws to emulate Wales. Although I fully support organ donation, there are reasons to be cautious about an opt-out law. If it doesn’t achieve the desired effect, it’s pointless.

It’s worth noting that, in Spain—the high achiever of the organ donating world—no increase in donations was noted until 10 years after an opt-out law was passed, when well staffed transplant coordinating teams were instigated. Additionally, Spain has organ donor cards that citizens can carry but no register of people who have opted either in or out. The systems are thus quite different.

Furthermore, internationally, any rise in deceased donation tends to be accompanied by a decrease in living kidney donations.

But, above all, what is the effect of presuming donation? A forced, presumed, or expected gift is not a gift. A striking feature of families who have allowed donation has been the desire to help others and the feeling that some shred of good has come out of their profound loss. If the sum of free will to donate is decreased, how can this benefit be realised to the same extent?

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

Follow Margaret on Twitter, @mgmtccartney

Cite this as: *BMJ* 2017;356:j1028

Why the Children and Social Work Bill needs to be amended

It cannot be assumed that innovative practice is a force for good

Safeguarding vulnerable children is a priority for the Royal College of Paediatrics and Child Health. I have therefore been closely following the passage of the Children and Social Work Bill through parliament over the past few months. This bill updates and amends existing children's social care legislation and aims to "make provision about looked after children, make other provision in relation to the welfare of children, and make provision about the regulation of social workers."

Currently making its way through the House of Commons, the bill originated in the House of Lords last year, where it was introduced with the controversial Clause 29, which would grant local authorities powers to "test different ways of working." This clause meant that local authorities could

deviate from existing children's social care legislation—with permission from the secretary of state—and act outside the scope of the law in developing new processes and mechanisms for delivering children's social services.

The sheer breadth and depth of these powers—and the lack of detail about how they would be supervised or monitored—caused great concern among the children's sector and in the House of Lords. Peers voted to scrap the clause during their final reading of the bill in autumn 2016.

However, a government amendment tabled to the bill during the House of Commons committee stage has reintroduced this measure. Despite including more detail about how these powers to test different ways of working may work in practice, we remain concerned about their scope and potential impact.



The lack of detail about how these powers would be monitored caused great concern

Unfettered innovation

To be clear, the college is by no means against innovation; in fact, we encourage it. But we are concerned about the notion of unfettered innovation implied in this bill. This legislation will have the potential to have an adverse impact on some of the most vulnerable children in the UK. Children who may have suffered from accumulative trauma and physical and emotional abuse, including sexual abuse, are extremely vulnerable.

For many of these children the local authority is their "corporate parent." Their contacts within these

Deflecting blame for the NHS crisis

In February, the BBC's week long "NHS Health Check" depicted the current troubles on the NHS front line. In a television interview the health secretary, Jeremy Hunt, responded to stories about patients stranded for months in hospital or for hours on trolleys in overcrowded emergency departments.

Hunt asserted that such incidents were "completely unacceptable" with "no excuse," but strangely omitted his own leadership responsibility. In charge for four years with a very hands-on management style, he was also a cabinet minister in governments that drove through Andrew Lansley's disastrous Health



Follow David on Twitter, @mancurianmedic

and Social Care Act, cut funds available for social care, and presided over a widening NHS funding gap.

As before, Hunt proclaimed his "passionate commitment" to patient safety. But preventing further decline in NHS performance needs more than rhetoric. It requires funding, staffing, and a helpful political environment.

As pressures mount, shifting blame to undeserving or marginal scapegoats has become endemic in the political, public, and press conversation on the NHS's woes. Recouping wasted millions from "health tourists" is one example. This approximate £300m saving is small at 0.3% of total NHS spending, before the costs we'd

Preventing further decline in NHS performance needs more than rhetoric. It requires funding, staffing, and a helpful political environment

expend in the chase. And an alarming suggestion by the *Telegraph's* Allison Pearson, of scrapping NHS translation services because people should either "bring a relative or learn to speak English," would save far less, with untold opportunity costs.

