Doctors must do better on gender

Medicine has a shameful history when it comes to sex, gender, and identity. Attempts have been made to “fix” sex, for example, by intervening surgically to “normalise” the genital appearances of intersex people. This happened despite a lack of evidence of benefit and showed disregard for individuals’ feelings over time—including a lack of full information about their own condition or support, especially regarding fertility. Even well intentioned medicine can do grievous harm.

In recent years terms such as “non-binary” and “gender fluid” have entered the mainstream. The Office for National Statistics may make declaration of sex voluntary in the 2021 census, out of concern that it discriminates against and.offends transgender people. NHS IT systems don’t respond flexibly: for example, transgender men may still wish to be invited for cervical screening. The Gender Identity Bill, now in consultation, would allow people legally to self declare their gender rather than being required to live as their preferred gender for two years and have a medical diagnosis of gender dysphoria before it’s granted.

And a clear rise in referrals of children to specialist gender identity services has been seen in recent years. Yet the role assigned to medicine can’t be separated from societal attitudes and abilities. The debate on gender occurs in an environment where boys are seen as being boys, and girls as girls, because of how they behave rather than their biological sex.

Frequently, media narratives describing parents’ realisation that their child may be transgender occurs when the preschool child is doing or wearing things outside society’s expectations. Yet playing with dolls doesn’t make children female, just as playing with trucks doesn’t make them male. Therapists are right to be concerned about overdiagnosis and overtreatment. But this can be perceived by parents as a barrier rather than a caring, evidence based response.

Many children with gender dysphoria will grow up without reassignment surgery but will be gay or bisexual. One concern is that gender reassignment makes homosexuality “disappear”: in Iran being gay is illegal, but the rate of gender reassignment surgery is the highest in the world.

In some people, gender reassignment is beneficial but prognostication can be complicated by missing data, surgical complications, and—at least in previous cohorts—higher levels of associated psychiatric morbidity than in the general population. Insensitivity hurts; treatments have side effects; and suicide, tragically, has been the result for people who have been inadequately supported.

We need better long term data, but research into rates of de-transition has been stymied by ethics committees apparently more concerned about controversy than helping people to make good decisions. This doesn’t help anyone. The need to treat women and men differently has usually been for reasons of biology and fairness—from sports to access to rape crisis shelters and within the criminal justice system.

Respectful, calm debate is necessary. How society and medicine deal with gender requires critical review in terms of the potential for unintended harms, even if there are no easy answers.

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Cite this as: BMJ 2018;360:k1312
Professional judgment versus customer expectations

Guidance on prescribing antibiotics for sore throats is heightening tension between clinical judgment and patient expectations

At recent meetings I’ve attended, doctors have been berated for their ongoing failure to think of patients as customers; for the continued paternalism of the profession; and for its failure to adapt to modern expectations.

One doctor responded by asking what value should be attributed to professional expertise and judgment when it is pitted against customer expectations?

The new NICE guidance on prescribing antibiotics for sore throats, and the growing problem of antibiotic resistance, throws this question into sharp relief.

In the past few months, I have had to refer two people with urine infections to hospital for intravenous antibiotics because all oral antibiotics had failed. I have been a GP for 20 years and never had to do this before, so the consequences of increasing antibiotic resistance are feeling more and more tangible.

When it comes to sore throats, research suggests that if a GP makes a clinical judgment (using explicit criteria) on whether a patient needs antibiotics, they are right about 80% of the time. So, one in five people who might benefit from antibiotics will be denied a prescription. While most untreated minor bacterial throat infections will go away in around a week, the risk of complications (such as tonsillar abscess) is lower, but not completely removed, if antibiotics are prescribed.

When a patient with a sore throat says they want antibiotics I cannot, therefore, say unequivocally that they do not need them. Only that, in my professional judgment, they are unlikely to benefit from them. Some patients are relieved to hear this. Others are up in arms that I am not giving them what they want.

Treatment plans can be negotiated in many ways: as customer-supplier encounters; peer-to-peer co-decisions; or paternalistic diktats. Negotiation may involve a few minutes’ conversation, or a longer exploration of doctor and patient priorities linked to a hunt for common ground and a way to reconcile both views. It can also involve heated and emotionally draining interchanges.

