Sepsis is not the only emergency

Just ask . . . could it be sepsis?” The Sepsis Trust has issued posters instructing parents to ask this, as “it’s a simple question but could save a life.” It’s also produced a list of what to look out for. Any child who is breathing quickly, has a fit or is unconscious, looks mottled, blue, or pale, has a non-blanching rash, is very lethargic or difficult to wake, or is abnormally cold to touch “might have sepsis”; and anyone whose child under 5 is not feeding, is vomiting repeatedly, or has not passed urine in 12 hours is urged to seek advice.

General practice is not hospital, and it has a different population. Detecting already very sick children in general practice is usually easy, as they’re obviously ill. It’s also very rare. Children with infections are often unwell, but not seriously: they are managing physiologically. Detecting the unwell child who’s going to become very ill without secondary care intervention is very hard.

All children with certain common conditions—such as an upper respiratory infection or an open wound—are at risk of sepsis, but they’re unlikely to contract it. In the early stages of illness it’s impossible to be sure that this child in front of me won’t develop sepsis in the coming hours or days.

Children can be terrifying, because they can get ill quickly. They can also get well quickly: parents of children who perk up in the consulting room often apologise for bringing in their now smiling child as an emergency (I’m invariably pleased, although I usually wonder whether I’m being falsely reassured).

The commonness of minor illness and the potential for rapid change mean that tools used for risk assessment in secondary care can’t easily be used safely in primary care.

In recent years a new tool was added to many GPs’ electronic note systems. GPs keyed in the temperature recording, and it triggered a cascade of further interventions to investigate and manage sepsis. I know many GPs who switched it off or stopped recording temperatures in the way that made it light up.

Before anyone accuses GPs of being lax, consider the number of alerts already present that distract from, rather than assist in, management. If every doctor read every alert generated during every consultation and drug prescription the NHS would be immobilised, to the detriment of patients waiting for assessment and worsening while doing so.

There is another problem. Sepsis is not the only life threatening emergency. Tools to encourage the consideration and exclusion of just one diagnosis, when many are possible and equally important, don’t work the way primary care should. Is it right to place an onus on parents—and, if so, shouldn’t they also inquire whether their unwell child has asthma, meningitis, a brain tumour, or significant arrhythmia?

Given the unconscionable strain on the NHS, I fear that false positive risk assessments will mean delays for people who really do need inpatient care.

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NO HOLDS BARRèD Margaret McCartney

"Before anyone accuses GPs of being lax, consider the number of alerts already present that distract, rather than assist in, management"
Cheap, undervalued, expendable: junior doctors in 2017?

NHS trusts are still treating trainees as if they are expendable at a time when morale should be a priority

A family friend isn’t happy. Fresh from graduation—and only days from beginning his first proper job—Sam has yet to see a contract, a rota, or even basic information about what he can expect to be paid. And no, he isn’t embarking on a career as an Uber driver, Deliveroo courier, or some other entrant into Britain’s burgeoning gig economy. Sam is a final year medical student. Five A levels, a degree in medicine, and another in science under his belt: he is the kind of graduate big firms would leap at. But the employer failing him so dismally—before he’s even started—is Britain’s biggest, the NHS.

Sam’s experience is not unique. As is depressingly usual for this time of year, junior doctors and medical students have been peppering social media with forlorn posts asking their peers what to do about their new employers, the NHS trusts ignoring their pleas to provide them with a contract, rota, or confirmation of salary in advance of starting work. These requirements are hardly outlandish. In what other job—graduate entry or otherwise—are you expected to sign a waiver opting out of the European working time directive and start work without being told what you will be paid or what your working hours will be? It says something about doctors’ capacity to accept their lot that any of us tolerate being treated with such disdain.

A colleague, only three years into her training, summed it up like this: “I just assumed this must be how it’s done in medicine. Whenever I’ve asked for a contract and salary details before starting work, I’ve been made to feel like I’m doing something wrong. The implication was that I should be grateful I had the opportunity to be a doctor, so just stop being so demanding. When you look back on it, it’s madness.”

