> It would save an awful lot of time and money if leaflets for standard procedures could be standardised

NO HOLDS BARRED Margaret McCartney

Post-spinal op guidance needs a jog

When should I start running after a microdiscectomy? In weeks 1 and 2, walking is challenging enough. Week 3: the last few rays of summery sunshine, and I regard other runners with frank jealousy. I want to go running, but I'm scared of undoing the benefits of surgery. As one protocol says, I have "patient anxiety regarding reherniation risks."

But where does this anxiety come from? "Sports should be avoided for three months," says my local leaflet. But sex can be resumed "fairly soon, provided that you avoid any strenuous activity and are lying on your back." This is unexpected, and I wonder what the evidence is. What will it actually take to undo the surgeon's good work?

The internet gives me other opinions. Were I having the same operation in west Hertfordshire I'd be advised to "take it easy" for the first six weeks but to then "increase your activity as comfort allows," being back to baseline by 12 weeks (no mention of sex).

Patients at Guy's and St Thomas' are advised that they can get back to "heavier work and sports after two to three months" (also no mention of sex). In Oxford, "Jogging is okay after 10 weeks." At Royal Berkshire NHS Trust, "Jogging, running, and heavy lifting should be avoided until six months after the operation." (If that weren't bad enough, "you may resume sexual relations as long as you remain the passive partner for the first six weeks.")

But all hail Queen Elizabeth Hospital, Birmingham, which has an extensive, sympathetic leaflet saying that "jogging can be started immediately." Joy! But that's under "low impact" exercise; the next paragraph, rather confusingly, contradicts this by saying that "high impact exercise is running, jumping or twisting, for example, jogging," and that this shouldn't be started until four weeks because "you need time for the disc to heal."

I get the feeling that no one actually knows the answer to running after spinal surgery. Are there randomised controlled trials? I'm not bothered about short term pain, only about increasing the chance of recurrence. There is a Cochrane review, comprising trials of low or very low quality evidence, which focuses on post-op rehabilitation and concludes that high intensity exercise programmes produce slightly less pain and disability. Great. Many trials in interventions of exercise say that people were encouraged to get back to "usual activities"—but they don't specify what these are.

I can find only one study that included jogging as an exercise, as opposed to physio led, strengthening-type exercises. It had only 52 patients in it, and just a third were women. Is that enough? Trials are under way to compare prescribed restrictions on movement (together with electronic monitoring) with "unrestricted activities." Will they look at a subgroup of runners? In any case, the results won't be in for a while.

Given that the evidence I'm looking for doesn't seem to exist, can I be part of some kind of crowd generated trial myself? Alas, I see no trials on the UK Clinical Trials Gateway that can answer this, and the randomiseme.org project seems to have run out of money and disappeared.

In the meantime, it would save an awful lot of time and money if information leaflets for standard procedures could be nationally standardised and locally tweaked, to represent the evidence and state the uncertainties. There's no clear evidence of harm: the sun is out, my trainers are on.

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PERSONAL VIEW Michael Marmot

We urgently need to stop the UK's health decline

Inequality, the slow-down in life expectancy, and the north-south divide all need tackling by policymakers

Alarm about the nation's health is a rational response to recent evidence. Current national health problems should be treated with as much urgency as a winter bed crisis in the NHS. The recent evidence has three components that are probably linked: improvement in life expectancy, going on for 100 years, has slowed since 2010; health inequalities, which probably reduced during the 2000s, have grown again since about 2012; and the persistent north-south divide in health—particularly marked among younger people.

Life expectancy

Between 1920 and 2010, life expectancy increased from 55 to 78 in men, and from 59 to 82 in women. We simply got much healthier as a society, remarkably quickly. Over this period, life expectancy increased by about one year every four years. There was, however, a marked slowing of the rise after 2010. From 2011 to 2016 life expectancy increased by about one year for every 6.5 years in men and one year for 10 in women.

The big question is: why? Perhaps we are getting close to peak life expectancy—the argument being that it has to level off at some point. Data from Eurostat would suggest that is not the case. It shows the rise in life expectancy each year in 25 EU countries. Between 2006 and 2010, the improvement in the UK was about the middle of the range. While there was a slowing in most of the countries listed, it was particularly marked in the UK: from 2011 to 2015 the increase was slowest among women and second slowest among men. If we keep this up, we will become the sick men and women of Europe.

ALAMY

The credit crunch bit deep in britain

The fact that the rise of life expectancy slows, if not flattens, in the UK after 2010, means we have to ask what happened in 2010 and beyond. Austerity is an obvious candidate. Spending on the adult component of social care was reduced by more than 6% since 2009-10, at a time when the population of those aged 65 and

ACUTE PERSPECTIVE David Oliver

Blaming hospitals can only make winter bleaker

Our increasing inability to meet the four hour target for emergency departments has been used as a surrogate for all the NHS's ills. Stories of overcrowding, long waits on trolleys, and ambulances stacking up outside make the headlines week after week. But there have been lamentably few informed discussions in the media of the systemic causes behind the pressures at the hospital front door.