I recently had a patient who asked for a specific test. I didn’t decline the request but, after examining for an underlying cause, I suggested another management option. I suggested that if this didn’t work, we could review the situation and I would then order the

Moral distress in hospital doctors

The concept of “moral distress” in nurses was described by Andrew Jameton in 1984. He defined it as occurring when one knows the right thing for a patient but institutional constraints make it impossible.

The medical literature has plenty on physician burnout, poor working conditions, and their effects on wellbeing. We haven’t discussed moral distress as much as nurses do, although we clearly experience it too.

The Point of Care Foundation has worked with over 180 organisations throughout the NHS, specifically supporting clinical teams. The foundation’s director, Jocelyn Cornwell, told me, “I have learned that moral distress is widely felt by doctors and nurses but also porters, ward clerks, paramedics—and by managers, when they are aware of the pressure and unable to mitigate it. In short, everyone who works close to or directly with patients is at risk.”

Morale, engagement, and wellbeing in clinical staff affect quality of care, sickness absence, and retention—described especially clearly by Michael West and Jeremy Dawson for the King’s Fund. The 2018 British Social Attitudes survey of 3000 citizens showed a sharp drop in public satisfaction with the NHS. Short staffing, underfunding, worsening access, and waiting times were the biggest issues raised.

The 2017 annual NHS staff survey showed deteriorating morale and engagement, with work pressures and staffing gaps cited. And NHS Improvement’s recent workforce report showed that one in 11 NHS clinical posts is unfilled, including 8% vacancies for doctors—higher by far in some specialties or regions.

In recent months we’ve had reports of short staffing, lack of capacity, and unmanageable demand putting care quality and patients at risk, such as in general practice, emergency medicine, psychiatry, paediatrics, and intensive care. This, in turn, leaves doctors feeling unable to give the standard of care they were trained to or that patients want.
Rushed, missed, or risky care will inevitably lead to fear and feelings of loss of control among conscientious medics. Interest is growing in resilience training. But I’m not convinced there is good evidence for its benefit. And, surely, resilience should be for the difficult emotional burden of caring, responsibility, and carrying risk—not for unacceptable and potentially dangerous working conditions.

The Point of Care Foundation has had success in introducing Schwartz rounds, now formally evaluated in a longitudinal National Institute for Health Research study with positive results for staff morale. During these rounds staff can share the difficult emotional effects of providing care while retaining compassion in a facilitated safe space.

Cornwell cited as key factors in improving conditions: shared values and mutual support; managers being willing to talk openly about pressure (and finding ways to mitigate it); and low tolerance for poor behaviour. She also emphasised the behaviour of senior clinicians and managers—in valuing, role modelling, and engaging teams—as being crucial to staff.

Maybe the starting point in handling moral distress in doctors and other health workers is to speak its name rather than play down its existence.

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BMJ OPINION Samantha Anthony

Career breaks should be supported, not feared

As I near the end of a one year career break, it has become clear to me that this opportunity to temporarily step aside from medicine has been hidden away as though it’s a closely guarded secret. It is something to which we are all entitled, yet many doctors are unaware of the option. It is time to acknowledge what a break can offer, because as individuals, and as a profession, we could benefit immeasurably.

As doctors, we are inherently committed to our responsibilities, but this can present another barrier to career breaks. In an already pressurised system, the expectations placed upon us, and those we place upon ourselves, can stop us from feeling that we have the “right” to take time out. Regardless of specialty, our duty of care is at our core: duty to our patients, our teams, our vocation, and to carrying out our obligations. But it can seem like a never ending continuum.

Some may say that there aren’t enough of us already, and that extended absences could place further staffing pressures on the NHS. But keeping up the pace indefinitely isn’t sustainable and it inevitably takes a toll on doctors. While we can’t easily reverse the greater troubles that our NHS is facing, we can try to tackle the burnout, ill health, resentment, and voluntary departure of doctors that is widely reported as rife right now. Reports of deteriorating mental health and suicides within our profession cannot be ignored.

