For more than 400 years, monarchs such as Henry VII touched the face or neck of people with scrofula. This disease—tuberculous cervical lymphadenitis—was also known as “the King’s evil.” It often improved anyway, giving the impression that unquestioned authority and ritual could produce miracles.

George I ended the practice, and royal touches now involve flashes of media magic. Prince Harry scored global headlines by stating that he sought counselling after his mother’s death. This has been broadly viewed as brilliant advocacy for de-stigmatising mental distress and encouraging people to talk. Such is Harry’s reach that Simon Wessely, president of the Royal College of Psychiatrists, thinks that “in just 25 minutes he has achieved more good than I have in 25 years.”

Who can fail to like someone willing to play an innocent game of strip billiards, or to feel sorry when previous mistakes and indiscretions are plastered on global front pages? It’s not Harry’s fault that he was born into privilege, or that the population finds the monarchy’s personal lives fascinating. Paradoxically, the lack of privacy that makes him well known and his declaration newsworthy may have also contributed to the distress he disclosed. Personal tragedy lived in public has its own stresses.

Urging people to talk about mental distress is one thing, but what comes next? Celebrities have publicised episodes of mental illness for decades, and I don’t see meaningful investment in services. In fact, 57% of clinical commissioning groups plan to decrease spending on mental health services.

Our benefits system has discriminated against people with mental illness and is associated with an increase in suicides and self reported mental health problems. Inpatient beds are lacking—meaning many admissions to hospital miles away—as are suitable facilities in the community, including housing, to discharge people to.

Talking among ourselves won’t sort out these enormous problems. If I refer someone with a suspected cancer they’ll be seen within two weeks. Not only will their times to treatment be researched and audited but they may have a specialist nurse to support them. They may also have a dedicated charity worker to ensure that they get the benefits they’re entitled to.

If my patient, however, has anorexia or depression or—totally flummoxing the system—psychosis in addition to drug or alcohol addiction, things are different. Patients can bounce painfully between the walls of departments, which too often seem designed to keep people out.

It’s understandable: departments are underfunded and overstretched. If poor, illiterate patients don’t have a ferocious advocate and can’t, for example, keep phoning back a service to confirm that they really still need to be seen, they may simply drop off the waiting list altogether.

If waiting lists to be admitted for cancer treatment were as long as those for treating alcoholism, we’d be outraged. Instead, there’s a quiet acceptance that this is just how it is.

The king’s touch turned out to be a coincidence or a placebo effect. Harry has done a good thing. But not all medical suggestions by the monarchy should be acted on—homeopathy, especially—and it seems dangerous to rely on the goodwill of famous people to overturn systemic problems in nationally funded health and social care.

Strong pressure is needed to take mental illness as seriously as any other, but it must be matched by financial commitment to ensure that it happens. Celebrities may help, but shouldn’t we make sure that they aren’t needed?

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Observations
Alastair Faulkner, Mike Reidy, and James McGowan

Should we abandon routine blood tests?

Blood tests for patients attending hospital regardless of clinical need is wasteful and potentially damaging

Historically, blood tests in secondary care were requested for defined indications and only after a detailed clinical history and patient examination. Like modern day imaging requests, every investigation required justification.

Twenty first century technology has changed this dynamic. Blood analysers can now process thousands of samples every day at a fraction of the former cost, the potential workload of laboratories has become the expected workload, and “routine bloods” has entered the lexicon of clinical practice.

Studies have shown that the NHS is a comparatively efficient system by international standards. The UK spends less per capita on laboratory tests than other economically developed nations, with fewer errors. Growing evidence, however, shows the extent of unwarranted variation in spending by NHS acute hospitals.

Overuse of blood tests might be an important source of this variation.

Department of Health for England figures show that more than 230 million biochemistry and 47 million haematology investigations were requested in 2014-15 at an estimated cost of more than £415m to secondary care, with estimates of up to £3bn for the whole NHS. These represent substantial potential savings. The waste associated with “routine bloods” is damaging for clinicians, finance managers, and patients.

Questioning the status quo

Blood tests are undoubtedly important diagnostic tools, central to guiding the investigation and management of many conditions. In many emergency and acute medical departments, however, requesting a standard battery of blood tests has become the norm—with no distinction made between patients. Ordering the “full house” of full blood count, urea and electrolytes, liver function tests, and C reactive protein might be acting as a psychological comfort blanket for clinicians, masking an over-reliance on investigations or a lack of confidence in clinical judgment.

Furthermore, clinical guidelines might have enabled tests to be ordered more systematically, increasing their volume over time. Logically, the notion that every “routine” investigation is necessary is not sustainable, and several articles have reported that up to 60% of abnormal investigations documented in medical notes do not lead to further investigation.

Departments of surgery are not immune. A retrospective cross sectional study found that an orthopaedic department requested 895 liver function tests and 307 clotting studies for 216 acute trauma patients in one month. Only four patients had a documented history of liver disease, and only 10 were taking anticoagulant medication. A literature review of orthopaedic acute trauma patients found that 26% were given a full blood count on admission, with risk of infection, or history of bleeding, and 28% were given a clotting screen.

The waste of money is damaging clinicians, finance managers, and patients.

Acute perspective

David Oliver

Fighting the pyjama paralysis in hospital wards

The momentum of Nottingham University Hospitals’ social media campaign “End PJ Paralysis” has been growing, with clinical teams around the country joining in and reports appearing in the national media.