Last week a Department of Health spokesperson said that "we have robust plans for winter," in response to the Labour Party's call for an urgent £500m cash injection. We can all keep calm and carry on, then?

Dangerously full hospitals, struggling to cope with demand

It's wrong to hold hospital leaders and teams solely to account for problems not in their gift to solve

they can't control, are a year round phenomenon.But fears of "winter pressures" get everyone talking in autumn. Politicians fear bad headlines. National health leaders feel that heat and transmit it down to hospital boards. The boards may in turn put pressure on clinical teams, who are already running to stand still.

It is right to insist that acute care hospitals do everything possible to improve patient flow, refine processes, minimise delays, and collaborate with local partners. And there is excellent best practice guidance from NHS Improvement to back them up. How well hospitals implement such guidance varies, as does their use of scarce hospital beds. But it is wrong to hold hospital leaders and teams solely to account for problems beyond their doors and not in their gift to solve.

Yet it was reported last month that chief executives of acute trusts had been summoned to NHS headquarters to be browbeaten over winter and emergency department waits and overcrowding. Some of these senior leaders were reportedly forced to group chant "we can do this," pledging to improve their performance. There were also reports of resignations following political pressure on hospital chief executives the week before the meeting. Such coercive approaches have long been discredited in healthcare, but we still default to them.

Not long after this now notorious

We have to ask what happened in 2010 and beyond. Austerity is an obvious candidate

over grew by one sixth. Health service spending slowed after 2010. Both these cuts will have an impact on quality of life for older people. We must ask whether they are having an impact on the length of life.

Health inequality

The thrust of my reports and my book, *The Health Gap*, is that health and health inequality are important measures of the degree to which society is meeting fundamental human needs. Health is not simply related to healthcare, important as that is when people get sick, particularly for the elderly with multiple needs.

There is evidence that social action to reduce health inequalities may work. A report from the University of Liverpool compared life expectancy in the poorest 20% of districts in England with the English average. In the 2000s the gap narrowed. It began to widen again after about 2012. The researchers took the, reasonable, view that it would take a little while for a New Labour government's explicit aim to reduce health inequalities to take effect. Hence, they didn't start the examination in 1997. Similarly, it would take a while for the Coalition government's change of direction to have impact. Thus, they looked from 2012 on, rather than 2010.

The north-south divide

Further evidence is from the University of Manchester and documents the continuing and rising health disadvantages in the north of England compared with the south. One striking finding is what happened in the 1980s: the mortality of young men increased, and there was no north-south difference. But the south's health recovered much more quickly than the north's. It is likely that the continuing social and economic disadvantage in the north plays a key role.

It is tempting to attribute these problems to particular government policies. Tempting, but wrong. For example, the credit crunch bit deep in Britain. That causes real social and economic problems, but could it affect mortality at older ages where the majority of deaths occur? I don't have an answer to these questions, but I am writing to Jeremy Hunt, urging him to tackle these problems in the nation's health. It is urgent.

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meeting, the CQC's new inspector of hospitals, Ted Baker, gave an interview in which he spoke much welcome good sense about our historical failure to invest in community and primary care services and the consequent pressure on acute hospitals.

Last week a King's Fund report concluded that the NHS has among the lowest per capita bed numbers and fullest hospitals in the developed world. Hospitals running so close to 100% occupancy cannot optimise patient flow or maintain the flexibility to cope with small surges in demand.

Meanwhile, social care provision has been savagely cut since 2010, access to intermediate care services outside hospitals is insufficient and worsening, delayed transfers of care of patients stranded in hospital have risen exponentially, and there is a huge workforce and workload crisis in general practice and community nursing. Numbers of patients arriving at hospital front doors are still rising.

Even in NHS England's admirable "new models of care" vanguards, admissions continued to rise—just a bit more slowly than elsewhere. We won't solve any of these issues in time for Christmas, and there is no magic workforce tree on which to spend Labour's proposed funding boost.

Putting responsibility onto hospital leaders and staff is understandable—it doesn't make it right.

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BMJ OPINION Ahmed Kazmi

Learning lessons from the Grenfell Tower tragedy

I am a GP working close to Grenfell Tower, and I was present at the rescue centre on the day of the fire. The past few months have been hard and busy for everyone, both the local community and service providers. I can only speak for the medical service, of which I am one cog in a huge machine.