"The elderly" and "bed blockers" (that is, citizens with genuine health needs and entitlements) are serially targeted. So too are the "30% of patients in A&E" who "don't need to



local authorities may be the only professionals they feel they can trust. That trust must not be eroded by work that, while it may be innovative, might not be carefully evaluated and rigorously monitored. It cannot be taken as axiomatic that innovative practice is a force for good.

This bill could mean that health professionals across the country would be working outside a legislative framework in an unstandardised and inconsistent manner to deliver children's services. Without a framework to ensure consistent standards, the power to test different

be there." This is despite the College of Emergency Medicine saying that it's "absurd" to blame patients and disputing that figure. Smokers and drinkers "should pay for their own treatment," a recent report concluded. And Lord McColl said that we shouldn't blame "the elderly" but "grotesquely obese children."

Also castigated are already overstretched GPs who won't open their surgeries or who drop out-of-hours work, and hospital doctors who Hunt says have a "nine to five culture" or are "avoiding management roles."

Another canard is bureaucracy and management. NHS management costs are low compared with most systems. Many administrators merely support a politically willed internal

ways of working could open the floodgates to all kinds of practices in the name of supporting children's social care.

The clause may add to the disrupted lives of these children. Many have already had to move to different places of care, which can mean a change in the local authority responsible for them. Under this clause a move could also mean a shift in practice, a different way of working, and a new way of offering support—all of which could contribute to feelings of instability and insecurity.

There is no need for this clause. Local authorities are already doing innovative work under current legislation. They should share that good work.

If this clause does go through, it is imperative that local authorities act in the best interests of children to make sure their needs are at the heart of any new initiative. Interventions introduced on their behalf must be subject to robust evaluation, including the use of properly conducted randomised controlled trials, using social equipoise as a guiding ethical principle. We owe it to these children—some of our nation's most vulnerable citizens.

Geoff Debelle is officer for child protection, Royal College of Paediatrics and Child Health
geoff.debelle@bch.nhs.uk

Cite this as: *BMJ* 2017;356:j999

market and the pointless complexity caused by Lansley's reforms. The BMA is allegedly "scaremongering" and NHS Providers "misjudged," for highlighting NHS funding and staffing.

This hoopla is a sideshow distracting from the real causes. With a growing and ageing population, rising treatment costs, and a workforce crisis, successive governments have chosen to fund services inadequately and—through inexpert, ideology driven meddling—send the service into serial, distracting reorganisations.

Before dishing out blame, we should all reflect. A mirror sometimes helps.

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

Cite this as: *BMJ* 2017;356:j1026

BMJ OPINION Thomas Sharp

Has NHS workforce morale hit rock bottom?

I recently read an article that gave an alternative to the usual rhetoric about the NHS's performance this winter; namely, that it has been a miracle the NHS has been able to perform as well as it has in the face of growing pressures and budgetary cuts.

The article stressed that one reason the service has been able to cope so admirably is because of the dedication and hard work of its staff. Given my personal experience of working as a doctor, this article served to crystallise some interesting questions, reflections, and concerns.

One thing that has struck me during my clinical training and early working life is how underappreciated frontline clinical staff are in comparison with workers in the private sector. I worked for five years as a research chemist before retraining as a medic, and I can attest to how much more valued you are made to feel as an employee in the private sector. Private companies are fully aware that their staff are key assets, and they are treated as such—not only in monetary terms.

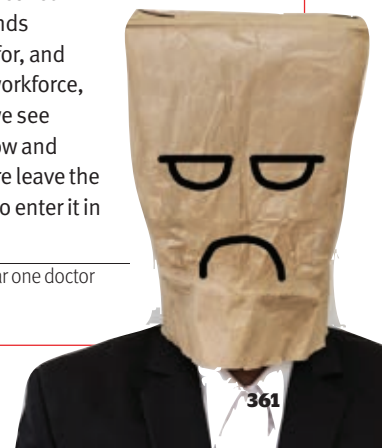
This doesn't appear to be the case for those in the state sector. In light of the fact that the NHS would simply not be coping as well as it is if not for the "extraordinary" efforts of staff, it seems all the more amazing that they are not made to feel truly valued.