Far from employers, teams, and trusts fearing career breaks, they should support them and recognise that all parties can reap the rewards from doctors restoring their motivation and energy. Career breaks may even improve the retention of our workforce and, if made more accessible, doctors may feel more supported and reassured in the knowledge that there is the option of a timeout along the endless tunnel of their high intensity working lives. And, surely, planned absence is better than unplanned.

We work for a large part of our lives, and should be looking to extend the quality of both. We owe it to ourselves and to our patients, to take time out when we need to. And I know I will return a better doctor for it.

Samantha Anthony has trained in surgery and general practice and now works in dermatology as an associate specialist at West Hertfordshire Hospitals NHS Trust

Cite this as: BMJ 2018;360:k1366
Learning to embrace online GP services

Technology, providers and practices must be rigorously evaluated if we are to maximise benefits and minimise risks, say Martin Marshall and colleagues

KEY MESSAGES

- Opportunities to access primary care online are developing at pace and offer considerable advantages for some patients over traditional models of service provision
- Online services may also be unsafe for patients, exacerbate inequalities, and risk destabilising established services
- The benefits are more likely to be realised, and the risks minimised, if online services are integrated into the established model of general practice, rather than set up in competition

The health sector has been slower to adopt technological innovations than the banking, retail, and travel industries, but it is catching up. In 2017 the global digital health industry was worth £19bn and over 320 000 mobile health apps were in regular use. Online consulting is one of the fastest growing technologies. In the US it has been commonplace for over a decade. Similar services are now being established in the UK, driven by rapid developments in the supporting technologies, consumer demand for convenient and accessible services, and the need to find solutions to rising workload and constrained resources.

We examine how online consulting is developing in UK general practice and its emerging benefits and risks. We focus on text and video based online technologies, which are being used as alternatives to face-to-face consultations. In addition, we explore a number of complex questions that the emergence of online consultations is raising for policy makers, practitioners, and patients.

The online consultation market in general practice is expanding at pace: eConsult, Babylon, askmyGP, Dr Matt Ltd, Push Dr, Doctor Care Anywhere, GP at Hand, Anytime Dr, Dr-Plus, and many others have been established in recent years. Most of the online systems have been developed by private entrepreneurs and some have substantial backing from private investors.

In December 2017, 34 online providers had been inspected by the health regulator, the Care Quality Commission (CQC), to provide services in England. Broadly, three categories of service are emerging. First, systems such as eConsult or askmyGP are integrated into the electronic medical record systems of established general practices, and the service is provided by practice staff as part of a comprehensive NHS funded service. Second, systems such as GP at Hand offer services delivered by clinicians operating separately from established general practice teams, though they might be working in a business partnership with established practices. The services are funded by the NHS but may only be available to specified low risk patient groups or may be limited to specific activities, such as prescriptions or fitness to work certificates. Some of these providers offer follow-up face-to-face consultations when required. Third, private services are available on a payment scheme, on a pay per consultation basis, or as a job benefit.

A growing number of online services are developing advanced technologies such as artificial intelligence (AI) and machine learning to support or replace decisions made by clinicians.

Disrupting the system

Digital online consulting and associated technologies are “disruptive innovations” with the potential to disturb and perhaps displace current ways of working. Established power brokers in the system are either promoting or responding to the disruption in different ways.

The government is promoting the use of new technologies as a central plank of its industrial strategy. Policy makers see online consulting as a way of reducing GP workload and providing more accessible care at lower cost. For this reason, they have provided financial support to increase uptake of online systems by established general practices. At the same time some GPs are suspicious that policy makers are quietly encouraging private providers to shake up the established system.

Industry and private investors are making considerable investments in both the technologies and the promotion of online services. They will expect a healthy return in the medium term from the UK and other developed countries and in the longer term from the growing middle classes in emerging economies.

Regulators—primarily the CQC, the General Pharmaceutical Council, and the GMC—are playing catch up as online providers test legal and ethical boundaries. In its first round of regulation in 2016-17 the CQC found that only four of 28 providers were fully compliant with regulations, and 15 required enforcement action. Problems were found with confirming patient identity before prescribing drugs, unreasonable assumptions about mental capacity, poor safeguarding, failure to seek informed consent, and inadequate communication with patients’ registered GPs.

The BMA and the Royal College of General Practitioners state that they
are supportive of new technologies in principle but also express concern about the negative effects of emerging online services on patient safety, equity, and on the sustainability of the current model of general practice provision.