Many health managers and administrators have still not resumed their pre-Grenfell duties. Providing optimal care hasn't been easy. The magnitude of the event, the socioeconomic deprivation, the political reverberations, the pre-existing physical and mental health burden of the residents, the difficulties in inter-agency information sharing—these are just some of the obstacles that have had to be surmounted in order to organise the right care for the right people.

Despite these obstacles, it is inspiring to see how rapidly and successfully the NHS responded to the event. Medical provision was present on the ground immediately, with bereavement counsellors and psychologists also visiting from the start. There is a 24 hour help line. GP surgeries are running clinics to screen for post-traumatic stress disorder and referring those who need further assessment. I've seen the benefits in patients: small steps of progress and normalisation, hints of hope that healing and recovery are possible and underway. For an organisation already stretched to near breaking, to achieve this is, I think, worthy of praise.

The event has challenged me as a doctor and a human. The pathology is on a community level. How do you treat an entire community for bereavement? I did not receive that lecture at medical school. Grenfell bleeds into every consultation; whether patients come for a repeat prescription, for backache, or for insomnia, Grenfell usually arises in the conversation.

How do you treat an entire community for bereavement?

I think Grenfell has brought a few lessons to the foreground. With acid attacks, terror attacks, and the like now occurring regularly in the UK, do we need to factor that into the way in which we are trained? Does primary care need to incorporate more medicine that treats the community as a single unit? And with a workforce already struggling with burnout, do events like these make workers more resilient or more vulnerable? I would recommend that we are proactive in tackling these issues.

Ahmed Kazmi is a GP in west London

ANALYSIS

Are there alternatives to accelerated access to new therapies?

Patients deserve to be offered newly developed treatments, but the "miracle cure" rhetoric is impeding rational policy making, argue **Jessica Pace and colleagues**

It is almost impossible to turn on the television or open a newspaper without hearing about the "miraculous" benefits of the latest medicines. The targeted cancer therapy idelalisib, for example, was touted as a revolutionary treatment that would "melt away" your cancer,[1] while the new leukaemia drug venetoclax has been described as being so innocuous that it is "like taking Panadol [paracetamol]."[2]

While much of this rhetoric centres on cancer medicines, new treatments for other chronic and life threatening conditions such as diabetes,[3] cystic fibrosis,[4] and Duchenne muscular dystrophy[5] are also described as miracle cures.

The mass media is replete with stories of terminally ill patients who have been given a second chance by these new miracle drugs. However, alongside such stories of triumph are darker stories—of patients having access to these life saving drugs denied or compromised by excessively conservative regulators or cost conscious public or private insurers (payers). Headlines over the past few years include "Aussie patients denied funding for 30 life-saving drugs,"[6] "Dying mum fights for life-prolonging drugs the NHS won't fund due to cost,"[7] and "Company denies drug to dying child."[8]

This rhetoric is indicative of an increasingly pervasive social expectation, which we refer to as the access imperative. By this we mean the view that patients with severe or life threatening diseases should not have to wait (as long as they do) for regulatory approval or formal subsidy before they can access medicines. This access imperative seems to be gaining in strength, leading to numerous recent inquiries into the adequacy of existing regulatory and reimbursement systems including in the UK and Australia,[9 10] and calls to expedite access to promising new treatments.

Politicians across the political divide seemingly accept the need for faster access as truth. For example, President Donald Trump recently labelled the US Food and Drug Administration's (FDA) regulatory approval processes "slow and burdensome" and vowed to deregulate the drug industry,[11] while Barack Obama's vice president, Joe Biden, committed to speeding up the approval of promising new cancer drug combinations.[12] In countries with publicly funded insurance programmes, politicians appeal to voters by promising to provide funding for medicines that have been rejected by payers.

The drug industry and industry funded consumer groups worldwide also promote faster access, encouraging patients to demand timely and affordable medicines,[14]

Politicians across the political divide seemingly accept the need for faster access as truth

and advocate for the right to try experimental therapies without the usual regulatory oversight.[15]

Global responses

In response to this pressure, many countries have introduced formal programmes that provide earlier access to medicines, targeting both regulatory and reimbursement processes. Some of these accelerated access processes are relatively uncontroversial because they simply improve the efficiency of current decision making processes—for example, Europe, Japan, the US, and Canada require regulatory bodies to prioritise applications for marketing approval for drugs deemed to be potentially life saving or a significant improvement over currently available treatments for serious conditions.[16-19] Others, however, are more problematic, as they suspend or erode current

standards of safety, efficacy, or cost effectiveness.