Private companies are fully aware that their staff are key assets, and they are treated as such

Frustratingly, the efforts of staff seem to be taken for granted. There will be a point where they have had enough, when they simply cannot go on working in this way. Recently published data allude to this point—the proportion of junior doctors choosing to directly enter specialty training is just 50%, and, after the bursary system was scrapped, applications for nursing degrees have also dropped. I have had conversations with senior colleagues considering sabbaticals; they are frustrated and worn down by the constant grind of service needs—a scenario that I'm sure is repeated across the country.

One way to stop the drain of personnel could be to make the workplace and the realities of the job more attractive. None of my colleagues have lost their love of the profession, but the reality of working in the modern NHS is starting to take its toll. My concern is that, unless the service finds ways to show appreciation for, and increase the morale of, its workforce, the current rota vacancies we see on the front line will only grow and become harder to fill as more leave the profession—or choose not to enter it in the first place.

Thomas Sharp is a foundation year one doctor currently working in Margate



OBITUARIES

Roshini M Alles

Consultant in audiovestibular medicine Royal National Throat, Nose and Ear Hospital (b 1953; q University of Sri Lanka (Colombo) 1978; MS, MSc, FRCS), d 28 August 2016



Roshini Alles was appointed to her consultant post in 1993. Her key clinical interests were in disorders of the central auditory nervous system, young adults with hearing loss, and patients with diagnostically complex presentations. Roshini was the unit training director for audiovestibular medicine and lectured and examined at UCL. She was on the national steering committee on auditory processing disorders and was involved in developing the Department of Health's 18 week pathways for adults with hearing loss and tinnitus and in writing its guidelines for good practice. She leaves her husband, Pasqual, and two daughters.

Deirdre Lucas

Cite this as: [BMJ 2017;356:j467](#)

Joan Elliott

Child psychiatrist South Tyneside (b 1936; q Durham 1960), died from cardiac failure on 28 December 2016



Having decided on a career with children, Joan Elliott did a spell in paediatrics. She then trained as a child psychiatrist and became a consultant in Aberdeen. She married Pat Elliott, a paediatrician from North Shields, and obtained a consultant post across the river in South Tyneside. She was involved in the training and mentoring of many child psychiatrists, who found her a great support. She and Pat shared a passion for foreign holidays and for gardening. At one stage they had over 450 different plants, all fully catalogued, in what was not a huge garden. Most people take pictures on their holidays, but the Elliots brought back tape recordings of the sounds of their favourite places. Her husband died three years before her, and she leaves two stepchildren.

Neela Shabde, Alan Craft

Cite this as: [BMJ 2017;356:j470](#)

Leonard Irving Liebling

Consultant psychiatrist Birmingham (b 1938; q Birmingham 1962; DPM Eng, FRCPsych), died from metastatic bladder carcinoma on 3 November 2016



Leonard ("Len") Irving Liebling's ambition was to be "the first sane psychiatrist." After working at Middlewood psychiatric hospital in Sheffield as senior registrar he became a consultant at Highcroft Hospital in Erdington, where he continued to pursue his interests in group work and therapeutic communities. He researched lithium as a treatment for manic depressive psychosis. An honorary founding consultant member of the Royal College of Psychiatrists, he served on the college's national council. Latterly Len left the NHS and entered the newly created Woodbourne Priory Hospital in Birmingham to see patients at leisure. Len married twice and leaves three children from his first marriage.