Its starting premise is that we should get more hospital inpatients out of nightwear, out of bed, and into their day clothes to speed their recovery and help minimise harms from prolonged immobility.

The perils of bed rest as treatment for hospital inpatients were recognised in the 1940s by Richard Asher, in his seminal essay The Dangers of Going to Bed and they were elegantly reviewed by Allen and colleagues years later. Marjory Warren, the mother of UK geriatric medicine and Asher’s contemporary, described in a series of papers the benefits for patients and for hospital bed utilisation of getting “infirm and bedridden” people out of bed and on their feet.

The kind of long stay inpatient wards Warren described no longer exist. And rapid increases in hospital admission numbers, mirrored in scale by reductions in beds, mean that patients who might formerly have been halfway down an old-style Nightingale ward are now long since discharged home. Beyond some fracture management, bed rest as a prescribed treatment is rare.

However, excessive bed rest is still all too familiar. These days it’s more likely to be an inadvertent by-product of competing pressures on the time of a depleted nursing workforce, compounded by variable availability of physiotherapists, occupational therapists, and their assistants. Getting people up and dressed and being more independent can fall down the pecking order.

The median age of inpatients is rising, with pre-existing mobility impairment prevalent on
Fighting the pyjama paralysis in hospital wards

ACUTE PERSPECTIVE

David Oliver

support system-wide efforts to agree high quality clinical care and might minimising waste while maintaining would be a pragmatic approach to the management of my patient?” This test give me more information?”

of clinical decision making from “can there be a culture of clinical overinvestigation. Ordering unnecessary tests is driven by the fear of missing important details and the potential for subsequent litigation. We therefore need to change the psyche of clinical decision making from “can this test give me more information?” to “will the result of this test change the management of my patient?” This would be a pragmatic approach to minimising waste while maintaining high quality clinical care and might support system-wide efforts to agree best practice in diverse contexts.

The literature on “too much medicine” finds its modern home in the Choosing Wisely and overdiagnosis movements, which promulgate the principles of value based healthcare. In Scotland, Catherine Calderwood’s “Realistic Medicine” initiative outlines a strategy to cut unnecessary variation and waste while improving the quality and safety of care.

As clinicians, we have a duty to lead culture change as effective stewards of clinical resources, who are capable of playing an active part in the long term sustainability of our health service. The transformation of blood tests has helped to cement a culture of tools to “because we can” tasks

Rethinking what is “routine”

The literature on “too much medicine” finds its modern home in the Choosing Wisely and overdiagnosis movements, which promulgate the principles of value based healthcare. In Scotland, Catherine Calderwood’s “Realistic Medicine” initiative outlines a strategy to cut unnecessary variation and waste while improving the quality and safety of care.

As clinicians, we have a duty to lead culture change as effective stewards of clinical resources, who are capable of playing an active part in the long term sustainability of our health service. The transformation of blood tests has helped to cement a culture of tools to “because we can” tasks

review of preoperative laboratory investigations in elective surgery patients found that routine tests rarely influenced anaesthetic management, produced many false or borderline results, and placed an unnecessary financial burden on the system.

admission. Even in wards geared up for post-acute rehabilitation, many patients leave much less mobile than they were before the acute episode that led to their admission. Even a few days’ bed rest can cause rapid decline in muscle strength and aerobic capacity, especially in patients with pre-existing sarcopenia.

Other harms of bed rest include higher risk of thrombosis or delirium, pressure sores, infection or contractures, loss of confidence, and greater dependence. It can also cause incontinence by too often resorting to catheters, pads, or bedpans or by causing constipation, instead of assisting and encouraging patients to toilet as they usually would. Bed rails can compound the problem, and evidence for their use is poor.

Whenever possible we should divert more patients to ambulatory care and away from beds. As for the others, we need to stop reflexively putting them into flapping-open gowns and pyjamas. And, if on a ward round we see patients still in bed in nightclothes with bed rails up, it’s the responsibility of everyone in the ward team to challenge and change this.

David Oliver is a consultant in geriatrics and acute general medicine, Berkshire davidoliver372@gmail.com Follow David on Twitter, @mancunianmedic

BMJ OPINION Matt Morgan

The (free) elephant in the burnout room

As an intensive care consultant, the risk of burnout is ever present.

Every day I deliver devastating news to families when they least expect it. I make life changing decisions with limited information in a time critical manner. I have passionate debates with other specialties about what is best for patients. However, I don’t believe that these are the precipitants to my potential future burnout. It is the calm research meeting, with coffee and pastries provided, starting at 10 am on Thursday that will be my downfall. That is because Thursday is my day off—yet I will be in work.

In the past four weeks I have spoken at three public engagement events, travelled to London twice to speak at medical conferences, attended intensive care planning meetings with government representatives, taught undergraduates and postgraduates, and discussed links with industry with a local innovation hub.

In few other industries would a professional be asked to provide expertise with little or no expectation of being paid

I have done all of this because I enjoy it and because it is important to me and to others. However, I have done much of it in my “free time” for no cost, even though I have often incurred costs myself: financially, physically, and psychologically.