Humiliating

Madness indeed. Another colleague describes being called by human resources shortly after being signed off sick for a fortnight. Despite having informed his seniors of his serious illness, HR informed him that they expected him to find his own locum cover, that the rota gap was his fault, and that it was unprofessional and unacceptable that he had not filled it.

“It was humiliating,” he told me. “I was vulnerable. But they expected me to email my colleagues, explain my health problems, and persuade someone to cover for me. It made me

Is the NHS trying to help or bully social care?

Social care in England has been hit hard by cuts in local authority funding imposed by the coalition government. Its funding is not ringfenced, and, unlike NHS care, provision is based on means testing and is now severely rationed. Local authorities, which must operate within their means and without the last minute bailouts available to NHS providers, are further constrained by the political compromises and short term planning that arise from electoral accountability.

An estimated 400 000 fewer people now receive statutory support than in 2010. Most social care provision is commissioned from private providers, which have suffered from the impact of Brexit and the living wage on the labour market, and their margins.

All this affects acute NHS provision. Delayed care transfers rose 31% in 2013-15 alone, most quickly in social care. And many patients with complex care and support needs are admitted to acute beds. Backtracking attempts have been made to plug the funding gap, through initiatives such as the Better Care Fund. But the National Audit Office is clear this has not delivered the preconditions of reducing admissions or delayed transfers.

Increasingly, we hear calls to prioritise social care rather than the NHS for new spending. An additional £2bn for social care over three years was recently announced—surely a “well done” for NHS leaders, altruistically advocating for more social care funding at their expense. Scratch the surface, however, and the new money is heavily skewed towards getting social care to help acute NHS provision and, as winter approaches, to avoid overcrowding and emergency care scandals. The £2bn came with government planning guidance emphasising the need to reduce delayed transfers by 2000-3000 a year, with the Care Quality Commission inspecting local authorities against
is the NHS trying to help or bully social care?

David Oliver

Many patients I see defaulting approaches we need to embed. Is the antithesis of the collaborative culture we need if personalisation, prevention, and help people be more independent. The credo of social care is based on personalisation, prevention, and help people be more independent.

A blind eye

Responsibility rests most obviously with employers. There are 152 acute hospital trusts in England. That means there are potentially 152 chief executives who are choosing to turn a blind eye to—or—worse—simply not caring that the institutions they lead are failing to give their junior doctors basics such as a contract, a rota, and a confirmed salary before employing them. There may well be individual trusts that can confirm their junior doctors are not being treated this way. But can all trust chief executives guarantee that from this point onwards, none of their junior doctor employees will be subjected to these practices—and if not, why not?

Is the NHS trying to help or bully social care?

One of the glimmers of hope emanating from last year’s dispute between junior doctors and the government was the chorus of pledges from powerful institutions to tackle low morale among doctors in training. I thought—perhaps naively—that this would mean proper action, not mere words. So how is it that a full year later, in August 2017, NHS trusts still get away with treating their newest doctors—the ones filled with hope and enthusiasm—with such disdain?

Is it really beyond the combined might of the health secretary, NHS England, NHS Employers, the GMC, and Health Education England—all of whom have promised to tackle low morale in an alienated doctor workforce—to ensure that trusts can no longer exploit their youngest and most vulnerable medics in this manner? And, in an era of unprecedented NHS staff shortages, can any of them really afford not to? Around one in 10 specialty training posts were unfilled this year. So on basic economic grounds—if not decency—ensuring juniors do not feel expendable ought to be a priority.

BMJ OPINION Sharon Roman

Breaking bad news

It is a struggle to know how best to give a patient bad news. Unfortunately, there is no magic formula. Being given a diagnosis is personal in nature, but uniform in truth.

It can be a revelation to a patient: the pieces of the puzzle finally fit. It almost brings a sense of relief—they have not been imagining or exaggerating their symptoms. But it’s a short lived relief as other emotions begin to take over: fear, anger, and more.