Michael Toseland

Cite this as: [BMJ 2017;356:j466](#)

Charles Lyn Perry

General practitioner Haverfordwest (b 1925; q Cardiff University School of Medicine 1950; MRCP), died from complications of prostate cancer on 6 September 2016



Shortly after graduating Charles Lyn Perry ("Lyn") married Elisabeth Thomas, whom he had met during their studies. He undertook national service with the Royal Air Force in the Cotswolds and completed GP training in Dinas Powys, south Wales. In 1955 he moved to Haverfordwest and joined what became the Winch Lane practice. He was active in obstetrics in general practice until it was moved to the local hospitals in 1977, the year in which he was awarded a Queen's Jubilee Medal for reviewing activities in establishing NHS joint consultative committees. After retiring in 1990, he continued to pursue his leisure activities in photography and wildlife and developed a special interest in bryology. Predeceased by Elisabeth he leaves three children, four grandchildren, and one great granddaughter.

Andrew Perry

Cite this as: [BMJ 2017;356:j498](#)

E G Gerald Roberts

Paediatrician Wrexham (b 1919; q Welsh National School of Medicine, 1944; MRCS, DCH, FRCP Lond), d 14 November 2016



Edwin George Gerald Roberts ("Gerry") was the first paediatrician to be appointed to Wrexham General Hospital; his duties initially covered the whole of north Wales. He built a reputation for his holistic, multidisciplinary care of disabled children—pioneering work in the 1950s and 60s. He persuaded health, social services, and education to join forces under one roof, as one team. He introduced combined clinics and had a strong focus on communication. Gerry held an honorary consultant paediatrician post at the Robert Jones and Agnes Hunt Orthopaedic Hospital and served on influential committees. He was president of the Welsh Paediatric Society in 1976-78. He retired in 1984. He leaves his wife, Dorothea; children; grandchildren; and great grandchildren.

Geraint Owens

Cite this as: [BMJ 2017;356:j501](#)

Kurt Schapira

Consultant psychiatrist Newcastle Health Authority (b 1928; q Newcastle Medical School 1952; MD, FRCP, FRCPsych, DPM), d 20 November 2016



Kurt Schapira was born in Vienna but escaped to England on the Kindertransport in March 1939. In 1956 he was appointed research fellow in Newcastle and participated in reviewing all known patients with multiple sclerosis (MS) resident in Northumberland and Durham on 1 January 1958. His interest in psychiatry resulted in his joining Newcastle University's department of psychiatry in 1961; he became senior lecturer in 1970 and was appointed consultant psychiatrist to Newcastle Health Authority in 1974. His research included anxiety and depression, suicide, and attempted suicide. He was also adept at treating anorexia nervosa. He leaves Eva, his wife of 51 years; three children; five grandchildren; and four great grandchildren.

Kenneth Davison, Hamish McClelland, Alan Kerr, Martin Schapira

Cite this as: [BMJ 2017;356:j499](#)

Archibald Percy Norman

Specialist in cystic fibrosis and co-founder of the CF Trust

Archibald Percy Norman (b 1912; q Cambridge/Middlesex Hospital Medical School, London, 1939), d 20 December 2016

Paediatrician Archie Norman spent most of his career helping children with cystic fibrosis, a then newly described condition. He worked long hours and earned a reputation for good organisation, frugality, and an insistence on the highest of standards. But for all their rigour and self discipline, those years were tranquil when compared with what must have been among the formative experiences of his life: service in the Royal Army Medical Corps during the second world war.

War service

On joining the armed services as a captain in 1940, Norman was posted to Cyprus, then to Palestine, Lebanon, and Syria. He spent 1942 in Cairo and then alongside troops fighting in the Western Desert. With a shrapnel wound in his leg, he was unable to evacuate his dressing station fully before a German advance overran it. He spent the rest of the war as a prisoner, using his medical skills when allowed. Most of the time was spent in Italy, but towards the end of the war he was transferred to a camp in Poland.

Liberation, when it came, was far from instantaneous. A memoir compiled by one of his sons, the former MP who shares his father's name, describes how Norman, as the senior officer, "led 150 troops back through territory held by Russia... living off the land and what rations they could extract from nearby Russian headquarters." Using transport that included horse drawn wagons, they travelled through Ukraine. "After a week fending off bandits and living off soup and black bread, they arrived in the Crimea, on the shores of the Black Sea." From there they were shipped back to Britain.