**What are the benefits and risks?**

Advocates and sceptics of online consulting are inclined to express highly polarised views about the benefits and risks for patients, carers, professionals, and the health system (see table overleaf). The emerging models of online consulting lack rigorous, independent research evidence about their cost effectiveness or adverse consequences from a general practice setting. Technology is highly culturally dependent so the relevance of international evidence is questionable. Some commentators ask whether conventional approaches to evaluation, particularly ones focused on linking rapidly changing interventions to health outcomes, are incompatible with or, by stifling innovation, possibly detrimental to an innovation culture.¹¹ ¹²

Notwithstanding these criticisms, the rapid growth of online consulting and its potential risks for patients and negative effects on established services indicate the need for a systematic approach to evaluation—not least because in the absence of rigorous research, anecdote and partial marketing data are being passed off as evidence by those with commercial interests.

Some additional insights can be gained from research carried out in related fields. Evidence shows that the pace of uptake and the effect of new technologies in the health sector, such as NHS walk-in centres, was often overstated in the early days; their unintended consequences were poorly understood, and they were more likely to generate demand than to reduce it.¹⁶ Telehealth technologies in general have less impact and higher costs than established care.¹⁳ Some evidence indicates that new technologies are more effective when they are integrated with established services, rather than set up in parallel to them.¹⁸

**Unanswered questions**

The current evidence base does not provide a glowing endorsement, but the continued growth of online consulting is inevitable, whatever its merits and risks. Despite the hyperbole—one advertisement claimed “you will never go to the doctors again”—the roll-out of online consulting is likely to be less disruptive than some people hope and others fear. Online providers are developing partnerships with general practices, finding common ground with the regulators, and considering offering their services for underserved populations such as the homeless. In a few years’ time online services may be fully embedded in established general practices.

This is more likely to happen quickly and effectively if current initiatives are rigorously evaluated—in particular examining the effects on demand, workload, and equity—and the evidence heeded. It is also more likely if health service staff are properly equipped and trained to use the technologies safely and to their full potential, if funding mechanisms are reformed to offer incentives to integrate online services with conventional ones, and if regulators have more powers to tackle unacceptable performance, particularly when services are provided from geographical locations outside their jurisdiction.

The rapid growth of online consulting is revealing some new ethical and philosophical questions. Firstly, general practice is designed to provide comprehensive services for all patients in a geographical locality, a model that even when implemented imperfectly has been shown to deliver good outcomes at low cost.¹⁹ By contrast, private online providers detached from conventional general practices explicitly segment the population, providing services primarily for the healthy working population and excluding people with long term conditions, multimorbidity, and mental health problems.

Proponents argue that doing so frees up resources for the NHS to focus on those with greatest need and improves access for some populations who are historically poorly served, such as adolescents. Opponents claim that it generates new demand and unrealistic expectations and disadvantages groups who are unable to use online services. The effect of the new technologies on different population groups needs to be carefully evaluated.
Second, online provision of care adopts a different stance from face-to-face care in terms of the balance between the sometimes competing domains of quality. When a patient is prescribed antibiotics for a sore throat by an online GP, without having access to the patient’s records or examining the patient, the doctor may be favouring patient access and experience over safety and cost effectiveness. This may be what patients want, but whether they are making an informed decision is unclear.

Third, encouraging, albeit implicitly, patients to pay for some online GP services touches on the debate about how best to fund the NHS and raises concerns that such services may act as a vehicle for privatisation of the NHS by stealth. The business model underpinning some of the private online providers is essentially one of co-payment, a model that challenges one of the founding principles of the NHS— that care should be free at the point of delivery.20

Finally, the provision of online services challenges established thinking about risk. In conventional face-to-face consultations the clinician holds most of the information necessary to manage clinical risk—the patient record, data derived from a full assessment of a condition, and clinical expertise. The clinician is therefore held in law to be responsible if something were to go wrong. Online consultations may be operating in a different arena. Patients have chosen, knowingly or otherwise, to seek help from a clinician who has less information at their fingertips. Online consultations may therefore be more risky for both parties, but clarification is required about who bears this risk.