Those involved in research have an additional, non-remunerated part of their work life. The design, conduct, analysis, and publication of medical research is a huge time, and life, consuming process. The desired outcome, alongside improved patient care, is often a paper published in a respected journal. That same journal is a corporate entity, profiting from the work and time effectively donated by highly skilled professionals. Viewed from the outside, this is a bizarre situation.

To be clear, I do not want money to do these tasks. What I would love is time to do them. In few other industries would a professional with a demanding full time job be asked to provide expertise with little or no expectation of being paid—either in financial terms or with time. Yet in medicine, it is par for the course. While this may, in some ways, be a good thing, it does contribute to the phenomenon of burnout and is a topic worthy of exposure and further debate.

Matt Morgan is an intensive care consultant and lead clinical editor for BMJ's onExamination
Drug marketing: how does promotion correspond with health value?

Tyler Greenway and Joseph S Ross assess the effectiveness, usefulness, and affordability of the drugs that get the heaviest promotion.

The pharmaceutical industry uses a variety of techniques to promote its products to clinicians, including gifts and free food, advertisements, and detailing by company representatives. Although manufacturers might argue that drug promotion supports physician education, which in turn leads to more informed prescribing, studies have shown that greater contact with drug sales representatives is associated with an increased likelihood of prescribing brand name medications when cheaper alternatives exist.1,2 More recent studies have shown that payments from drug companies are associated with a greater likelihood of prescribing promoted drugs.3-5 In the US, physicians have extensive financial relationships with the drug industry.6,7 However, since August 2013, the Physician Payments Sunshine Act requires that the industry publicly discloses all payments to physicians of $10 (£8) or more or $100 on aggregate. This legislation led to the creation of the Open Payments Database, which archives all industry payments to individual physicians and teaching hospitals.8 Early analyses of the database show that numerous small gifts can often add up to large sums of money,9,10 potentially creating powerful incentives for physicians to prescribe selected drugs. Between August 2013 and December 2014, $3.53bn was paid to 681 432 physicians in the US by 1630 pharmaceutical companies to promote numerous drug products. We assessed the health “value” of drugs being most aggressively promoted to physicians to better understand implications of pharmaceutical promotion for patient care.

Assessing drugs’ value

We obtained data on the top promoted drug products from the Open Payments Explorer, created by the non-profit investigative journalism group ProPublica to make the Open Payments database more easily accessible to consumers.11 We identified the 25 drugs associated with the largest total payments to physicians and teaching hospitals from August 2013 to December 2014, including numerous small gifts can often add up to large sums of money.

### Table 1: Top promoted, top selling, and top prescribed medicinal products in US*

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<tr>
<td>Eliquis (apixaban)</td>
<td>Humira (adalimumab)</td>
<td>Acetaminophen/ hydrocodone</td>
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<tr>
<td>Bydureon (exenatide)</td>
<td>Sovaldi (sofosbuvir)</td>
<td>Levofloxacin</td>
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<tr>
<td>Invokana (canagliflozin)</td>
<td>Remicade (infliximab)</td>
<td>Lisinopril</td>
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<td>Xarelto (rixrivarinib)</td>
<td>Rituxan (rituximab)</td>
<td>Metoprolol</td>
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<tr>
<td>Brilinta (ticagrelor)</td>
<td>Enbrel (etanercept)</td>
<td>Simvastatin</td>
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<tr>
<td>Victoza (liraglutide)</td>
<td>Lantus (insulin glargine)</td>
<td>Amlodipine</td>
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<tr>
<td>Latuda (lurasidone)</td>
<td>Avastin (bevacizumab)</td>
<td>Metformin</td>
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<tr>
<td>Birinertix (vortioxetine)</td>
<td>Herceptin (trastuzumab)</td>
<td>Omeprozole</td>
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<tr>
<td>Humira (adalimumab)</td>
<td>Advair (fluticasone, salmeterol)</td>
<td>Atorvastatin</td>
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<tr>
<td>Aubago (teriflunomide)</td>
<td>Crestor (rosuvastatin)</td>
<td>Abaverol</td>
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<td>Abilify Maintena (aripiprazole extended release)</td>
<td>Neulasta (pegfilgrastim)</td>
<td>Amoxicillin</td>
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<tr>
<td>Copaxone (glatramer)</td>
<td>Neupogen (filgrastim)</td>
<td>Hydrochlorothiazide</td>
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<td>Symbicort (budesonide, formoterol)</td>
<td>Lyrica (pregabalin)</td>
<td>Alprazolam</td>
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<td>Pradaxa (dabigatran)</td>
<td>Ablify (aripiprazole)</td>
<td>Azithromycin</td>
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<tr>
<td>Botox (onabotulinum toxin type A)</td>
<td>Revlimid (lenalidomide)</td>
<td>Fluticasone</td>
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<td>Ability (aripiprazole)</td>
<td>Gleevec (imatinib mesylate)</td>
<td>Fusenoside</td>
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<td>Samsca (tolvaptan)</td>
<td>Pevnar (Pneumococcal 13-valent Conjugate Vaccine)†</td>
<td>Gabapentin</td>
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<tr>
<td>Belviq (lorcaserin)</td>
<td>Copaxone (glatramer)</td>
<td>Seltane</td>
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<tr>
<td>Subsys (fentanyl)</td>
<td>Zepa (ezetimibe)</td>
<td>Zolpidem</td>
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<tr>
<td>HP Achar (repository corticosterone)†</td>
<td>Januvia (sitagliptin)</td>
<td>Tramadol</td>
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<tr>
<td>Xeljanz (tufacitinib citrate)</td>
<td>Symbicort (budesonide, formoterol)</td>
<td>Citalopram</td>
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<tr>
<td>Azilect (rasagiline)</td>
<td>Nexium (esomeprazole)</td>
<td>Prednisone</td>
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<tr>
<td>Seroquel XR (quetiapine fumarate)</td>
<td>Atripla (efavirenz, etravirine, tenofovir disoproxil fumarate)</td>
<td>Acetaminophen/oxycodone</td>
</tr>
<tr>
<td>Tecfidera (dimethyl fumarate)</td>
<td>Truxada (emtricitabine, tenofovir)</td>
<td>Ibufprofen</td>
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<tr>
<td>Levemir (Insulin detemir)</td>
<td>Avonex (interferon β 1a)</td>
<td>Celebrex</td>
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*Top promoted drugs identified from ProPublica’s Open Payments Explorer, top selling drugs and the top prescribed drugs were identified using information obtained from IMS. †Excluded from our analysis because not a drug.