The son of a GP and a nurse, Norman grew up in a Lancashire mill town until his family moved



Archie Norman took up respiratory disease at a time when cystic fibrosis was still untreatable

to Eastbourne when he was 10. Having read medicine at Cambridge University he started his training at London's Middlesex Hospital. Here he met the paediatrician Alan Moncrieff, under whose influence he first opted for his mentor's specialty. Eventually—after returning from the war—Norman joined Moncrieff at the Great Ormond Street Hospital for Sick Children as a resident physician.

Specialisation

Alan Craft, emeritus professor of child health at Newcastle University, says that Norman was one of the first paediatricians to specialise. Factors such as the advent of the NHS and of antibiotics enabled Norman to pioneer the development of a holistic and effective pattern of care.

Norman set up a respiratory clinic and research centre for children with asthma as well as cystic fibrosis. Although other such clinics soon appeared around the country, the one at Great Ormond Street was, and long remained, the largest of its kind. He went on to develop life tables to estimate the likely, and often very

limited, survival time of his patients. He also set up a lung function laboratory, the cost of which was met by the press baron Lord Beaverbrook.

"Norman was one of the first people with a deep interest in cystic fibrosis," says James Littlewood, a retired consultant paediatrician and now chairman of the research and medical advisory committee of the CF Trust.

Norman was appointed, in 1953, to a consultant post at Queen Charlotte's, one of London's leading maternity hospitals. In 1968 he was responsible for the care of the first ever quintuplets born in Britain. But it was cystic fibrosis that continued to be his principal preoccupation. In seeking the help of physiotherapists and dieticians, he was a pioneer of multidisciplinary care in the disorder.

CF Trust

Norman was also attracted to the notion—then viewed without much enthusiasm by most doctors—of creating an association for patients with cystic fibrosis. As Craft recalls, the idea was sparked by the father of one of Norman's patients. In 1984, with the help of a business colleague and of another doctor who himself had a daughter with cystic fibrosis, he set up the CF Trust. Craft describes Norman as the "quiet inspiration and driving force" behind the enterprise.

Craft and Littlewood are united in their admiration for Norman. "A quiet, determined man who got on and did what he thought was best," says Craft. "He was reticent about himself and always reluctant to talk about his own contribution." Littlewood describes Norman as a leader. "To stick your neck out and take an interest in cystic fibrosis when he did took a bit of courage because there wasn't a lot going for it in those days."

In what manner and to what extent the quiet determination that characterised Norman's career was a product of his wartime experiences must remain a matter of speculation.

Geoff Watts, London
geoff@scileg.freemove.co.uk
Cite this as: *BMJ* 2017;356:j312

LOCUM PAY CONTROVERSY

Locums have extra charges and fewer opportunities

Iacobucci highlights a contentious issue in the NHS (This week, 4 February). Shortages have created an indispensable role for locums. Given pay discrepancies between locum and NHS trust employees, we may wonder whether their value is worth the cost.

Locums often cover multiple hospitals and aren't always afforded departmental access, IT passwords, or sufficient handover. Reduced quality of care may result from available provisions rather than ability. The role may match that of an NHS employee, but the shift may be vastly different.

Trust employees earn less but have greater support in further education, resources, and revalidation. Locums have agency appraisal/revalidation charges and fewer opportunities for audit, feedback, or work based assessments.

Pay capping was initially successful, but failures to increase basic salaries, alterations to contractual hours, and impending Brexit have removed any incentive.

We should focus less on those taking advantage of the system and more on fixing it.

Natalie G Jumper (njumper@gmail.com)

Cite this as: *BMJ* 2017;356:j961

PREVENTING DIABETES

NHS diabetes prevention is vital but needs reviewing

I agree with Barry et al that we will not sustainably reduce type 2 diabetes without major changes to work/living environments (Research, 7 January). However, I support the principles of the NHS Diabetes Prevention Programme.

