> Hospitals looking at the abyss of financial balance sheets under austerity-onomics are unlikely to have viewed the updates as affordable

NO HOLDS BARRED Margaret McCartney PPA COLUMNIST OF THE YEAR

The NHS needs big, firm IT pants

A massive spread of "ransomware" has infected computers around the world, including many in the NHS. Operations have been cancelled, many test results can't be accessed, and investigations such as x rays have been made near impossible—all as predicted in *The BMJ* last week.

Essentially, hackers infect old computer operating systems, which are still used in much of the NHS. Many similar attacks have occurred before, if less well publicised, and many more are likely. Some US hospitals have actually paid ransoms amid great fear, in particular, about litigation resulting from theft of medical records. Natural disasters are one thing, but electronic disasters may not be far behind. An infrastructure meltdown involving power, healthcare, communications, and transport could effectively disable a country.

The question of apportioning blame is now unfolding. Amber Rudd, the home secretary, says that the NHS "must learn" from this and upgrade its systems.

"We have known for a number of years that this is one of the most dangerous threats to this country," she told the BBC, insisting that the government was investing in cyber security, etc etc (Jeremy Hunt's absence from the media immediately after the ransomware attack was notable).

Something Must Be Done. But, apart from telling your 1.7 million staff not to open dodgy looking emails, just what is that "something"? It's investment, but investment in the right things.

This is a system failure of the "fur coat and nae knickers" variety. This expression—charmingly used by Glaswegians to explain the showy, attention seeking nature of some Edinburghers who exhibit a superficial layer of glamour while lacking the necessary foundation garments (conflict of interest: I'm from Glasgow)—exemplifies the NHS's attitude towards technology.

Windows XP was released in 2001, but the Department of Health stopped making payments for updates in 2015. This may have saved £5.5m a year centrally, but hospitals looking at the abyss of financial balance sheets under austerity-onomics are unlikely to have viewed the updates as affordable once they had to fund them themselves.

We keep skimping on the basics. Some £8m was thrown at care.data before it was scrapped, and telehealth has cost millions but failed to save the money promised. And we may have all but forgotten HealthSpace, an early electronic record ditched in 2010 after patients described it as neither useful nor easy to use.

The NHS is throwing money at showy, attention seeking IT projects while it fails to invest in the basics—and, here, in keeping software updated. There are many possibilities as to what the NHS might do with computers and data—but we need big, firm, all embracing pants underneath it all.

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com
Follow Margaret on Twitter, @mgtmccartney
Cite this as: *BMJ* 2017;357:j2352

the people to spend the time needed advancing that collection. Academics now represent 4.2% of the consultant level workforce compared with 8.7% in 2016. And with fewer paediatricians entering training it is hard to see how that downward trend will change.

Chipping away of time

General paediatric and neonatal rotas have an average vacancy rate of 14%. This means 14% more work being taken on by those in post. Something has to give. It is the insidious chipping away at the time allowed clinicians and health professionals to contemplate additional projects that I fear will be the downfall of the healthcare we provide.

Some may suggest we are in a time of uphill struggle, so it is all hands on deck until this crisis is over—but this is not going to be over in a day or a week. The torrent of patients who need immediate care keeps coming and all the "routine" and "non-urgent" tasks for patients not directly in front of you slip to the bottom of the list.

Audits, reflective learning, quality improvement, research, promoting good public health, reporting concerns adequately—all these good practice measures have less time dedicated to them. What is left is an unintended side effect that hits the population who rely on the national health service to keep them well.

Emma Parish is a specialty trainee in paediatrics ejparish@hotmail.co.uk

This article first appeared on BMJ Opinion at bmj.co/impact_rota_gaps.

Cite this as: *BMJ* 2017;357:j2337

Rota gaps are endemic and morale often poor among junior and senior doctors, with fewer entering core or higher specialty training

Staff with a background in hospitals can't all seamlessly shift to community working, which requires different skills, mindset, and adjustment to a new culture. And the fallout from Brexit is already threatening our complacent reliance on overseas staff.

As for hospital medicine, 44% of the consultant physician posts advertised were unfilled last year. Rota gaps are endemic and morale often poor among junior and senior doctors, with fewer entering core or higher specialty training. And we've failed to plan adequately for a workforce that's increasingly female, flexible, and less than full time.