### Key Messages

- US physicians receive billions of dollars each year from drug companies as part of drug promotion.
- Top promoted drugs were less likely than top selling and top prescribed drugs to be effective, safe, affordable, novel, and represent a genuine advance in treating a disease.
- Clinicians should question the value of drugs being most heavily promoted by pharmaceutical manufacturers before prescribing them.
Compared with top selling and top prescribed drugs, the most aggressively promoted drugs are less innovative

Next, we estimated drugs’ value to society. In theory, value to society (as opposed to the manufacturer) depends on the relative effectiveness and safety of the drug, its priority among available therapeutic alternatives, its level of innovation as an advance in therapy, the prevalence of the disease for which it is indicated, the disease’s attributable morbidity and mortality, and the cost to patients and insurers. The ideal drug would be effective, safe, novel, recommended as first line therapy for common diseases causing substantial morbidity and mortality, and affordable. We estimated drug value using five proxy measures of these characteristics, selected to be readily intuitive and reproducible by practising physicians (box, below). We also determined the value top 25 drugs by 2014 US sales and the top 25 most prescribed drugs in the US during 2013, identified from IMSHealth data (2014 data for top prescribed drugs were not available when we did the study). A complete list of all included drugs, and how each was categorised, is available in the appendix on bmj.com. We used Fisher exact tests to compare categories of top 25 drugs, calculated using JMP 10.0 (SAS Institute, Cary, NC), using a P value of 0.025 to account for the two comparisons made for each measure.

CRITERIA FOR ASSESSING DRUGS’ VALUE

Innovation was assessed following a schematic established by the US Food and Drug Administration (FDA). Drugs representing new mechanistic pathways in treating indicated diseases were considered first in class. Drugs that provided meaningful advance over existing treatments and received FDA “priority review” status were designated advance in class. Drugs that met none of these criteria were considered addition to class.

Effectiveness and safety were assessed by using the ratings systems of the robust French watchdog Prescrire International. For drugs for which Prescrire ratings were not available, assessments were extrapolated based on Prescrire statements. For instance, many commonly used drugs such as levothyroxine and metoprolol are recommended in Prescrire guidelines but have no official Prescrire rating.

Generic availability was used as a proxy measure of affordability. We used the Drugs@FDA database to determine if the drug was generically manufactured in the US or if there was another generic drug with comparable clinical value available in the US.

Clinical value was also determined by proxy measure, based on whether each drug was on the World Health Organization list of essential medicines for 2015. Drugs containing multiple active ingredients, including asthma combinations and HIV drugs, were considered to be an essential medicine if any of its ingredients were on the WHO list.

First line status, or recommended as a first line treatment, was determined using guidelines accessed through the National Guidelines Clearing House. If relevant specialty society guidelines could not be identified, UpToDate, an evidence based, peer reviewed clinical decision support resource, was used to determine first line status.
Table 2 shows the comparison of value for the identified drugs. Top promoted drugs were significantly less likely to be innovative than top selling drugs (8/24 (33%) vs 18/25 (72%); relative risk (RR)=0.46, 95% confidence interval (CI) 0.25 to 0.86) but not than top prescribed drugs (13/25 (52%); 0.64, 0.32 to 1.26). Furthermore, top promoted drug were significantly less likely to be rated by Prescrire as possibly helpful or offering an advantage than top prescribed drugs (RR=0.25, 95% CI 0.10 to 0.62), although the difference with top selling drugs was not significant.

Only one of the top promoted drugs was on the WHO essential medicines list, compared with nine top selling drugs (RR=0.12, 95% CI 0.02 to 0.85) and 14 top prescribed drugs (0.07, 95% CI, 0.01 to 0.52). Fewer top promoted drugs were considered first line treatments than top selling drugs and top prescribed drugs but the difference was significant only for top prescribed drugs (0.42, 0.23 to 0.76). Generic equivalents were available for 15 (63%) top promoted drugs, eight (32%) top selling drugs, and all top prescribed drugs (table 2).