For doctors, it’s worth remembering that your words and this moment will last a lifetime. You can never take back this time, this life changing moment for your patient. Pick up the chair in the hospital room, and move it to the bedside. While it may have been a long day for you, it will be an even longer one for your patient. If the setting allows, come back to check in before you leave; you can be a constant in a new world of uncertainty—even if it is for just one day.

Write down the name of the diagnosis (I have what...?). Have some facts at hand, if possible, along with some reliable resources for more information. Perhaps even offer the name of an organisation that can offer links to support groups and other trustworthy, helpful sources. The web is full of misinformed, though well meaning, websites.

In person, be mindful of your body language and soften your words with your posture. If you are cold and hard, the news will be harsher. I don’t need a hug, but I do ask for solicitude and compassion.

You can never take back this time, this life changing moment for your patient

As I write this I am awaiting the results of a biopsy. When I admitted that I had delayed joining my husband during a trip in order to keep my appointment, the option of a telephone call was offered. I could receive an answer to the question of cancer thousands of kilometres away from home, but with my husband.

So here I sit, in a hotel room, waiting for my phone to ring, my thought-out questions written neatly beside it. If the news is bad, I am hoping for a personal touch, something that shows my doctor remembers our brief visits.

If possible I’d like my doctor to find a way to—over the distance—pick up the chair and bridge the gap.

Sharon Roman studied economics at the University of Toronto and Simon Fraser University. She had her first MS attack around the age of 30.
Keeping up with the Johanssons: How the UK’s health spending tallies with the rest of Europe

Decisions about what is the appropriate amount for states to spend on health require more than a simple comparison with what other countries allocate, argue John Appleby and Ben Gershlick.

The latest data published by the Office for National Statistics (ONS) for the UK and the Organisation for Economic Cooperation and Development (OECD) for other countries, suggest that previous figures have underestimated how much the UK spends on health compared with other countries.

The changes in accounting make no material difference to actual spending on health. Nonetheless they raise important questions, not least on the implications for arguments about the appropriateness of the level of health spending in the UK. Although the new data help us understand the UK’s relative health spending, they do not imply that the UK is spending the “right amount” any more than the previous data meant that the UK was not spending enough.

Here we describe the new spending figures, the reasons for the revisions, and the extra detail the new accounts provide about spending on different types of healthcare.

What’s new?
The latest internationally agreed revisions—the System of Health Accounts 2011—show that rather than a total (public plus private) spend of 8.7% of gross domestic product (GDP) in 2014, the UK spending was in fact 9.8%.

Total spending was 12.4% (£19.8bn) higher in 2014 than estimated under the previous definition (table 1). Current public spending was 13.4% (£16.8bn) higher and private spend 31.0% (£8.6bn) higher.

The reasons for these increases are shown in figure 1, which breaks down the differences in total spending between the old and new accounting methods for 2014. Along with some (relatively) small additions to spending, capital spend (on items that are used for several years, such as buildings and IT) at £5.6bn, is the largest exclusion.

Key messages
- New methods of assessing health spending suggest that the data have previously underestimated how much the UK spends on health compared with other countries.
- The UK spends roughly the same on health as the average of other EU-15 countries.
- Its spending on different areas of care is also in line with EU averages.
- Decisions about the appropriate amount to spend on health require more than a simple comparison with other countries.

The amount Greece spends per person a year on healthcare, almost half what is spent by the UK.

Fig 1 | Breakdown of the effect of new calculation method (SHA 2011) on UK healthcare spending figures, 2014 (NPISH=Non-profit institutions serving households)
Long term care (eg, residential nursing homes) and health related social care (the majority of local authority social care spending, including care where the need results from a health condition or supporting activities of daily living such as walking and bathing) plus payments to carers (£25.4bn in total) are the largest additions. The figures continue to include preventive care, but the new accounting methods further blur the line between health and healthcare. Several of the changes in the accounting method are to adjust for problems identified in the previous method that reduced the comparability and accuracy of countries’ estimates. This comparison is only possible using 2014 data published by the ONS. Since then the OECD has revised the total UK spend from £179.5bn to £178.6bn for 2014. Nevertheless, the ONS breakdown remains illustrative of the new accounting changes.

How does the UK compare?