Understaffing begets poor morale—further damaging recruitment and retention. Employers can do more to support staff. But, in a nationally funded system, we need better workforce planning and more accurate numbers. The Lords' report and the Nuffield Trust have made a series of sensible recommendations. Let's adopt some of them.

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

Cite this as: *BMJ* 2017;357:j2192

BMJ OPINION Clare Macdonald

Primary care can play a vital role in breastfeeding support

The World Health Organization recommends that infants should be exclusively breast fed until 6 months of age, and then to 2 years and beyond alongside complementary foods. Despite this, only 1% of UK babies are exclusively breast fed at 6 months, and even at just 6 weeks only 23% are exclusively breast fed.

There is well documented evidence that increasing breastfeeding rates would lead to a fall in childhood otitis media, respiratory tract and gastrointestinal infections, and probably type 2 diabetes and obesity. Economic modelling shows that by increasing breastfeeding rates at 4 months to 45%, and ensuring that 75% of neonatal discharges are breast fed, there could be 53 930 fewer GP consultations each year. Despite this, there is limited funding for the provision of readily available and high quality breastfeeding support—with up to 85% of women stopping breast feeding before they want to.

Rightly or wrongly, families do contact their GP when other specialist channels fail them. So why don't we harness these presentations to protect and promote breast feeding—safe in the knowledge that this will cut the future workload generated by the baby before us?

The GP Infant Feeding Network is advocating for best practice

As well as reducing infant illness, increased breastfeeding rates would lead to reduced maternal breast cancer: breast feeding is protective for triple negative breast cancers, which are aggressive, difficult to treat, and which predominantly affect premenopausal women. Protection of, and support for, breast feeding could mean that fewer of us would need to support children grieving the loss of a mother.

GPs with commissioning roles should understand the value of breastfeeding support in a health economic context. We are not best placed to provide specialist support, but we should have clear referral pathways to allow easy access to prompt expertise for our patients.

There are moves afoot to acknowledge the crucial part that primary care can play in infant feeding. Norwich clinical commissioning group is rolling out a scheme for practices to become "breastfeeding friendly," with the provision of training and support. The recently formed GP Infant Feeding Network is advocating for best practice and promotes collaboration between GPs and associated colleagues.

Clare Macdonald is a GP working in Leicester and a member of the GP Infant Feeding Network team

ANALYSIS

The law and informed consent: where are we now?

Two years after the landmark negligence case against an obstetrician in Lanarkshire, **Sarah Chan and colleagues** discuss the consequences for practising doctors

The Montgomery *v* Lanarkshire case of March 2015[1] drew fresh attention to informed consent. Nadine Montgomery, a woman with diabetes and of small stature, delivered her son vaginally; he experienced complications owing to shoulder dystocia, resulting in hypoxic insult with consequent cerebral palsy. Her obstetrician had not disclosed the increased risk of this complication in vaginal delivery, despite Montgomery asking if the baby's size was a potential problem.

Montgomery sued for negligence, arguing that, if she had known of the increased risk, she would have requested a caesarean section. The Supreme Court of the UK announced judgment in her favour in March 2015. The ruling overturned a previous decision by the House of Lords,[2] which had been law since at least the mid 1980s.[3] The Supreme Court established that, rather than being a matter for clinical judgment to be assessed by professional medical opinion, a patient should be told whatever they want to know, not what the doctor thinks they should be told.

Doctors at the coalface have received little official direction on how their practice should change

Many organisations (in particular the General Medical Council, which intervened to make submissions in the case) said that the Montgomery decision had simply enabled UK law to catch up with current GMC guidance; others hailed it "the most important UK judgment on informed consent for 30 years."[4] Doctors have expressed their concerns about its potentially radical effects on patient care and clinical practice.[5]

We held a public debate in 2015, including doctors, lawyers, and medical students, which showed renewed tension between the professional discretion of doctors and patients' choices[6]; indeed, the verdict has been characterised as supporting patient autonomy over medical paternalism.[3-9] But what are the implications for doctors' practice and their legal liability? Two years after the Supreme Court's decision, we examine the effects of the Montgomery ruling on clinical and medicolegal practice.