Online consulting in general practice presents real benefits for patients and opportunities for clinicians and for the health service. But it comes with potential risks for all parties. These risks could be minimised by ensuring that rigorous evaluation takes place and that people using online services are fully informed, and by developing online services as an integrated part of established general practice and not in competition with it.

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Robina Shah, chair, patients and carers partnership group, Royal College of General Practitioners, London, UK

Helen Stokes-Lampard, chair, Royal College of General Practitioners, London, UK

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LETTERS
Selected from rapid responses on bmj.com
See www.bmj.com/rapid-responses

SERIOUS ABOUT PREVENTION

Government must act on prevention
The Institute of Health Promotion and Education agrees that now is the time to become “serious about prevention” (Acute Perspective, 24 February). We have consistently argued for more funding to cope with our current and future public health priorities. The case for funding is reinforced by evidence of how effective interventions have resulted in major successes in public health. Specifically, we urge the government to act in five key areas:

1. Produce a long term UK public health strategy
2. Tackle capacity problems in the NHS and schools, especially in areas with high levels of deprivation
3. Promote the health of NHS staff
4. Make personal, social, health, and economic education compulsory in all schools
5. Give power and resources to directors of public health so that they can become the true “masters of public health.”

Having a healthy population would have economic benefits and relieve much of the pressure on our overloaded NHS.

Michael Craig Watson, associate professor, Nottingham
Sue Thompson, secretary, Welwyn

Cite this as: "BMJ 2018;360:k1279"

WHATSAPP FOR CLINICIANS

NHS should work with WhatsApp
Rather than continuing with a WhatsApp service where data are moved out of the protection of the UK law or spending to build or buy a new service (Technology, 17 February), why not work with WhatsApp or similar to create an NHS friendly service?

The large tech companies already have the technology and scale to deliver a service. Only small modifications would be needed to keep the messages of registered NHS users in the UK and in a way that is compliant with healthcare data governance. NHS Digital is warming to cloud storage and could help with governance.

This would be the best of both worlds, with users getting a familiar user experience and reassurance that their data are as safe as any other NHS service and the big tech companies getting some income and a case study in helping patients get better care.

Chris Russell, simulation fellow, Croydon

Cite this as: "BMJ 2018;360:k1295"

LETTER OF THE WEEK

Reversing our drift into social disintegration
Oliver’s call for public health interventions throughout life does not go far enough (Acute Perspective, 24 February). Only a reversal of our continuing drift into social disintegration can begin to restore the nation’s health. Seven decades ago, Britain was poor but the new NHS was embedded in relatively secure provisions of housing, education, employment, and welfare. We are far richer now, but we can’t rely on any of these provisions.

We are better informed too. The human fetus is exquisitely sensitive to the nutritional and emotional states of the mother, which if substantially compromised will affect the neurology, physiology, and psychology of the child, sometimes for life. Yet integrated perinatal health and welfare provision are barely visible. As evidence based early interventions are contested, another generation of children and parents is neglected.

As Oliver describes, well intentioned public health initiatives are lethally undermined by cuts. These lead to greater inequality, associated with higher infant mortality and poorer health.

Marmot has shown how social status affects people’s capacity to keep healthy. He cites the World Health Organization’s pronouncement that “social injustice is killing people on a grand scale.”

“Getting serious about prevention” means acknowledging that our NHS cannot survive in current social conditions. The scientific knowledge we now have puts a moral obligation on the medical profession to argue forcefully for a healthier and more just society.

Sebastian Kraemer, honorary consultant psychiatrist, London

Cite this as: "BMJ 2018;360:k1316"

GIFT OF CREATIVITY

Artistic boost with Parkinson’s disease
John McLean experiences greater creativity since receiving the diagnosis of Parkinson’s disease and says that levodopa might be fuelling his recently enriched artistic skills (The Big Picture, 3 February). He is probably right.

Many clinical observations have shown that antiparkinsonian drugs—namely, dopamine agonists and levodopa, might boost pre-existing creativity or even awaken artistic skills.

New creativity has been seen in other brain diseases, such as frontotemporal dementia, without the contribution of drugs, raising the question of whether the neuropathology of Parkinson’s or its combination with dopaminergic treatment is responsible.