The UK is not particularly unusual in the amount it spends on health compared with the other 14 original countries of the EU. Sweden, France, and Germany all spend 11.1% or more of their GDP on health whereas Portugal, Greece, and Luxembourg all spend 9% or less of GDP.

The UK is about average for overall spending, with health spend as a percentage of GDP the ninth highest out of the 15 EU countries (fig 2). It is marginally above the unweighted average of the other 14 countries and about 1 percentage point above the OECD average (excluding the UK). Matching this OECD average would imply a reduction in UK spending of about £15bn.

This is a major revision from the UK’s position with the old definition, under which its health spending as a percentage of GDP was below the EU-14 and OECD averages (both weighted and unweighted). Growth in health spending

| Table 1 | Comparison of UK healthcare spending in 2014 estimated using old and new (System of Health Accounts 2011) definitions |
|------------------------------------------|-------------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| | Old estimate | SHA 2011 estimate | Change |
| | £bn | £bn | £bn (%) | % point GDP |
| Total (public+private) | 158.8* | 178.6† | 19.8 (12.4) | 1.1 |
| Current (public+private) | 153.2 | 178.6 | 25.4 (16.8) | 1.4 |
| Public (current) | 125.4 | 142.2 | 16.8 (13.4) | 0.9 |
| Private (current) | 27.8 | 36.4 | 8.6 (31.0) | 0.5 |

*Includes capital spending (£5.6bn).
†Excludes capital. The SHA 2011 accounting changes mean capital is no longer included in the main estimate of total health spending (see fig 1).

A QUARTER of the Netherlands’ spending goes on health related long term care. It is Europe’s highest spender in this area
In terms of absolute spending (adjusted to reflect different purchasing powers of currencies in different countries) the UK spends £2800 per person a year on health.

Trends in health spending are gradual—on average only slightly higher than GDP growth. As a result, movement in the rankings of countries’ spending is usually minimal unless there are major changes in health systems, serious economic events, or redefinitions of health spending.

In terms of absolute spending (adjusted to reflect different purchasing powers of currencies in different countries and adjusted to a base year, for comparison) the UK spends $3675 (£2800) per person a year on health. This is just below the EU-14 average ($294, or 7.4% less). This is considerably closer than under the previous definition, with the UK now spending almost $1000 more per person. It is still much less than the Netherlands ($4857 (£3700)) but much more than Greece ($1870 (£1420)).

The amounts spent on different types of healthcare vary widely. Two thirds of spending in Portugal goes on curative care, whereas for Belgium it is less than half (fig 3). The UK is about average—spending about the EU average of 56% on curative care. The Netherlands spends the most on health related long term care (over a quarter of its spending).

As the population gets older, and lives longer with more morbidities, preventive and long term care will become more important. Understanding how money is being spent in these areas across the EU can help inform this transition from a more traditional medical model (with a strong focus on curative care) to a different approach and gives an idea of the financial implications of this. High spending countries spending less on curative care might reflect the short term costs of this approach, but that is unlikely to explain it all.

Some of the variations—between proportions of total health and care spend of countries on curative compared with preventive care or outpatients compared with day case activity—might simply reflect different interpretations of the new accounting rules. But some will be real (and perhaps loosely correlated with total spending levels), reflecting a combination of factors; for example, historical differences in the way health systems are organised and funded, variations in relative costs of different forms of care, medicocultural variations, patient preferences and needs, and deliberate policy (such as investing more in preventive care or encouraging more day case work as a substitute for inpatient care).

In curative care, for example, the UK, along with Ireland, Portugal, Sweden have moved further than other countries in shifting care away from inpatient care to day case, outpatient, and home based care (table 2). This reflects decades of trends in the UK of activity driven by deliberate policy and enabled by changes in clinical practice.

What do international comparisons suggest for UK spending?

At a country level at least, the level of healthcare spending depends on several factors, with changes in (national) income (ie, GDP) being important. Cross sectional comparisons show that countries with higher GDP per person tend to spend more on healthcare.