Response to the ruling

Some clinicians said that retrospective application of the judgment could "open the floodgates" for claims in relation to doctors' past actions.[10] Others thought that the Montgomery ruling was unlikely to have this effect, however "excited the claimant law firms might become initially."[11] Legal opinions were reserved, describing the ruling as "the belated obituary, not the death knell, of medical paternalism."[12] Some argued that the standard imposed merely reflected good practice[13] and would make little practical difference to clinicians.[8] Nevertheless, the concern generated by the ruling might affect doctors' behaviour and other potential cases.

Doctors at the coalface have received little official direction on how their practice should change in light of the ruling. We have heard anecdotally that some hospitals are in the process of updating their procedures on informed consent, but few have completed this. Although the Medical Defence Union and the Medical Protection Society have each issued statements and updated their guidance, as have some royal colleges (such as the Royal College of Surgeons), other bodies such as the GMC and the Royal College of Obstetricians and Gynaecologists (RCOG) have yet to do so.

RCOG's difficulty in providing guidance perhaps reflects the unique nature of obstetrics—essentially helping two patients through a normal and inevitable physiological process. A further challenge is that the risks of birth can change dramatically and quickly, making

KEY MESSAGES

- The Montgomery judgment clarified the standard for informal consent and disclosure
- Doctors cannot withhold information because they disagree with the decision the patient is likely to make
- Training and education must be updated and fit for purpose

The Supreme Court established that a patient should be told whatever they want to know, not what the doctor thinks they should be told

detailed discussion and informed decision making difficult. These "emergencies" might be exempt from the Montgomery ruling, depending on their nature and timing, but complications of labour (such as sudden and profound fetal distress or major maternal haemorrhage) are not, even though, as was noted in the judgment, choices about management of labour cannot generally be deferred. GMC guidance says that the consenting process is not a snapshot but an ongoing process. Planning for labour emergencies is essential, so that the doctor and patient can discuss the patient's wishes if an emergency should arise.

RCOG has proposed pilot programmes to identify what resources women, clinicians, and health services need to comply with the Montgomery ruling. Training and educational materials must be fit for purpose. Obstetricians urgently need guidance.

Legal consequences for doctors

The Montgomery decision redefined the standard for informed consent and disclosure. Previously, the Bolam test[14] in England and the Hunter *v* Hanley test[15] in Scotland were used to determine what should be disclosed. These tests ask whether a doctor's conduct would be supported by a responsible body of clinicians.

The Bolam test was affirmed in Sidaway *v* Bethlem Royal Hospital Governors and others,[2] although the ruling was not unanimous, with judges placing different weight on the patient's right to make informed treatment decisions versus the doctor's professional judgment in disclosing information.

The Montgomery case firmly rejected the application of Bolam to consent, establishing a duty of care to warn of material risks. The test of materiality defined in the Montgomery ruling was whether "a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."[1] The solicitor representing Montgomery spoke of the decision as having "modernised the law on consent and introduced a patient focused test to UK law."[16]

Retrospective cases

Constitutionally, the Supreme Court cannot make new law; it can only state what, in theory, the law has always been. Doctors may have been treating patients as they understood the law to be, as in the Sidaway case, but the Supreme Court has told us that this was wrong[3] and that anyone who practised according to Sidaway was also wrong.

In practical terms, the ruling should apply at least back to 1999, when Montgomery saw her obstetrician. Guidance in effect at that time from the GMC,[17] BMA,[18] NHS, and the Scottish Office[19] supported a doctor's duty to disclose relevant information and risks. So the Montgomery principles have been known—or should have been known—by doctors for many years.

Since the Montgomery ruling, several attempts have been made to introduce a consent based claim to cases that were under way before the decision. One such attempt in Scotland has, so far, been unsuccessful.[20] Two English cases have allowed consent claims to be added after the Montgomery decision.[21 22] Some cases have succeeded on a Montgomery basis[23]; we (AA) understand that others have settled before litigation ever started or was concluded, as the claims were unanswerable in the light of Montgomery.

We (ESC) have noticed that a considerable proportion of cases of obstetric negligence raised since Montgomery involve consent in addition to standard complaints of substandard care. These issues are not always pursued, but obstetric litigation practice has noticeably changed, making professional training and clarity with respect to guidelines an even higher priority.