Numerous jurisdictions have introduced systems that allow for provisional approval of medicines on the basis of less complete data (such as surrogate markers) on the condition that post-marketing studies are done to resolve any uncertainties about safety or clinical effectiveness.[20-23] Many countries also allow individual patients to apply to regulators for use of unregistered medicines through special access schemes or early access programmes.[24-26]

Several "managed entry" or "coverage with evidence development" schemes have also been established for therapies that have been approved by regulators but not (yet) funded. These schemes allow for funding of a therapy at a price justified by the evidence available at the time a decision is made, with ongoing coverage—and final price—decided after the accumulation of data from clinical trials or "real world" use.[27-30] Formal programmes to fund therapies not deemed to be cost effective by health technology assessment agencies (such as the UK's recently reconstituted Cancer Drugs Fund[31] and Australia's Life-Saving Drugs Program[32]) have also been established. These formal schemes exist alongside "compassionate access" or "individual patient use" mechanisms, in which drug companies fully or partly subsidise medicines that have not been subsidised by public or private insurers.[33]

Effects of accelerated access

Good arguments exist for accelerating access to medicines. Patients in desperate situations—such as those with life threatening illness or rare diseases for which there is no available treatment—should have timely access to potentially beneficial therapies and be provided with hope of a cure.[33] It is asserted that it is up to these patients and their physicians, not regulators, to determine when it is reasonable to try a therapy.[35] In addition, many people believe that particular groups of patients, such as those with rare diseases, are disadvantaged because of the difficulties of conducting clinical trials in small patient populations and demonstrating cost effectiveness when drug companies need to charge more to recoup their investment.[36]

Existing regulatory and subsidisation processes may indeed be too slow to meet the needs of patients with limited life expectancy. For instance, a recent analysis found that average approval times of six major regulators ranged from 304 days for the US FDA to 511 days for Swissmedic.[37]

Rigid adherence to inflexible standards for safety, efficacy, or cost effectiveness (such as an emphasis on large phase III randomised controlled trials) may also prevent timely access to new therapies. Many drugs that were initially approved using accelerated pathways have subsequently become part of standard care, lending credence to the view that we need to modernise regulatory processes. Notable examples include bicalutamide for advanced prostate cancer, imatinib for chronic myeloid leukaemia, anastrozole and letrozole as adjuvant treatment for postmenopausal hormone receptor positive breast cancer,[38] and antiviral medicines for HIV/AIDS (including darunavir, raltegravir, and etravirine).[39 40]

However, failure to register or fund a drug does not necessarily mean the regulatory or reimbursement systems are cumbersome or unfair.[41] There may be too much uncertainty about a drug's safety or efficacy, or it may have low cost effectiveness or be unaffordable.

Evidence is growing that accelerated approval of medicines may cause serious harm. For example, medicines approved since the US accelerated approval pathway was introduced are more likely to be withdrawn from the market or receive a new "black box warning" than those approved before its introduction.[42]

Medicines made available via accelerated approval mechanisms may also prove to be ineffective. The independent drug bulletin *Prescrire* assessed all 22 drugs that had been granted conditional approval in the European Union since 2006, finding that less than 40% of these offered an advantage over current therapies, and there were insufficient data to make a judgment for nearly a third.[39] Similarly, most oncology drugs approved in the US between 2008 and 2012 were approved on the basis of surrogate endpoints, and further follow-up showed that more than half of these had no or unknown effects on overall survival.[43] Some, such as bevacizumab (Avastin) for breast cancer[44] and gemtuzumab ozogamicin (Mylotarg) for chronic

KEY MESSAGES

- Both patients and clinicians are immersed in rhetoric emphasising the potential benefits of and urgency of access to new medicines
- Policy makers are under increasing pressure to approve and fund medicines with poor quality evidence on safety, efficacy, and cost effectiveness
- Alternative approaches are needed to meet the desire for quicker access and protect the interests of current and future patients as well as the broader community

myeloid leukaemia[45] also had serious side effects and were withdrawn from the market.

Although identifying more suitable surrogate endpoints could reduce these problems, we believe that negotiating lower evidence standards, whether in terms of endpoints or experimental design, to accelerate access to medicines can expose patients to futile treatments that, at best, provide false hope and, at worst, cause serious harm.

Changes to reimbursement systems that involve disregarding usual cost effectiveness thresholds for the subsidy of medicines also have serious consequences for healthcare systems by creating opportunity costs and overwhelming budgets. The recent changes to the UK Cancer Drugs Fund are a case in point. After the fund exceeded its budget by 50% in 2014,[46] and without assessment of the effect of the resources spent, in 2016 it was converted to a managed access programme that will provide funding for therapies for two years while further data are gathered.[47] More permissive cost effectiveness thresholds may increase not only overall expenditure but also the prices of medicines. In 2004, a report commissioned by the US Congress concluded that removing price controls (which includes cost effectiveness analysis) would greatly increase revenues from patented medicines—by, for example, almost 60% in Australia and more than 30% in the UK.[48]

Countering the rhetoric

Speeding up access to medicines is clearly appropriate and beneficial in some cases. The problem is that the rhetoric surrounding accelerated access makes it difficult to assess the necessity and feasibility of such programmes. Combating this rhetoric will not be easy, as it is natural for researchers to want to promote their work to improve their status and chances of receiving lucrative research grants; for manufacturers to promote their product to increase their market share (and therefore the return on investment for shareholders); and for media outlets to tell emotive stories to sell papers.