The revised spending figures for 2014 suggest the UK is spending about what might be expected; just 0.7% less per capita than expected given the size of its GDP (equivalent to UK health spending of just £1.25bn) (fig 4).
Another view of the effect of the accounting changes is how NHS spending would have to change in order to match other countries’ spending levels. Figure 5 shows that matching the EU-14 average spend implies a (relatively) small decrease in NHS spending of just £2bn. Matching the spending level of Sweden on the other hand would require an increase of £24bn.

**Spending decisions**

Arguments about how much to spend on healthcare in the UK often draw on the fact that the UK spends less as a proportion of its GDP than other countries (for example, Tony Blair’s commitment for increased spending from 2000[1]). The big boost to UK health spending between 2000 and 2009 was in part based on a desire to “keep up with the Joneses” (or, rather, the Johanssons, the Schmidts, et al). Indeed, the goal set at the turn of the century was to match the average spend of other EU countries. 2 But the fact that the UK seemed to lag behind other countries’ health spending was never a sufficient argument to spend more. It also presumed that the basic spending figures were comparable.

The latest health and social care accounting revisions are designed to provide a more comparable description of spending. But it would be wrong to suggest that this new accounting system perfectly captures exactly how much different countries spend on health and health related social care. The lines between categories of spend are still not always clear, and country level interpretations of the accounting conventions are likely to vary.

For the UK, a particular issue is that over half of the net increase in its health spending is the result of £13.5bn of public spending on health related social care being reclassified as health spending. This is close to the total public spend on adult social care in England. 2 So, the accounting gain on health is largely offset by the loss on the social care. Unfortunately, as the UK (along with around half of OECD countries) does not supply the OECD with data about non-health related social care spending it is impossible either to see the effect of this accounting transfer or to compare countries’ combined health and social care spending.

The new data may muddy the water on the question of whether the NHS (in the narrow sense) is underfunded or overfunded, especially without a clear understanding of how investment in health and social care affect each other. In the UK (particularly in England) the systems are funded, accessed, and delivered very differently. But this is not true in all countries, with social care playing a different role in many countries from that in the UK. By including social care spending are we glossing over these differences?

However, the important question raised by the new accounts is about the adequacy of public funding of health and social care in the UK. Does the change in data simply point to a need to think (and debate) differently about funding? As Keynes (allegedly) said: “When the facts change, I change my mind. What do you do sir?”

There is no doubt that arguments for increased health spending based on the UK’s (historically) low level relative to other similar countries has been substantially attenuated by the re-evaluation of the UK’s health spend. But just as previously being below average was not sufficient reason to increase spending, now being average is not sufficient reason to withhold spending. The data do not tell us that we should spend as much as Sweden or France, but they might tell us that we could.

Being average internationally is not synonymous with the most desirable level of funding (or, indeed, a level that maximises the benefits of the country’s scarce resources). What other countries spent on health was only ever a rough point of triangulation to inform domestic decisions. Many other factors will influence and drive such decisions in different countries—from variations in need, relative efficiency, and incentive effects arising from differences in funding sources and payment methods.

It also bears reiterating that the new accounting methods, while changing the UK’s standing internationally, do not change the reality of spending levels within the UK. A tough reality that—for many providers of health and social care—will not be eased by changes in definitions or accounting methods. And one in which the UK still employs fewer nurses (8.2 per 1000 population) than the OECD average (8.9), fewer doctors (2.8 v 3.3) and computed tomography scanners (8.0 per million population v 26.2). 2

Although the revised spending data shed new light on the UK’s relative international position, decisions about overall public health and social care spending are of course a matter for individual countries. A combination of the technical (as a society, what returns do we get from spending on health and social care instead of other things? What is a reasonable level of productivity improvement?) and the political (what is the electorate’s public spending preferences?) will inform those decisions.