The current epidemic is largely due to obesity, and the lag between necessary changes to policies/practices and obesity prevalence may take 20 years. By then around 60 million people will develop type 2 diabetes in

LETTER OF THE WEEK

Let the NHS manufacture generic drugs

We welcome the news that the Competitions and Market Authority is taking drug companies to task for overcharging the NHS for generic drugs (This week, 5 November). The authority is investigating Actavis for inflating the price of hydrocortisone by 12 000% since 2008, costing the NHS an estimated additional £69.5m a year.

Newly developed and patented drugs are sold at higher prices to recoup the costs of research and development incurred by the innovating company. Such innovation should be protected. However, after the companies have recouped their investment, such high prices are unjustified. The cost of generic drugs should be subject to market forces.

We must protect the NHS from these market failures. One option would be to develop an arm's length NHS organisation to manufacture essential drugs. This would enable the NHS itself to set the market price for generic drugs. Such a company could be run as a non-profit making NHS Trust with the aim of making generic drugs at cost prices, setting prices to ensure solvency, and ploughing profits back to getting approval for other generics. It would be subject to the normal regulatory processes of the Medicines and Healthcare products Regulatory Agency to maintain excellent safety standards in the UK, but would not have a profit motive. Innovation of new drugs would remain protected by patents, but generic drug prices would fall.

Karim Meeran (k.meeran@imperial.ac.uk),
Sirazum M Choudhury, John Wass

Cite this as: *BMJ* 2017;356:j947

England alone. Given the efficacy of prevention trials we must support high risk patients to prevent or delay the condition.

The programme's current inclusion criteria are based on HbA_{1c} and fasting glucose. In most prevention trials, criteria were impaired glucose tolerance with or without impaired fasting glucose. It's worrying that GPs' most widely used test has such poor sensitivity for the main criteria in the original studies.

We need robust analysis before stepping up recruitment so that the programme's inclusion criteria can be modified.

Nicola Guess (Nicola.Guess@kcl.ac.uk)

Cite this as: *BMJ* 2017;356:j993

Do we need new diabetes prevention trials?

We read with interest Barry et al's article on the efficacy and effectiveness of screening tests and interventions in pre-diabetes (Research, 7 January). Fasting glucose, two hour glucose, and HbA_{1c} can all be used to identify high risk patients, so none can be considered a gold standard. Also, concordance between the three tests is poor. Evaluating fasting glucose and HbA_{1c} against elevated two hour glucose will inevitably give poor results.

People with HbA_{1c} defined pre-diabetes have high cardiovascular risk and all cause mortality, and preventive interventions are

important. However, people with pre-diabetes identified by HbA_{1c} are not likely to have the same glycaemic abnormalities as those with elevated two hour glucose. This is ignored by the American Diabetes Association, which bases recommendations for prevention on studies of people with impaired glucose tolerance only.

New prevention trials must focus on improving glycaemia and reducing cardiovascular risk in people with pre-diabetic HbA_{1c}.

Kristine Færch (kristine.færch@regionh.dk),
Dorte Vistisen

Cite this as: *BMJ* 2017;356:j1003

DOCTORS AS MANAGERS

Engaging doctors in management: start early

I read with interest your article on whether NHS doctors "avoid" management roles (This week, 4 February). The problem isn't a lack of motivation but a lack of opportunity. Throughout the US and Europe many medical schools have offered joint clinical and management training programmes (MD/MPH, MD/MBA) for over a decade, and many doctors undertaking these schemes become active clinicians and managers.

Beyond qualifications, a culture of engaging UK juniors with management is absent, highlighted by Hunt's recent proposal to encourage "senior" NHS professionals to study management. Evidence suggests that UK medical students would be receptive to learning about management but that teaching is inadequate and lacks cohesion. This risks institutionalising the view among newly graduated doctors that management isn't a practising clinician's concern.

Given the current climate in the NHS, there is a pressing need for curriculum review to nurture clinicians with the skills to effect change.

Adam M Ali (adamali@post.harvard.edu)

Cite this as: *BMJ* 2017;356:j1005