Understanding promotion

Compared with top selling and top prescribed drugs, the most aggressively promoted drugs in the US are less innovative, rated less favourably by Prescrire, and are less likely to be recognised as first line treatments by national guidelines, included on the WHO essential medicines list, and available as a generic. Although not all the differences were significant, and the sample sizes and multiple comparison limit the statistical power, the direction and magnitude of the differences suggest that top selling and top prescribed drugs, not top promoted drugs, were more likely to represent the ideal drug that is effective, safe, affordable, novel, and represents a genuine advance in treating a disease.

This raises concerns about the purpose of pharmaceutical promotion and its influence on patient care. One view is that drug companies don’t need to promote high value drugs. If a genuinely innovative drug becomes available that significantly advances patient care, such as sofosbuvir (a top selling drug), this information might be expected to spread rapidly among clinicians, perhaps through peer reviewed publications and scientific meeting presentations, requiring little active promotion by the manufacturer. Conversely, a “me-too” drug with minimal benefit over previous treatments in a class with generic alternatives, such as rasagiline (a top promoted drug), might need robust promotion to facilitate its use.

Efforts are needed to better evaluate the value of drugs, ensuring that this information is readily available at the point of care so that it can inform clinical decision making, promoting use of higher value medicines. Of course, choice of drug may be influenced by factors other than those we included in our value ratings, such as patient experience of treatment, previous treatment, cost effectiveness, and out-of-pocket costs or health plan costs. Even the existence of a comparable generic therapeutic option may depend on clinical context. For example, apixaban can often be replaced by warfarin, but not in patients who have contraindications to warfarin.

Our list of top promoted drugs accounted only for payments to US physicians and teaching hospitals from August 2013 to December 2014. We did not include other promotional efforts, such as advertising to physicians, direct-to-consumer advertising and disease awareness efforts coordinated with patient advocacy organisations, pharmaceutical detailing to physician offices, or efforts to raise product awareness at professional and scientific meetings that did not include transfers of value such as a meal or gift, or continuing medical education through third parties. Furthermore, US data on payments to physicians from pharmaceutical manufacturers are available only since 2013 and our results may not reflect behaviour before this time or outside the US. However, we expect patterns of promotion to be similar, even if coverage and reimbursement policies differ.

Despite these caveats, our findings suggest that pharmaceutical promotion should be met with healthy scepticism. Clinicians should consider taking steps to limit their exposure to industry promotion, including detailing by company representatives and sponsored educational events. They could also consider engaging with “academic detailing” programmes—educational outreach by pharmacists, nurses, and physicians that provides non-commercial, evidence based recommendations about medication choices.

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John Kenyon French Mason

Long serving Royal Air Force pathologist who later helped pioneer medical jurisprudence

Ken Mason’s distinguished medical and medical jurisprudence career, which spanned 74 years, can be divided into three main parts.

He spent the first part serving for three decades as a forensic pathologist in the UK’s Royal Air Force. He rose through the ranks to become group captain and director of the RAF’s aviation and forensic pathology department and was regularly summoned to investigate aviation accidents. In recognition of his contributions to the forensic pathology of aircraft accidents, Mason in 1973 was awarded a Commander of the Order of the British Empire (Military Division).

Forensic medicine

In 1973, at the age of 53, Mason retired from the military and began the second part of his career, accepting an appointment as Regius professor of forensic medicine at the University of Edinburgh. He wrote several textbooks on forensic medicine and on medical law and ethics. In 1983 he co-authored *Law and Medical Ethics* with Alexander McCall Smith, now emeritus professor of medical law at the University of Edinburgh and a well known novelist.

Graeme Laurie, professor of medical jurisprudence at Edinburgh, says *Law and Medical Ethics*, now in its 10th edition, was the first British textbook to cover medical law.

In 1985, at the age of 65, Mason—once again—retired, assuming status as emeritus professor of forensic medicine. He then—once again—went back to work and began the third part of his career, this time as an honorary fellow in Edinburgh Law School. Focusing on medical law and ethics, he worked closely with his good friend McCall Smith. Mason had no formal training in law, says Laurie, adding: “He was self taught in that regard.”

John Kenyon (“Ken”) French Mason was born on 19 December 1919 in the city of Lahore, at the time in India but now in Pakistan. His father was serving in the RAF. Mason studied at Peterhouse College, University of Cambridge, receiving his bachelor’s degree in 1939. He continued medical training at St Bartholomew’s Hospital in London and qualified from Cambridge in 1943.

Mason served as squadron medical officer with the RAF during the remainder of the second world war. After the war he spent the next two decades helping to develop the air force’s aviation pathology services. His many investigations led to improvements in aircraft safety. In one case, he discovered a design fault in the seating of one aircraft model. His discovery resulted in a change of seat design to the now standard A frame.

In 1962 he published his highly regarded book *Aviation Accident Pathology: a Study of Fatalities*. Mason’s examinations in the book of fatal aircraft ejection attempts led to a redesign of the ejection seat.

Basil Purdue, formerly of the forensic medicine unit at the University of Edinburgh and now an independent forensic pathologist on the Home Office register, was Mason’s co-author of the 1993 book *The Pathology of Trauma*. He says: “I have never encountered or heard of a medical practitioner so well versed in medical law—true medical jurisprudence. The Edinburgh law students, probably the brightest and best in Scotland, used to try to catch him out by posing ingenious medicolegal conundrums, but I never heard of a single one succeeding. Ken would usually screw up his eyes and say: ‘No, no, no. Doe v Roe 1936 settles that.’”