Nadine Montgomery, pictured with her son Sam, was awarded damages of £5.25m in a landmark ruling that redefines the standard for informed consent

Subsequent cases

Looking at some of the cases in which the Montgomery ruling has been considered tells us about its interpretation to date. In Spencer *v* Hillingdon NHS Trust (April 2015)[23] the patient had bilateral pulmonary emboli after a hernia operation. He did not seek treatment immediately because he had not been advised of the risk of deep vein thrombosis or pulmonary embolism or of symptoms that might indicate these. The judge considered the Montgomery ruling and found that failure to inform the patient was a breach of the duty of care.

Shaw *v* Kovac (October 2015)[24] concerned a patient who died in 2007 after a transaortic valve implantation, which was then still the subject of clinical trials and not fully approved. The claimant's argument sought to use the Montgomery ruling to ground a claim for damages for the loss of life without informed consent. The court rejected this, holding that the Montgomery ruling did not create a right to informed consent as an independent cause of action, but simply set a new legal standard for the duty to disclose.

In Mrs A *v* East Kent Hospitals University NHS Foundation Trust (April 2015),[25] the claimant's baby, who was conceived using intracytoplasmic sperm injection, had a chromosomal abnormality. The claimant alleged that the trust was negligent in failing to advise of this possibility. The court applied the Montgomery test and decided that the risk was not material, because neither a reasonable patient nor the patient herself would have attached significance to it. Thus, although the test is focused on patients, doctors are not liable for every omission of disclosure to which a patient later objects.[25]

Clinical concerns and ethical arguments

Some doctors feared that more stringent disclosure requirements would risk overwhelming patients with information, causing distress or leading them to make poor decisions, while doctors' time would be taken up with lengthy explanations, creating a drain on healthcare resources.

Information overload is unlikely given that information should be tailored to the patient. But doctors must judge what is appropriate for each patient and how their exercise of judgment might be assessed by the courts. The doctor might think that disclosure of certain information could lead the patient to a decision that is not in their best interests, as was true for the Montgomery case. But the ethical and legal position is clear: doctors must not withhold information simply because they disagree with the decision the patient is likely to make if given that information.

Another concern was that the ruling would encourage "defensive medicine," shifting the focus from helping the patient to protecting the doctor. But doctors should have already been following GMC guidance, which highlights the importance of communication.[13]

Finally, doctors criticised the focus of patient autonomy over medical paternalism. But this is a false dichotomy—the idea of a fully autonomous patient making choices completely independent of the doctor's input does not reflect the complex reality of medical decision making, nor does the caricature of a paternalistic doctor riding roughshod over patients' objections.

Patients are not always aware of the facts of their treatment after consent related discussions,[26] and they are influenced by the way in which information is presented (the "framing effect").[27] But the difficulties of conveying information about treatment and risks should not be taken to indicate that patients are incapable of understanding medical information or that patient autonomy in decision making is meaningless.

The doctor's role is to ensure that relevant information is presented to enable the patient to use it meaningfully

Conclusions

The Montgomery case was framed as a clash of values—patient autonomy versus medical paternalism. In reality, medical decision making involves a nuanced negotiation of information. Today's patients can expect a more active and informed role in treatment decisions, with a corresponding shift in emphasis on various values, including autonomy, in medical ethics.

The full implications of the case are undoubtedly still unknown, but Montgomery has clear relevance for medical law and ethics. Ethically, it clarifies the existing shift towards a more cooperative approach in the consultation room. The Montgomery ruling has not radically changed the process of consent; it has simply given appropriate recognition to patients as decision makers.