However, the following steps would go some way to controlling it:

- Ensuring that press releases of research groups make factual claims that do not overstate the evidence (this could be a responsibility of institutions such as universities that oversee research)
- Extending or more strictly enforcing regulations prohibiting the promotion of off-label medications by pharmaceutical companies
- Encouraging media outlets to report on both positive and negative trial outcomes and not to set unrealistic expectations when reporting the latest research through, for example, the introduction of media standards for the results of drug trials and provision of alternative messages such as the importance of social solidarity and preventing the exploitation of vulnerable patients by researchers, politicians and members of the pharmaceutical industry.

Better response

It would be unrealistic, however, to believe that such strategies could ever fully stop the calls for greater access to medicines, which are underpinned by compassion and valid concerns such as inequities for people with rare diseases and promotion of biomedical innovation.[35-49] We therefore have to find different ways to respond. Perhaps the most obvious alternative—although it is often neglected—is to increase support for publicly funded clinical trials. Such trials, particularly if they allow for crossover and open label extensions, would provide patients with timely access to new therapies (without the public misconstruing them as proved therapies, which official regulatory and payer endorsements tend to imply). They would also protect patients from harm by providing adequate monitoring of both safety and efficacy and allow for further data collection before therapies are used more widely.

The rhetoric surrounding accelerated access makes it difficult to assess the necessity and feasibility of such programmes

Although increasing publicly funded trials would demand substantial investment, experience from paediatric oncology shows that it is both feasible and can have groundbreaking results. Many cancer treatments are licensed only for adults,[50] but most children receive access through clinical trials. This has been credited with increasing the overall five year survival rate for childhood and adolescent cancers from about 60% in the late 1970s to more than 80% today.[51]

Another approach could be to use drug pricing as a lever for promoting access to medicines. Linking prices to demonstrable evidence of effectiveness could allow for lower cost effectiveness thresholds for drugs with the highest evidence and would encourage companies to conduct high quality research to improve their revenues, even after the medicine is on the market. More ambitious pharmaceutical price reform strategies would also increase access to medicines, although they are likely to be strongly resisted by industry.

We cannot simply reject calls for accelerated access as the values that underpin these calls are genuine and deeply felt. But accelerated access programmes are not the best way of respecting these values. Approaches to facilitating access to medicines need to be based less on rhetoric and more on reason, and need to remain cognisant of both the importance of maintaining standards of safety, efficacy, and cost effectiveness and the realities of finite health budgets.

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NEW UK DRUG STRATEGY

Don't ignore social and cultural contexts

The government's drug strategy targets new types of drug misuse, including psychoactive substances, image and performance enhancing drugs, and "chemsex" drugs (Editorial, 19-26 August). But resources to implement the suggested partnerships with local services and sufficient funding for harm reduction are lacking.

It focuses on vulnerable groups but ignores the socioeconomic factors that generate exposures to harm and misuse among those groups.

Closer consideration of the cultural and social contexts of vulnerable groups could improve future debate on drug education and reflection on the effectiveness of harm minimisation strategies. We need research on how social, economic, and health policies create conditions that increase vulnerability, risk, and harm.

At best, the new drug strategy masks the causes of risk and vulnerability in the target groups. If anyone or anything should be targeted, it is the lack of a proper drug policy, not those at most risk.

Marco Scalvini, lecturer, London

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Bleak outlook for substance misuse services

The government's new drug strategy effectively announces the end of community substance misuse services (This Week, 22 July). The grant from Public Health England to local authorities to commission these services is labelled as being "ring fenced." But when local authorities are not legally required to provide services, ring fencing seems to disappear, and funding cuts of a third or more are common.

The report clearly implies that after April 2019 local authorities will be expected to fund all substance misuse services themselves with no grant from Public Health England.

We should lobby hard to make provision of these services a statutory responsibility. They should probably be back under the auspices of the NHS instead. Otherwise, anyone with a drug or alcohol problem—or seeking help for a relative or friend—will not be able to access any help at all.