Better performance may be related to the reduction of latent inhibition, a rise in novelty seeking, more divergent thinking, and novel conceptual combinations induced by dopaminergic drugs. Regardless of our understanding of the underlying mechanisms, the “gift” brings a bright side to life for Parkinson’s disease.

Rivka Inzelberg, professor, Ramat Aviv, Israel

Cite this as: "BMJ 2018;360:k1146"

Filling the niches in our system
WhatsApp is a brilliant example of physicians filling in the gaps of systems suffocated by bureaucracy and outdated technology. Instead of running scared behind knee jerk reactions of data protection, we as physicians, the NHS, the BMA, and the GMC should be seeking to mitigate these concerns by providing solutions that fill these niches in our system. Instead, doctors and other healthcare professionals are forced to make themselves vulnerable to improve communication and patient safety.

People fret over the “unsecure” nature of WhatsApp; what is so secure about the multitude of physical copies of patient lists that are printed every day and stored in scrub tops that seem designed to fling their contents at the slightest jiggle? Blaming the maligned foundation year trainee for losing a scrap of paper is much easier than accepting responsibility for creating a modern, integrated healthcare solution.

Guy S Handelman, radiology specialist registrar, Belfast

Cite this as: "BMJ 2018;360:k1311"
OBITUARIES

**Alexander Hugh Davies**
General practitioner
Chepstow, Monmouthshire (b 1933; q London Hospital 1958), died after a short illness on 23 March 2017
After house jobs at the London Hospital and in Bath, Alexander Hugh Davies (“Alec”) served for three years as a medical officer with the Royal Air Force in Cyprus. He gained excellent experience in caring for RAF personnel and their families before settling into his career in general practice. He spent four years in general practice in Canterbury before moving to Chepstow, where he worked until retirement. After seeing cases of liverfluke in the practice, he co-wrote a paper published in The BMJ. The original slides are still used for teaching purposes. Outside medicine, he was a passionate fisherman and an enthusiastic, loyal supporter of Welsh rugby. He enjoyed family holidays in Pembrokeshire and France. Alec leaves his wife, Margot; four children; and 14 grandchildren.
Alison Blakeway, Margot Davies
Cite this as: BMJ 2018;360:k1210

**Geraint Roberts**
Consultant obstetrician and gynaecologist West Wales General Hospital (b 1940; q University Hospital of Wales 1964; FRCOG), died from cardiac arrest while on holiday in Majorca on 9 October 2017
Geraint Roberts came from a small mining village in Wales and was inspired to do medicine because of his own ill health—severe asthma—in childhood. He dedicated his working life to obstetrics and gynaecology and was a consultant in Carmarthen from 1973 until he retired in 2001. He was an especially keen teacher and lecturer at both undergraduate and postgraduate level and was a frequent examiner at final MB in Cardiff and London. He chaired many committees, was involved in medicolegal defence work, and was a member of the Expert Witness Institute. In retirement he enjoyed travel, reading, and military history. He leaves Glenys, his wife of 50 years; two daughters; and four grandchildren.
Bethan Non Matthews
Cite this as: BMJ 2018;360:k1205

**Michael William Newbery Nicholls**
Microbiologist, dean of postgraduate medical education, and medical editor (b 1931; q University College London 1955; MRCS Eng, FRCPath), died from prostatic cancer on 17 February 2018
Michael William Newbery Nicholls embarked on his career in clinical pathalogy and microbiology in the early 1960s. As the first medical microbiologist in West Sussex, he worked at Chichester, Worthing, and Shoreham hospitals. In 1976 he took a year’s leave and established microbiology laboratories in two hospitals in Kuwait. In 1990 he was appointed postgraduate dean of medical education (University of London) for South East Thames Regional Health Authority. He was honorary secretary and later president of the Fellowship of Postgraduate Medicine, and editor in chief of the Postgraduate Medical Journal. Predeceased by his wife, Pam (née Heme), a paediatric physiotherapist, he leaves two sons and five grandchildren.
Harold Lipman
Cite this as: BMJ 2018;360:k1198