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**Fig 5** | Percentage change in UK total health spend if it matched other EU-14 countries’ spending levels in 2014 through changes in NHS spending alone
OBITUARIES

Jack Macfarlane Stuart

General practitioner
Coleshill, Warwickshire
(b 1918; q Birmingham 1942; MBE), d 26 January 2017
After qualifying Jack Macfarlane Stuart served in the Royal Army Medical Corps in Scotland and Europe. In 1949 he joined a practice in Coleshill, Warwickshire, where he spent the following 41 years serving the community diligently, kindly, and with great energy. As an innovator, he set up disease registers, patient held records for housebound patients, and joint diabetes clinics with hospital consultant units. His energy extended to local societies as a founder or a member of the gardening club, local history society, heart club and the civic society. In recognition of his commitment to community life, he was awarded an MBE in 2002 and in 2009 was admitted as an honorary freeman of the Borough of North Warwickshire. Predeceased by his first wife, Stella, he leaves his second wife, Bena, and four children.

Sarah Shannon

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Helen Alexandra Breen

Staff grade community paediatrician Omagh, Co Tyrone, Northern Ireland
(b 1961; q Edinburgh 1984; DRCOG, MRCGP), died 12 February 2016
Helen Alexandra Breen arrived in Edinburgh in 1979. She was always clear in her intentions of obtaining her medical degree and returning to her native Northern Ireland to practise. She completed her house jobs and senior house officer rotation at Altnagelvin in Derry (Londonderry). She completed her general practice training in Strabane. Helen then joined the community paediatric team in Tyrone and Fermangh and became a well respected community paediatrician in Omagh. She thoroughly enjoyed exercising her medical skills alongside assisting in the running of her husband’s farm and bringing up three daughters. In her youth she had enjoyed playing squash, was a competent pianist, and played the violin. Helen was an excellent cook and a superb hostess. She leaves her husband, Nigel; three daughters; and a sister.

Jean Sandra Wilson

Cite this as: BMJ 2017;358:j3553

Ernest George Knox

Professor of social medicine Birmingham University (b 1926; q Durham 1949; MD, FRCP), died from bronchopneumonia on 6 March 2017
After qualifying, Ernest George Knox (“George”) initially worked as a paediatrician in Newcastle. He was a research clinician for the Thousand Families Study and coauthor of the book Growing Up in Newcastle upon Tyne. A self taught mathematician, he developed programmes for the gargantuan earliest computers, in order to facilitate the study of diseases in populations. He was appointed professor of social medicine and head of department at Birmingham’s health services research centre. He went on to investigate the causes of childhood cancers and published many original papers on these and other diseases. In retirement he continued to produce research at home in his den, as well as assisting younger colleagues with their own work. He leaves his wife, Betty, after 66 years of marriage; three children; and one granddaughter.

Vivien Drake

Cite this as: BMJ 2017;358:j3556

Alexander (“Alasdair”) Shearer Lovat Kennedy

General practitioner
Pittenweem (b 1926; q Glasgow 1949; DOst RCOb, DPH Glas), died from old age on 6 May 2017
After qualifying Alexander (“Alasdair”) Shearer Lovat Kennedy did his national service in the Royal Air Force. He undertook junior hospital positions including orthopaedics, a specialty in which he retained a lifelong interest. In the period up until the mid-1970s, singlehanded GPs would be expected to be available 24/7 for consultations, emergencies, and births. Somehow Alasdair managed to achieve this commitment while undertaking a whole range of activities that embedded him in the community. He attended weekly Rotary meetings and was an accomplished golfer, singer, sailor, tennis player, and skier. Alasdair was a Christian. He invariably conducted himself in a manner completely consistent with practical Christianity. Predeceased by his wife, Gillian, Alasdair died in a nursing home in Elie, Fife.

Donald Coid, Andrew Kyle

Cite this as: BMJ 2017;358:j3554

Robert Charles Nightingale

Consultant radiologist Ipswich Hospital NHS Trust (b 1947; q St Mary’s Hospital Medical School 1973; MRCP, FRCR), died from acute heart failure on 20 July 2016
After training posts in London Robert Charles Nightingale (“Bob”) entered radiology training at Addenbrooke’s Hospital in Cambridge. He was appointed consultant at Ipswich Hospital in 1983. With his colleagues he provided a general radiology service and subsequently developed special interests in musculoskeletal imaging and nuclear medicine. His respected opinion, approachability, and cheerful demeanour were appreciated by all, including junior clinical colleagues, whom he was ever ready to advise on interpretation and further appropriate investigation. He was an avid reader with a deep knowledge of history and archaeology, which he fuelled in his retirement by travel with his wife, Mary, a general practitioner. Possibly his most proud achievement in retirement was learning to drive a steam locomotive. He leaves Mary and their three sons.