Joss Bray, substance misuse specialist doctor, Alnwick

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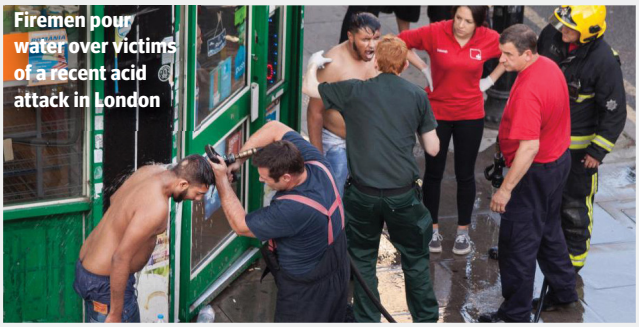

Firemen pour water over victims of a recent acid attack in London

REX/SHUTTERSTOCK

LETTER OF THE WEEK

Medical students lack burns awareness

Grundlingh and colleagues discuss the increasing prevalence of attacks with corrosive substances (Editorial, 5-12 August).

The reduced role of plastic surgery in the undergraduate curriculum has contributed to medical students graduating with little experience with burns. But as junior doctors they might commonly encounter minor burns, so the ability to accurately assess burn severity and offer appropriate treatment and referral is a vital skill. Given that complications such as scarring and contracture are largely dependent on timely and appropriate care, the lack of burns teaching at undergraduate level is hard to justify.

Current literature shows how poorly prepared undergraduates are to assess and treat patients with burns. One study found that 90% of students lacked the confidence to treat a burn and another reported that 17% of medical students were unaware that chemicals can cause burns. Perhaps the study days that burns units offer to healthcare professionals could be integrated into the undergraduate curriculum.

The need for public education extends to medical students. With limited time to cover the required curriculum, dedicating just one day to the assessment and immediate treatment of acute burn injury, while simultaneously covering long term burn sequelae, seems logical. We mustn't underestimate the cumulative effects of burns awareness in medical students across all their future working environments and the consequential benefits for patient care and burns outcomes.

Lynsey R Williams, final year medical student, London

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2017 drug strategy is not fit for purpose

We are concerned at the lack of focus on harm reduction in the government's new drug strategy. It acknowledges that the rise in drug related deaths is "dramatic and tragic" but proposes no concrete plan to reduce them.

Heroin and morphine deaths rose by 109% in England and Wales between 2012 and 2016. Harm reduction initiatives such as opioid substitution treatment and needle and syringe programmes are only mentioned fleetingly in the strategy; others are completely absent.

We call on the government to implement the recommendations of the Advisory Council on the Misuse of Drugs to tackle opiate related deaths. These include a national heroin assisted treatment programme.

Chris Ford, clinical director, London
David Nutt, chair, London
Niamh Eastwood, executive director, London
Deborah Gold, chief executive, London
John Jolly, chief executive, London
Fionnuala Murphy, head of advocacy, London
Kate Halliday, executive director, London
Jamie Bridge, senior policy and operations manager, London

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BLACK WEDNESDAY

Consultant staffing might be a challenge in August

The BMJ notes that the Academy of Medical Royal Colleges and NHS employers released joint recommendations about Black Wednesday (60 seconds on . . . 29 July). These suggested introducing mandatory inductions, reducing elective procedures, and ensuring consultant availability.

In the theatres and anaesthetics division at The Royal Cornwall Hospitals NHS Trust, the average total days of annual leave taken by consultants in August in 2013-15 was 196.7 days, nearly twice as many as in June (102.2 days). Similar trends were reported in the emergency department, oncology, clinical imaging, and pathology.

If these trends are consistent throughout the health service then perhaps we should reconsider when junior doctors begin work.

Raphael PZ Rifkin-Zybutz, medical student, Oxford
Thomas Taylor, medical student, Oxford
Jonathan I Spencer, medical student, Oxford

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OBITUARIES

Neville Martin Bailey

Chief medical officer Isle of Man, epidemiologist, and general practitioner (b 1930; q Manchester 1954; MD, DPH, MSc, CBiol MRSB, MRCGP, MFCM), died from acute myocardial infarction and ischaemic heart disease on 27 March 2017

After three years' national service in the Royal Air Force, during which he studied for an external degree in zoology, Neville Martin Bailey had three careers—in general practice (in Peterborough); in tropical medicine (in Uganda and Kenya, where he worked for the East African Trypanosomiasis Research Organisation); and in community medicine in Hampshire, Worcester, Powys, and finally on the Isle of Man. He was a founder member of the Royal College of General Practitioners. He was honoured to be appointed a member of the Wales Council of the BMA and an honorary lecturer in the Welsh School of Medicine. Neville leaves his wife, Sheila; four children; and 15 much loved grandchildren.