Sarah W Chan, chancellor's fellow, Usher Institute for Population Health Sciences and Informatics, University of Edinburgh
sarah.chan@ed.ac.uk
Ed Tulloch, E Sarah Cooper, Andrew Smith, Wojtek Wojcik, Jane E Norman

Full author details on bmj.com

Cite this as: *BMJ* 2017;357:j2224

Thomas Starzl

US pioneer in immunology and transplantation

Thomas Earl Starzl (b 1926; q Northwestern University Medical School, Chicago, 1951), died from complications of influenza on 4 March 2017

On 1 March 1963, while working at the University of Colorado, surgeon Thomas Starzl performed the first human liver transplant. His patient, a 3 year old boy with biliary atresia, bled to death during surgery. His subsequent four liver transplant patients survived surgery but died from multiple infections and pulmonary emboli within a few weeks. Surgeons worldwide declared a moratorium on the procedure, forcing Starzl back to the drawing board to devise new procedures. Finally, in July1967, he operated on Julie Rodriguez, a 1 year old child with liver cancer, who became the first human liver recipient with survival exceeding one year.

But although Starzl undertook 175 liver transplants in Denver, with survival rates of 30-50%, he found himself right back to square one when he moved centres to the University of Pittsburgh in December 1981.

Anti-rejection drug regimens

Thanks to Starzl's tenacity, Pittsburgh became one of the busiest transplant centres in the world. At one stage, Starzl and his team were performing up to 600 liver transplants a year. Part of his success was down to his pioneering use of anti-rejection drugs. Initially he treated transplant patients with three drugs—azathioprine, steroids, and his "home made" antilymphocyte globulin, purified from the serum of horses immunised against human lymphoid cells.

Later, Starzl championed the use of FK-506 (tacrolimus), an anti-rejection drug derived from a fungus found in Japanese soil. His work led to phase III trials (which he declined to take part in) and tacrolimus being approved by the US Food and Drug Administration in November 1993.

The effort of early transplant surgery was enormous, with two separate operations (removal from the donor and transplant to the recipient). Starzl was often required to fly to different parts of the US to retrieve organs from donors. His scientific output made him one of the world's most cited scientists. Over the course of his lifetime he wrote a total of 2281 publications in 248 journals.

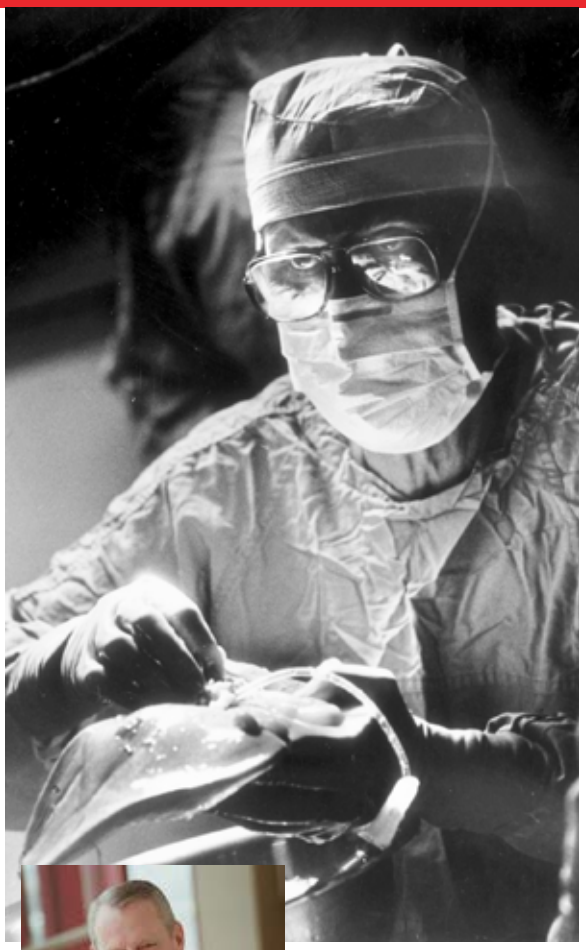
Thomas Starzl was born on 11 March 1926 in LeMars, Iowa, the second of four children of Roman Starzl, a newspaper editor and science fiction writer, and Anna Fitzgerald, a nurse. Starzl worked on his father's paper from the age of 12 and was astonished by the manual dexterity of printers who hand set newspapers letter by letter.