Martin Grimmer

Cite this as: BMJ 2017;358:j3558

Roelof Boersma

General practitioner
Northallerton, north Yorkshire (b 1934; q Edinburgh 1958; DOst RCOb), died from colonic carcinoma on 15 May 2017
Roelof Boersma and his family came to east Yorkshire from the Netherlands when he was an infant. After house jobs in Edinburgh, he spent a year in hospitals in Winnipeg, Canada, before returning to the UK. He did a year’s general practitioner training in Edinburgh and then became the fifth partner in a semirural practice in Northallerton, north Yorkshire, where he worked until he retired. He served on the local medical committee and was clinical assistant at the local maternity hospital. He became the practice’s first GP trainer, supporting the local vocational scheme for more than 20 years. In retirement he continued to work for HM Courts and Tribunals Service as a panel member. He leaves Anne, his wife of 55 years, and three children.

Anne Boersma, P J Edon, D W L Smith

Cite this as: BMJ 2017;358:j3551
Gordon Waddell
Orthopaedic surgeon who reformed the treatment of lower back pain

Gordon Alex Bryce Waddell, professor of orthopaedic surgery (b 1942; q Glasgow University Medical School 1967), died from mesothelioma on 20 April 2017

As an orthopaedic surgeon in the 1970s Gordon Waddell realised that the current model for treating back pain was not working. He identified three main problems: the standard advice of bed rest was incorrect, there was an over-reliance on surgery as a treatment, and the message that anything that causes pain must be avoided was wrong—“hurt does not mean harm” was his mantra.

Tackling back pain
Waddell was running a clinic in Glasgow and wondered why some patients were far more disabled by back pain than others. In what was a highly unusual move at the time, he formed a partnership with a young clinical psychology researcher, Chris Main, and together they investigated why some patients could barely walk while others were moving reasonably well, despite looking the same on physical examination.

Waddell was a conscientious data collector and, through careful observation and consideration of the evidence, he and Main realised that much of the medical assessment of back pain was unreliable. Waddell asked three doctors to examine the same patient and found that they came up with differing diagnoses. He also found that psychological factors were just as important as physical factors in terms of a patient’s disability: what a patient believed or had been told had an influence on how he or she responded to treatment.

Red flags and yellow flags
Together they came up with a new approach to clinical assessment and developed red flags (which indicated that urgent consideration of surgery was needed) and what later became known as yellow flags (which indicated that how the person was reacting to back pain needed to be tackled as an important aspect of management). This research led to a reappraisal of surgical interventions for lower back pain and a reduction in the number of operations being performed.

Unsurprisingly, some orthopaedic surgeons were unhappy at his findings, and Waddell was not always warmly received at meetings. Even he was initially uncomfortable about his findings. Some also believed that his discussion of some of the psychological aspects of back pain—or the non-organic signs, as Waddell called them—meant that patients were malingering. Waddell and Main later said: “Despite clear caveats about the interpretation of the signs, they have been misinterpreted and misused both clinically and medicolegally.”

Waddell’s interest in research led him to abandon surgery, and he set about tackling the problem of back pain at a society level, becoming a key member of the Clinical Standards Advisory Group on back pain set up by UK health ministers. He also advised a back pain committee in the US and developed clinical guidelines for the Royal College of General Practitioners.

Too much medicine
Much of his work culminated in The Back Pain Revolution, a medical textbook whose central message was that back pain had become overmedicalised. He enjoyed writing and communicating his ideas and was also co-author of a series of self help booklets for patients. The most successful of these was The Back Book, which was translated into 25 languages and sold two million copies.