Sheila Bailey

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Gordon Dale

Chemical pathologist Newcastle upon Tyne Hospitals (b 1936; q Durham 1960; MD), died from pneumonia after multiple strokes on 21 November 2016

Gordon Dale trained in chemical pathology before becoming a consultant at Newcastle General Hospital. His particular interest was in paediatrics. His expertise in amino acid metabolism helped in the early development of intravenous feeding in sick newborns, and he was a regular attender at the neonatal surgical unit at the Fleming Children's Hospital. Gordon played a key part in the progress of the newborn screening programme and recognised that by staining for acetyl cholinesterase in rectal biopsy specimens, a more accurate diagnosis of Hirschsprung's disease could be made. In 1972 he was invited to help establish the biochemistry laboratory in Makerere Hospital, Kampala, Uganda. He leaves his wife, Anne; two children; and four grandchildren.

Peter Dale

Cite this as: *BMJ* 2017;358:j4210

Charles Leonard Mansfield

General practitioner (b 1926; q King's College Hospital, London, 1952; MRCS Eng, DObst RCOG, MRCGP), died from lung cancer on 31 May 2017

Charles Leonard Mansfield trained as a general practitioner in south London before taking up a partnership at Knights Hill Surgery in Norwood in 1959. He remained a partner in this practice for 31 years while also working as a clinical assistant in rheumatology. He had a lifetime commitment to GP obstetrics and was involved in both home deliveries and deliveries at the GP unit at Dulwich Hospital. After retiring from general practice in 1991 he worked as an assessor for the benefits agency until 2000. He was a much loved member of the church community and church warden at St Peter's in Streatham and also served on the committee of Crown Dale Youth Club. Predeceased by his wife, Rosaleen, Charles leaves five children.

Nick Mansfield

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Alfred Lewis Hodgson

General practitioner Hackney, London (b 1931; q Liverpool 1956; MBE, FRCGP), died from cardiovascular failure (atrial fibrillation) on 8 August 2017

In 1959 Alfred Lewis Hodgson joined the general practice in Stoke Newington, London, where he was to remain for the rest of his career. He pioneered the use of the facilities at the new John Scott Health Centre. After the senior partner retired, Lewis worked singlehandedly until the arrival of numerous GP trainees, several of whom stayed on or returned as partners. In the mid to late 1960s the practice was delivering more than 50 home birth babies a year, and Lewis became chair of the local GP obstetrics committee and a member of Butler and Bonham's perinatal mortality survey. He was governor of St Bartholomew's Hospital (1970-75) and chairman of the City and Hackney division of the BMA (1987-92). In 1988 he was awarded an MBE for his services to the community. He leaves his wife, Marjorie, and four children.

Timothy Hodgson

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John Martin Ellison

Consultant obstetrician and gynaecologist (b 1939; q Leeds 1964; FRCOG, FRCSC), died from colon cancer on 13 September 2017

After practising medicine in England for six years, John Martin Ellison moved his family to Canada in 1971. While working and caring for two small children, he requalified in both general medicine and obstetrics and gynaecology. He practised general medicine initially in Port Colborne, and then obstetrics and gynaecology in Welland from 1973 to 2000. Until retiring in 2006 he then worked as a general practitioner at walk-in clinics. Martin's interests beyond medicine included tennis, golf, and cricket. He was an accomplished pianist, bassoonist, and vocalist. His love of languages led him to study Spanish in his retirement. He had a keen interest in politics and penned many intelligent, witty verses (strictly for private consumption). He leaves his wife, Anne; two sons; and four grandchildren.

Andrew Ellison

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Gladys Mary Tinker

Consultant physician with interest in geriatric medicine Cardiff (b 1945; q Edinburgh 1969; OBE, MSc, FRCP), died suddenly on 14 October 2016

Gladys Mary Tinker was appointed consultant in geriatric medicine in Cardiff in 1980 and chose to work at the newly developed unit at University Hospital Llandough, linked with the Sully Hospital rehabilitation service. As well as helping to set up the medical assessment unit, she developed a vibrant stroke rehabilitation service with a multidisciplinary team. She became clinical director for the elderly care directorate and was then medical director from 1997 to 1998. She received the Welsh Woman of the Year award in the management category in 1997 and an OBE for services to the NHS in 2003. She was a role model for junior doctors and her colleagues and was incredibly kind and supportive to the many overseas doctors who worked with her. She leaves her sister, Jeane.

Anne Freeman, Philip Routledge, Hamsaraj Shetty, Dwarak Sastry

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Jean-Pierre van Besouw

Championed and developed the role of anaesthetists

Jean-Pierre William Gerard van Besouw (b 1957; q Barts 1981; FRCA, FRCP Ed, FFMLM, 2014 FRCS (Hon), FCAI (Hon)), died from a brain tumour on 17 July 2017

Jean-Pierre van Besouw, who has died at the age of 60 nearly two years after being diagnosed with a brain tumour, championed the perioperative role of anaesthetists. Known to colleagues as J-P, van Besouw served as president of the Royal College of Anaesthetists (RCoA) for three years from 2012—referring to the college ceremonial robes he donned for official duties as "my high vis jacket." During the last two years of that term he also filled the role of vice-chairman of the Academy of Medical Royal Colleges.