Denver's first kidney transplant

Starzl joined the faculty at the University of Colorado in 1962, and within three months had undertaken Denver's first kidney transplant. One blip in his otherwise stellar career was a series of articles in the Pittsburgh Press, highlighting "favouritism" in the kidney transplant programme, where rich foreigners were pushed to the top of waiting lists. A federal grand jury began hearings in 1985 to see if the Presbyterian University Hospital and Starzl had allowed kidney transplants to be performed "for valuable consideration," which would be a violation of the National Organ Transplant Act. The US Justice Department investigated but in 1989 announced that no charges would be brought. Eventually, the Pittsburgh team developed a points system, based on factors such as the time spent on waiting lists and how sick the patient was, which became the national standard.

Health problems

In September 1990, at the age of 65, Starzl stopped operating, announcing that he was weary of surgery and emotionally exhausted from "an uncompromisingly difficult life." He had been deeply affected by the death of 14 year old Stormie Jones (whom he had given the world's first combined heart-liver transplant in 1984), and his work had also taken a huge toll on his health. In 1964 he contracted viral hepatitis, in 1986 he was partially blinded by a surgical laser, and in 1990 he underwent a heart bypass operation.



At the age of 65, Thomas Starzl stopped operating, announcing that he was weary of surgery and emotionally exhausted

Another casualty of his work ethic was family life. His first marriage, to Barbara Brothers, the mother of his three children (Tim, Rebecca, and Tom), in 1954, ended in divorce. He met his second wife, Joy Conger, a laboratory technician whom he married in 1981, when she knocked him off his bike. It took her a while to realise that he was her boss's boss. One tragedy of his later years was that Rebecca and Tom predeceased him.

In retirement he enjoyed a slower pace of life, catching up on the films he had missed, and taking out his dogs. At his funeral, which was held on what would have been his 91st birthday, Joy invited the congregation to sing "Happy Birthday."

Janet Fricker, Hemel Hempstead
janet.fricker1@btinternet.com

Cite this as: *BMJ* 2017;357:j1806

OBITUARIES

Rita Phiroz Anklesaria

Consultant anaesthetist Lister Hospital, Stevenage (b 1925; q G S Medical College/ KEM Hospital, Bombay, 1949; FFA RCS Eng), died from chronic respiratory insufficiency on 22 January 2017

Rita Phiroz Anklesaria grew up in India. She lost her mother at an early age, so she and her sister were sent to boarding school. Soon after qualifying she came to England. She did a senior house officer post at St George's Hospital in London. During her senior registrar post at the Whittington Hospital, Rita was invited to join the opera club, and this became her lifelong passion. The Royal Shakespeare Company was close to her heart too. She stood up for equal rights for women and was not easily cowed by male colleagues, always encouraging women colleagues to be vocal. I consider myself lucky to have found another Parsee Zoroastrian to work as an anaesthetist with me for 22 years.

Rumy Kapadia

Cite this as: *BMJ* 2017;357:j2019

Eric Lewis Blair

Professor of physiology Newcastle University (b 1924; q Durham 1948; MD, FRCP), d 27 September 2016

Eric Lewis Blair was appointed professor of physiology at Newcastle University in 1969 and became head of department in 1972. His research advanced the understanding of gastrin, secretin, and pancreozymin. He made major contributions to the methodology of extraction and bioassay and immunoassay of these hormones. He was also noted for building up research groups. His enthusiasm for medical education led to the integration of preclinical science with clinical medicine in a revamped medical course at Newcastle, and he pioneered the Bachelor of Medical Science degree there. At the time he retired, in 1988, he was academic subdean. In his retirement, he spent time in his garden or on the golf course, latterly in Quinta do Lago, Portugal. He leaves his wife, Dorothy; five children; and 17 grandchildren.

Stephen Blair

Cite this as: *BMJ* 2017;357:j2021

Geoffrey Munro Gill

General practitioner (b 1930; q Aberdeen 1953; MBE, FRCGP), died from oesophageal cancer on 10 March 2017

On completing his national service Geoffrey Munro Gill ("Geoff") did six months at Aberdeen Maternity Hospital before joining his father, James Gill, in general practice in Inverurie, Aberdeenshire. He pioneered one of the first health centres in the region in 1973, while being immersed in the BMA, both local medical committee and executive council, holding high office in each. He became a lecturer in the fledgling Aberdeen University department of general practice and was active in the Royal College of General Practitioners and many other organisations. He found relaxation in the theatre, world travel, and a fun game of golf once a week, and was a man of unwavering even temper and a colleague of total integrity and dependability. He leaves Margaret Philip, his wife of 59 years; three children; and four grandchildren.