Mason Institute

Mason never fully retired, but in 2006 he did decide to stop teaching. Asked at the time about the decision, he replied with a laugh: “I’m 86. And I think 86 is pushing it.” Also in 2006 Mason was honoured with publication of his Festschrift: *First Do No Harm: Law Ethics and Healthcare*. The book, with 37 chapters contributed by leaders in the subject, was edited by Sheila A M McLean, who called his body of work “incomparable.” Mason’s next book, *The Troubled Pregnancy: Legal Wrongs and Rights in Reproduction*, was published in 2007.

Mason’s wife, Betty, died in 1977. Mason leaves their two sons; two grandchildren; three great grandchildren; and his longtime companion, Diana Buchanan.
OBITUARIES

Martin Colebrook
General practitioner
Bedford (b 1934; q Cambridge/Guy’s Hospital 1958), died suddenly from a haemorrhagic stroke on 2 March 2017
Martin Colebrook was a partner at the Goldington Road Practice in Bedford from 1964 until he retired in 1994, and carried on as a locum there for a further eight years. He was the senior partner there for most of that time. In 1958, while staying in the Cambridge University Mission in Bermondsey, retaking obstetrics and gynaecology, he had met his future wife, Ruth, who was teaching there. Having married the following year, Martin did his national service in Barnard Castle, Catterick, and Carlisle before arriving in Bedford. In 1991 he spent a six week sabbatical as a medical officer with the HALO Trust in Afghanistan and also undertook clinics for the local population. Predeceased by a son, he leaves Ruth, three children, and five grandchildren.
Rob Colebrook
Cite this as: BMJ 2017;357:j1780

Richard Watton
Cite this as: BMJ 2017;357:j1753

Ruth Kennedy
General practitioner
(b 1956; q Liverpool 1980; DRCOG, MRCGP), died from a brain tumour on 24 February 2017
Ruth Kennedy moved to Sheffield in 1982 and trained as a general practitioner. She was a partner at the White House Surgery for 30 years. Her medical interests were women’s health, diabetes, and depression. Her compassionate care and commitment ensured a devoted following among the socially deprived community she served. She was a GP trainer for most of her career, and her registrars were all influenced by, and grateful for, her wisdom and support. Her sense of fun and love of life brought joy to her many friends and her husband, Mike. The couple loved the outdoors and had planned to spend retirement touring the Scottish Highlands. Ruth ran a local guide company. She had been retired just a year when she died. She leaves Mike and her brother, Nick.

Michael Kenneth Palmer
Consultant radiologist
St Helier Hospital, Epsom, and St Helier NHS Trust (b 1951; q Edinburgh 1974; FCR), died from gastric cancer on 30 January 2017
Michael Kenneth Palmer completed his radiology training at St George’s Hospital in London and was subsequently appointed at St Helier Hospital in Carshalton in 1983. He dedicated his life to his patients, the department, and St Helier Hospital, of which he was so proud. He not only led nuclear medicine and chest radiology but was also instrumental in the running of one of the first public appeals for a computed tomography scanner in the early 1980s. He will be remembered not just as a brilliant radiologist, but as an exemplary doctor, who was respected by all who knew him. He leaves his sister, Caroline; his nephew, Sebastian; his friends; and all the consultant radiologists and staff of the radiology department of St Helier Hospital.

Christopher James Lucas
Consultant psychotherapist
London and Colchester (b 1926; q University College, London, 1949; FRCP, FRCPsych), died after a short illness on 1 February 2017
Christopher James Lucas (“Chris”) became director and psychiatric adviser at University College London’s health centre in 1959, a post he held for the next 20 years. During this time, he undertook psychoanalytic training at the Institute of Psychoanalysis and trained in group psychotherapy. At UCL he was involved in counselling services for students and published several papers on students’ mental health. From 1978 to 1979 he was president of the British Student Health Association. From 1979 to 1986 Chris was a consultant psychotherapist at London’s Portman Clinic. On retiring he moved to Colchester, where he helped establish the Stockwell Centre. Predeceased by his wife, Sheila, a daughter, and his partner, Chris leaves two children and seven grandchildren.
Viv Lucas
Cite this as: BMJ 2017;357:j1756

William John Reilly
General practitioner and columnist (b 1925; q Glasgow 1948), d 29 November 2016
William John Reilly (“Bill”) went to medical school in Glasgow and did house jobs in Bury St Edmunds. National service with the Royal Army Medical Corps took him to Germany and Africa. In 1952 he started as a general practitioner in Dawley, Shropshire. He stayed in post until he retired in 1990 and was a member of the Shropshire local medical committee for many years. During the 1970s he published several Personal View articles in The BMJ and was a regular columnist for Medical News, for more than a decade. His column appeared under the nom de plume of William Paul. Bill died in a nursing home, in south Oxfordshire, surrounded by wonderful nurses and his family. Predeceased by his wife, May, he leaves four daughters, a son, and five grandchildren.