During his RCoA presidency he continued to work as a consultant cardiac anaesthetist at St George's University Hospital NHS Foundation Trust, the post he was appointed to on completion of his medical training in 1990. He saw this ongoing patient contact as an important base for his medicopolitical work.

"Still going strong"

Van Besouw's commitment to the hospital where he had worked as a registrar, after qualifying from Barts, appeared total: he was elected a trust governor in 2014, challenging pay rises for non-executive directors. It was to St George's that he turned for treatment when he received the brain tumour diagnosis. He took a certain pride in remaining alive beyond his doctors' expectations, tweeting at one point that he was "still going strong against the odds."

Having developed a special interest in cardiothoracic surgery, van Besouw was involved in many complex cardiac surgery cases, with patients travelling from around the country to St George's. He had a key role in developing the trust's cardiac intensive unit and its pioneering work on transcatheter aortic valve insertions.

His involvement in medicopolitics did not prevent him from securing three national clinical excellence awards between 2005 and 2013.

Perioperative physicians

Standing at around six feet and four inches, and with an affable personality to match, van Besouw used the RCoA presidency to push his vision for the profession; one in which anaesthetists are active outside the operating theatre, working as perioperative physicians involved in the care of patients before, during, and after surgery.

An early advocate of the college's national audit programmes, he also championed audit during his presidency—improving patient care and saving money for the NHS. With a sense of humour that colleagues say reflected his lifelong subscription to *Private Eye*, van Besouw was a popular figure at both St George's and the college.

Passionate about the education and training of the next generation of anaesthetists, he was an examiner for the fellowship examination of the Royal College of Anaesthetists for 13 years and chaired the college's exams committee for three years from 2009. He is credited with helping to reshape the college's training and education programme during those years and as president.

Sense of humour

He brought his sense of humour into the normally sacrosanct forum of oral exams. As lead examiner he introduced a "word of the day" award, which went to the examiner who best introduced a particular unconnected word or phrase into a question.

As head of St George's school of anaesthesia and as a clinician, van Besouw took both the exams and training of those working under him seriously, while adopting a personal approach. Years after qualifying, his former registrars were often surprised at how he remembered aspects of both their social and professional lives.

Van Besouw brought his sense of humour into the normally sacrosanct forum of oral exams

Van Besouw served on several significant reviews, including the Department of Health's cardiac workforce review team between 2008 and 2010, and the expert group for the Mid-Staffordshire inquiry. He also served as chairman of the Association of Cardiothoracic Anaesthetists before receiving honorary membership for his services to cardiothoracic anaesthesia.

Born in Dublin to an Irish mother and a Dutch businessman, van Besouw moved with his family to Leicestershire as a child. It was here that he developed an enthusiasm for rugby that was to see him remain a keen follower of the Leicester and England teams throughout his life.

He leaves his widow, Liliane, a former consultant in anaesthetics and intensive care, who works for the Medical Protection Society; and their three children.

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The US led air raids on Afghanistan began 16 years ago today

FROM THE ARCHIVE

The start of the War On Terror

On this day in 2001, almost a month after terrorist attacks in New York and Washington, DC, a US led coalition launched air strikes in Afghanistan, marking the beginning of military action in what was dubbed the "War on Terror." A few days later, *The BMJ* carried an editorial on "Reacting to terrorism" (*BMJ* 2001;323:822) from Douglas Holdstock, the then editor of *Medicine, Conflict and Survival*, the journal of Medact.

Holdstock observed: "Military action has begun. Currently this is being directed at the Taliban's (fairly limited) armed forces and al-Qaida training camps. There are said to be no immediate plans for undercover 'special forces' to capture Osama bin Laden. Calls for a massive attack on other countries supporting Islamic terrorists, including Iraq, Lebanon, and Syria, seem to have subsided. Even this more limited strategy has drawbacks. There have already been deaths; time will show how many of these are Taliban fighters and how many civilians. All will be regarded as martyrs, and revenge for their killings will lead to more terrorist violence."

PODCAST

Telephone consultations

Martin Roland, emeritus professor at Cambridge University, talks about a new study he co-authored evaluating the "telephone first" approach in general practice, in which all patients are asked to speak to a GP on the phone before being given a face-to-face appointment. He discusses how this approach affected practices' workload, how patients feel about them, and how much money they actually save.

Listen to the podcast at http://bit.ly/gp_telephone