Margaret Gill, Pierre Fouin

Cite this as: *BMJ* 2017;357:j2038

Robert Desmond Gibson Creery

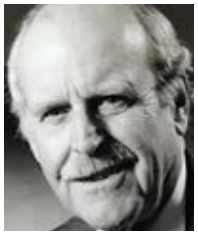
Consultant paediatrician (b 1921; q. Belfast 1943; MD, DCH, FRCP Lond), d 26 March 2017

After war service as a naval reservist, Robert Desmond Gibson Creery ("Desmond") trained in paediatrics in London, Bristol, and Belfast. As a senior registrar he contributed to the elucidation of the iatrogenic disease of infantile hypercalcaemia; metabolic disorders remained an abiding interest throughout his career. He held two consultant posts, in South Tyneside (10 years) and in Gloucestershire (17 years), where he was clinical tutor for many years. After the war, he continued as a naval reservist, retiring in 1963 as surgeon commander. He retired from the NHS in 1983 and moved to Guernsey, where he was employed as a locum in public health (community paediatrics) for five years. He leaves his second wife, Annette; five children from his first marriage; five grandchildren; and three great grandchildren.

Annette Creery

Cite this as: *BMJ* 2017;357:j2036

Robert John Cairns



Consultant dermatologist Kent (b 1921; q London Hospital 1943; FRCP), died from old age on 2 April 2017

After a short period as a general practitioner, Robert John Cairns developed an interest in dermatology and trained at St John's Hospital and St Mary's Hospital in London. He served as a dermatologist on a short service commission in the Royal Army Medical Corps and was posted to Germany. In 1951 he was appointed consultant to Maidstone Hospital, and for 20 years he singlehandedly provided dermatology services for Rochester, Gravesend, Dartford, and Sidcup hospitals. His publication record was considerable, and he held office in several professional organisations. After retiring he continued in private practice and did occasional hospital locums until 1996. He died peacefully at home with his family. He leaves his wife, Theresa ("Terry"); three sons; nine grandchildren; and five great grandchildren.

Robert Cairns, Stuart Cairns

Cite this as: *BMJ* 2017;357:j2035

Donald James Fairclough

General practitioner Yorkshire (b 1927; q Cambridge 1956; FRCGP), died from oesophageal cancer on 14 February 2017

In 1957 Donald James Fairclough joined the practice that his father, James Fairclough, had established in 1927. Newly married and soon with two sons, he quickly settled into family practice. He became a fellow of the Royal College of General Practitioners in 1984, which led to his involvement in the vocational training scheme. He discovered a gift for helping trainees, and this became a source of enduring satisfaction. He also wrote extensively for *Pulse* and *General Practitioner*. He was appointed provost of postgraduate medicine for Trent, covering teaching hospitals in Sheffield, Nottingham, and Leicester. After retiring in 1993 he continued with attendance allowances and was the referee for Barnsley Crematorium until his mid-80s. Donald leaves Lillias, his wife of 60 years; his younger son; and two grandsons.

Christine Bishop

Cite this as: *BMJ* 2017;357:j2117

HEALTH GAP

Death rate now rising in UK's poorest infants

The recent report by the Royal College of Paediatrics and Child Health highlights the stark gap in health between rich and poor children in the UK and shows that improvements made in recent years have slowed (News online, 26 January). The data on infant mortality released by the Office for National Statistics this month indicate that these improvements are reversing.

In 2015 infant mortality rose for the first time in a decade. Worryingly, the rate has been rising for the poorest children since 2010, while continuing to fall for more advantaged groups, thus widening inequalities.

Infant mortality is a sensitive indicator of the prevailing socioeconomic conditions affecting children. In recent years child poverty has risen, and services that support children have been cut. Health professionals and policy makers should be greatly concerned that these changes might now be leading to increased infant mortality among the most disadvantaged families.