Antony Fulford-Smith
Cite this as: BMJ 2017;357:j1738

John Stuart Morris
Consultant physician
Bro Morganwg NHS Trust, Wales; professor of medicine University of Riyadh (b 1938; q Welsh National School of Medicine 1963; MD, FRCP), died from acute myeloid leukaemia on 17 October 2016
In 1974 John Stuart Morris was appointed as consultant physician and gastroenterologist at the Bridgend and District NHS trust. In 1975 he became chair of medicine at the University of Riyadh. He returned to Wales in 1976 and helped with setting up the department of medicine, the move to a new hospital, and the development of a hospital formulary and gastroenterological services in Bridgend. He pioneered the development of integrated medicine, was active in the Royal College of Physicians, and published widely. He retired in 2003. He leaves his wife, Lucy; a son; and three grandchildren.
Huw Morris
Cite this as: BMJ 2017;357:j1748

Richard Watton
Cite this as: BMJ 2017;357:j1753

Michael Kenneth Palmer
Cite this as: BMJ 2017;357:j1743

Viv Lucas
Cite this as: BMJ 2017;357:j1756

William John Reilly
Cite this as: BMJ 2017;357:j1738

Christopher James Lucas
Cite this as: BMJ 2017;357:j1756

Ruth Kennedy
Cite this as: BMJ 2017;357:j1753

Michael Kenneth Palmer
Cite this as: BMJ 2017;357:j1743

Viv Lucas
Cite this as: BMJ 2017;357:j1756

Christopher James Lucas
Cite this as: BMJ 2017;357:j1756

Ruth Kennedy
Cite this as: BMJ 2017;357:j1753

Michael Kenneth Palmer
Cite this as: BMJ 2017;357:j1743

Viv Lucas
Cite this as: BMJ 2017;357:j1756

Christopher James Lucas
Cite this as: BMJ 2017;357:j1756
HERDOO2 rule and VTE

Oral contraceptive use is a provoking factor for VTE

In the validation study of the HERDOO2 rule (Research, 8 April), women considered to be at low risk of venous thromboembolism (VTE) discontinued oral anticoagulants. We question the definition of unprovoked VTE.

The HERDOO2 algorithm considers hormone related VTE to be unprovoked. We think that oral contraceptive use at the time of VTE is a removable provoking factor.

In the HERDOO2 study women under 50 who had a first hormone related VTE had a similar recurrence rate to those who did not have a hormonal provoking risk factor. The REVERSE study also found no significant difference in the risk of recurrent VTE between users and non-users of oral contraceptives. These point estimates are in line with a meta-analysis of individual patient data and with a large data linkage observational study. We would advise these women to seek alternative contraceptive methods before discontinuing anticoagulants. Identifying of whom (88%) continued anticoagulants.

The Royal Marsden Hospital's venture is undoubtedly peerless in its quality, but a service in a specialist cancer centre that focuses on patients with suspected breast, skin, or prostate cancer.

Enhancement of diagnostic services is essential if the UK is to catch up to its peer group nations in cancer outcomes. Poorer people are less likely to receive a tissue diagnosis and more likely to miss out on treatment. Distance to the diagnostic or therapeutic facility is a barrier to access.

Better outcomes come from starting treatment as early as possible. NICE guidance is based on referral when the probability of cancer is 3%. This means that, in some circumstances, 97% of people attending the service do not have cancer. Many people must be seen to maximise the opportunity for identifying those that do.

Diagnostic facilities must be accessible to all and have high throughput capacity. Providing them must have priority over Stevens's proposal to give patients a definitive diagnosis within 28 days by 2020.

The Royal Marsden Hospital's venture is undoubtedly peerless in its quality, but a service in a specialist cancer centre that focuses on diseases that mostly have a well defined presentation pattern does not seem to be the best model for future developments.

S Michael Crawford, clinical lead for research, Keighley

Cite this as: BMJ 2017;357:j2070

Author's reply

To classify oestrogen associated VTE as "provoked" would imply that women with oestrogen associated clots can't be further categorised as low risk (<5% at one year off anticoagulants) or high risk (>5%) because they are all "low risk" (that is, safe to discontinue anticoagulants). This is not the case.

REVERSE II showed that HERDOO2 could further stratify women with oestrogen associated VTE into low risk and high risk groups, with annual risks of recurrent VTE of 1.3% (95% confidence interval 0.2% to 2.4%) and 10.4% (6.2% to 14.5%), respectively.

In REVERSE II, 74 of the 397 (19%) women with oestrogen associated VTE were categorised as high risk by HERDOO2, 65 of whom (88%) continued anticoagulants. Identifying these high risk women who had oestrogen associated VTE is important so that they can be given the option of continuing anticoagulants.

Marc Rodger, professor of medicine and epidemiology, Ottawa, Canada

Cite this as: BMJ 2017;357:j2079

LETTER OF THE WEEK

Cancer diagnostic centres must have priority

Simon Stevens’s plan for cancer diagnosis includes setting up new multidisciplinary Rapid Diagnostic and Assessment Centres (This week, 8 April). The name of these facilities echoes a service at the Royal Marsden Hospital, which focuses on patients with suspected breast, skin, or prostate cancer.

Enhancement of diagnostic services is essential if the UK is to catch up to its peer group nations in cancer outcomes. Poorer people are less likely to receive a tissue diagnosis and more likely to miss out on treatment. Distance to the diagnostic or therapeutic facility is a barrier to access.

Better outcomes come from starting treatment as early as possible. NICE guidance is based on referral when the probability of cancer is 3%. This means that, in some circumstances, 97% of people attending the service do not have cancer. Many people must be seen to maximise the opportunity for identifying those that do.