Waddell grew up in Bishopbriggs, on the outskirts of Glasgow, to parents who were teachers. His earliest ambition was to become a trauma surgeon, and he spent a year in Birmingham at what was one of the UK’s first trauma centres. However, he decided that elective orthopaedics offered more of an intellectual challenge and spent a formative year in Toronto, Canada, as a spinal fellow, where he got his introduction to the major challenges of back pain.

Occupational health
In his later career, Waddell became interested in the world of work and health, contributing to the development of occupational health guidelines on back pain, published in 2000 by the Faculty of Occupational Medicine. He also became an adviser to the Department of Work and Pensions, and it was at this time that his message on disability and work became muddied. A major policy review by Waddell and Kim Burton concluded that work was good for health, but some misconstrued his message, believing that the focus was to force disabled people into work. In fact, the review found that good work was good for health—not just any work—and that good work can be therapeutic. He was awarded a CBE in 2003 for services to social policy and disability assessment.

Waddell leaves his wife, Sandra, and three daughters.

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Waddell’s research led to a reappraisal of surgical interventions for lower back pain and a reduction in the number of operations.
Vaccination effects vary between people

The EU court’s ruling that member states can decide whether vaccines cause harm applies to individual cases of suspected harm after vaccination (This Week, 1 July).

An emerging field, called adversomics, acknowledges that adverse events after vaccinations might be individually determined. This field is based on research that has shown variation in vaccine responses based on differences in innate immunity, microbiomes, and immunogenetics.

In the case of narcolepsy and one of the pandemic influenza vaccines, children with a specific HLA type elicited a different immune response, and genetic variants have been associated with risk of febrile convulsions after the measles, mumps, and rubella and smallpox vaccines.

Further research into risk factors could enable the tailoring of vaccination programmes to minimise harms. When suspected harms occur more frequently than the complications of the infections these vaccines are intended to prevent, continued public confidence relies on this advancement in vaccine safety science.

Rebecca E Chandler, physician, vaccine pharmacovigilance, Uppsala
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BMA ANNUAL MEETING

Unmet need in mental health provision

The rise in out of area placements is emblematic of increasing unmet need in mental health provision (BMA Annual Meeting, 1 July). Thousands more patients are being denied any bed, as admission thresholds inevitably rise.

Who is monitoring harms in these patients?

The Department of Health, NHS Improvement and NHS England, and the Care Quality Commission continue to criticise NHS staff and organisations when care and pathways inevitably fail, in abject denial of an intolerable loss of capacity in the system.

Having personal experience of someone close to me becoming psychotic, I refuse to collude with this cognitive dissonance. NHS England’s grandiose claims that its deeply flawed sustainability and transformation plans will improve care and outcomes, while further reducing capacity and quality, are bordering on delusional.

If genuine improvements are to be made, they must be developed alongside existing services and shown to work before cutting the already threadbare provision.

Nick Mann, GP, London
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BMA should suspend those who abuse social media

What a sign of the times when the BMA has to produce a code of conduct to advise doctors against publicly referring to a female colleague as a hippopotamus or to explain that publishing a colleague’s photograph alongside a four letter word is inappropriate! (BMA Annual Meeting, 1 July).

Such a code should not be needed: the General Medical Council’s Good Medical Practice is clear that one “must treat colleagues fairly and with respect.”

The GMC should act over these gross breaches. The culprits will be easy to identify. A salutary suspension or two would stop such behaviour, which must appal the public. The perpetrators are, obviously, BMA members. Will they be expelled from membership, and if not, why not?

Keith Baxby, retired urological surgeon, Dundee
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Strange things in the night

After falling into a deep sleep, I awoke and blindly grasped for my phone. I brushed against something that fleetingly luminesced like a swarm of blue-green fireflies.

It was an unopened copy of the 15 July issue of The BMJ! This was no hypnagogic hallucination, for I’ve repeated the phenomenon on several occasions in total darkness (albeit with less spectacular results) by vigorously rubbing the plastic envelope against the front cover. I assume this “natural wonder” is some kind of static discharge. It’s the most fun I’ve ever had with a copy of The BMJ and I commend it to readers.

Guy Stewart, core trainee in psychiatry, Bristol
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