David Taylor-Robinson, professor of public health and policy, Liverpool
Ben Barr, senior lecturer in public health, Liverpool

Cite this as: *BMJ* 2017;357:j2258

CHILD MENTAL HEALTH

Poor investment in child mental health

Wolpert et al discuss the limited evidence base for treatment in child mental health (Analysis, 15 April). We must also focus on the capacity of services, which have lost funding at a time of rising demand—referrals to young peoples' mental health services rose by 44% over the past four years. This has affected the availability of interventions that are known to achieve good outcomes.

We urgently need more funding to develop more effective targeted treatment interventions. We are currently working on a research project funded by NIHR to develop personalised interventions for families who fail to benefit from the parent training programmes recommended by NICE. But projects like this are rare. Mental health research in general is underfunded relative to overall disease burden, and only a tiny proportion is allocated to treatment research (4%-6%). Such poor investment in services and research would not be tolerated for physical health difficulties.

Eilis M Kennedy, consultant child and adolescent psychiatrist
Rob Senior, consultant child and adolescent psychiatrist, London

Cite this as: *BMJ* 2017;357:j2264

DAVOR PAVELIC / ALAMY

LETTER OF THE WEEK

Happiness research ignores social factors

As a sociologist, I was interested to read the interview with Paul Litchfield about happiness research (Interview, 15 April). The value and purpose of happiness research has been much debated and critiqued in sociology. Happiness and wellbeing undoubtedly have personal and interpersonal value, but we need to question the purpose of research that makes something previously considered a private concern into a matter of public and collective interest.

A sociological understanding of happiness research is important to medicine, because though health, happiness, and wellbeing are experienced individually, they are also a collective phenomenon shaped by social, political, and economic factors.

The origins of happiness research coincide with the rise of neoliberalism and its associated values of "free will," "self responsibility," and "individual choice." Neoliberal governments have used psychometrics to legitimise their social policies of austerity, blaming individuals for their marginalisation rather than acknowledging structural and systemic problems in the distribution of wealth and resources. Happiness research also tends to ignore the role of social and structural factors in wellbeing. Access to resources, the gap between rich and poor, and having adequate job opportunities are equally as important to health and wellbeing as happiness, if not more so. Decades of research in health sociology confirm that access to resources is the most consistent determinant of health and wellbeing.

Patricia N Neville, lecturer in social sciences, Bristol

Cite this as: *BMJ* 2017;357:j2252

RAPID TESTS FOR MALARIA

Do rapid diagnostic tests improve quality of care?

Hopkins et al show that rapid diagnostic tests might increase unwarranted prescription of antibiotics (Research, 1 April). They focus on treatment outcomes, but quality of care is more important.

We found that fever care for paediatric outpatients in Malawi was low quality in terms of completed fever assessments and antibiotic targeting, despite compliance with malaria treatment guidelines. The ultimate goal should be to empower health workers at peripheral clinics to manage non-severe non-malaria febrile illnesses without referral, even in weak health systems.

Integrated, holistic treatment strategies are critical for both patient care and antimicrobial resistance. They require funding to provide comprehensive support to health workers. Guidelines should be reviewed to clarify antibiotic prescriptions in the fever algorithm, which is currently unclear.

Improving the quality of clinical care, including adherence to malaria test results, requires stronger health systems, and rapid diagnostic testing is a unique opportunity to contribute to this effort.

Emily W Johansson, researcher, Sweden
Helena Hildenwall, researcher, Sweden
Humphreys Nsona, programme manager, Malawi
Valentina Buj de Lauwerier, global malaria adviser, UNICEF
Stefan Swartling Peterson, associate director, UNICEF

Cite this as: *BMJ* 2017;357:j2290

RURAL HOSPITALS

Providing surgical services in rural settings

Oliver outlines the challenges of rural healthcare (Acute perspective, 15 April).

The Royal College of Surgeons of Edinburgh has published a plan to provide safe and appropriate local general surgical services in a rural hospital setting. It requires close collaboration between rural consultants and visiting specialists who can share decision making and provide opportunities for additional operating in a high volume centre. National guidelines will need to be adapted.

Maintaining appropriate healthcare in rural areas requires a will by politicians to facilitate and fund these recommendations to provide a robust and appropriate rural healthcare system.

David Sedgwick, consultant general surgeon, Fort William
Gordon McFarlane, consultant general surgeon, Lerwick

Cite this as: *BMJ* 2017;357:j2324