Diagnostic facilities must be accessible to all and have high throughput capacity. Providing them must have priority over Stevens’s proposal to give patients a definitive diagnosis within 28 days by 2020.

The Royal Marsden Hospital’s venture is undoubtedly peerless in its quality, but a service in a specialist cancer centre that focuses on diseases that mostly have a well defined presentation pattern does not seem to be the best model for future developments.

S Michael Crawford, clinical lead for research, Keighley

Cite this as: BMJ 2017;357:j2070

FITNESS TO DRIVE

Mandatory reporting is common sense

Should healthcare professionals breach confidentiality when a patient is unfit to drive (Ethics man, 8 April)? The obvious answer is yes.

GMC guidance lists actions to persuade patients to report themselves. I would welcome the requirement to tell patients that driving against advice would invalidate their motor insurance.

The case mentioned by Sokol and the Glasgow bin lorry incident show that self reporting doesn’t work. The easiest and quickest way to reduce the risks and delays in the current system is to place a legal responsibility on doctors to report medically unsafe drivers.

Some people continue to drive against advice and while unlicensed. The driver in the Glasgow bin lorry incident continued to drive after his licence was revoked. If he had been truthful about his previous episodes of syncope at the wheel, and if mandatory reporting was required, he almost certainly wouldn’t have been driving on that day.

Glyn Phillips retired GP, Glasgow

Cite this as: BMJ 2017;357:j2087

Mandatory reporting doesn’t work

Sokol discusses the mandatory reporting of patients unfit to drive (Ethics man, 8 April). I am sympathetic to the victims of road crashes, but practice must be evidence based. Mandatory reporting of medical conditions relevant to driving does not work for epilepsy, dementia, or obstructive sleep apnoea. This is compounded by the breach of clinician-patient relationships and trust, which may lead to avoidance of treatment that reduces risk.

Further study might be helpful in considering mandatory reporting of alcohol misuse and dependence. Current guidelines of relatively long periods of driving cessation need to be considered to ensure congruence between mandatory reporting, effective treatment strategies, and a due balance between safety and mobility.

Solutions include public campaigns to remind drivers of their responsibility for their own health and to follow professional advice, with stringent penalties for driving against such advice. All doctors and related healthcare professionals should attain a core competence in assessing medical fitness to drive.

Desmond O'Neill, geriatrician, Dublin

Cite this as: BMJ 2017;357:j2085
Interviewing the next director general of the WHO

Later this month a new director general of the World Health Organization will be elected. The three finalists for what is one of the world’s most critical appointments are Tedros Adhanom Ghebreyesus, David Nabarro, and Sania Nishtar.

We have had serious ethical issues with young family members being expected to translate for their older family members during consultations. In some cases, children have inappropriately been expected to translate for their parents on personally sensitive subjects, and we have had to reschedule the consultation for when a professional translator could attend. Language difficulties don’t have to be barriers, and they can force us to really think about how we effectively communicate, but there are issues other than communication that one has to consider.

Jill E Thistlethwaite, general practitioner

“It’s useful to consider any interpreter as a person also requiring consideration and understanding.”

Mark W Davies, consultant in anaesthesia and perioperative medicine

“While it may be good practice to ensure an interpreter other than a family member is available during consultations, this article also emphasises the importance of patient choice. The underlying message, as so often, is that health professionals need to ask and not assume: some patients may prefer a family member or friend that they trust rather than a stranger, but [doctors] also need to be alert to possible power imbalances in family relationships and things that may be hidden during translation.”

Jill E Thistlethwaite, general practitioner

DIGITAL HIGHLIGHTS

Reflections on family translators

We recently published a “What your patient is thinking” article (BMJ 2017;357:j1511) by two sisters—one who discusses what it is like to translate for family members in healthcare environments, and one who describes the experience of having their consultation translated. It seems to be a tricky aspect of practice to navigate judging from the doctors who submitted rapid responses. You can read some of the dialogue it prompted below:

“We have had serious ethical issues with young family members being expected to translate for their older family members during consultations. In some cases, children have inappropriately been expected to translate for their parents on personally sensitive subjects, and we have had to reschedule the consultation for when a professional translator could attend. Language difficulties don’t have to be barriers, and they can force us to really think about how we effectively communicate, but there are issues other than communication that one has to consider.”

Jane Crawford, salaried GP

“It’s useful to consider any interpreter as a person also requiring consideration and understanding.”

Mark W Davies, consultant in anaesthesia and perioperative medicine

“While it may be good practice to ensure an interpreter other than a family member is available during consultations, this article also emphasises the importance of patient choice. The underlying message, as so often, is that health professionals need to ask and not assume: some patients may prefer a family member or friend that they trust rather than a stranger, but [doctors] also need to be alert to possible power imbalances in family relationships and things that may be hidden during translation.”

Jill E Thistlethwaite, general practitioner

You can watch those interviews online at bmj.com/who-dg

Association between active commuting and incident cardiovascular disease, cancer, and mortality: prospective cohort study
BMJ 2017;357:j1456

Implementing shared decision making in the NHS: lessons from the MAGIC programme
BMJ 2017;357:j1744

Margaret McCartney: Medical school interview courses are needless and unfair
BMJ 2017;357:j1916

New York University sacks professor for refusing flu shot
BMJ 2017;357:j1975

Management of chronic pain using complementary and integrative medicine
BMJ 2017;357:j1284