**Alfred Graham Findlay**
General practitioner
Staveley, Chesterfield (b 1927; q Glasgow 1950; DOBst RCOG), died from interstitial pneumonitis on 9 December 2017
Alfred Graham Findlay (“Graham”) met his future wife, Catherine, while doing house officer posts at Sunderland Royal Infirmary. During two years’ national service in Germany, he mostly worked as a GP for army families. He did his vocational training in Edinburgh and took an assistantship in Ashington, Northumberland. As a GP partner in another mining town—Staveley, near Chesterfield—from 1958 to 1991, he took pride in providing maternity care for his patients at Ashgate maternity hospital. This included forceps deliveries and home births. Graham retired to Warkworth, Northumberland, where he cared for his wife, maintained an active role in his local United Reformed Church, and enjoyed gardening and golf. He leaves his second wife, Cath; two sons; one daughter; and five grandchildren.
Christopher Findlay, Nigel Findlay
Cite this as: BMJ 2018;360:k1203

**Joseph Albert Gleeson**
Consultant radiologist (b 1931; q University College Dublin 1955; DMRD Eng, FRCP, FFR, FRCR), died from a cerebrovascular accident on 4 November 2017
Joseph Albert Gleeson (“Joe”) initially worked as a general practitioner before training in radiology at the London Hospital in Whitechapel. He was appointed consultant radiologist at the Chelsea and Westminster Hospital in 1967. One of the early pioneers of the double contrast barium enema, he was able to produce exquisite images and extract detailed information from them in a way that was admired around the world. He was deputy editor of the British Journal of Radiology and senior examiner for the Royal College of Radiologists. But it was for his love of, and dedication to, teaching that he will be best remembered. He leaves Deirdre, his wife of 60 years; three children; and seven grandchildren.
Fergus Gleeson
Cite this as: BMJ 2018;360:k1201

**A D B Webster**
Honorary senior lecturer and consultant immunologist Royal Free and University College Medical School, London (b 1940; q Cambridge 1965; FRCP Lond, MD Camb, FRCPath), died from sepsis and complications from his cardiac amyloid on 17 August 2017
A D B Webster (“David”) spent his early career at the clinical research centre at Northwick Park Hospital. Later, at the Royal Free Hospital, David made a huge impact and was involved in the proposal for, and development of, the Pears Building, a new medical research centre to be built in the hospital’s grounds. He was a founder member of, secretary to, and subsequently president of the section of clinical immunology and allergy at the Royal Society of Medicine. He was coauthor of Diagnosis and Treatment of Immunodeficiency, published in 1980. David died in the intensive care unit of Northwick Park Hospital. He leaves his wife, Lindsey; two children; and two grandchildren.
Helen Chapel, Brett Webster
Cite this as: BMJ 2018;360:k1204
Walter Werner Holland
Pioneer of European public health

Walter Werner Holland (b 1929; q St Thomas’ Hospital Medical School, 1954; CBE, MD, FFPH, FRCP, FRCPath), died from prostate cancer on 9 February 2018.

Walter Werner Holland was professor of clinical epidemiology and social medicine at St Thomas’ Hospital from 1968 to 1994. He was born into a Jewish family in Czechoslovakia, and his father, who had previously helped Germans fleeing the Nazi regime, left for England immediately after the occupation of Prague in 1939. Soon after, Walter and his mother followed.

Despite initially speaking little English, Walter was an accomplished student at Rugby School and subsequently at St Thomas’ Hospital Medical School. His interest in research was kindled when he was among a handful of students in his year to be selected for an intercalated BSc in physiology.

During national service with the Royal Air Force, Holland was posted to the Central Public Health Laboratory Service to work on vaccines against adenoviruses, but, in what would prove a serendipitous mistake, the manufacturers inadvertently destroyed a batch of vaccine, and he was offered the chance to investigate the 1957 influenza epidemic. He was working with Corbett Macdonald, and this introduction to epidemiology kindled his interest in research.

Holland’s research on air pollution was challenged by his view that it was a major cause of chronic bronchitis at the levels seen in the 1970s. His trial of multiphasic health screening found major problems with a procedure that was thought to be beneficial, causing private health providers to become incandescent. BUPA was especially charged when he revealed that they were charging £75 for a suite of tests that cost them £12. Similarly, his work on the government’s resource allocation working party was very unpopular in the south London constituency where he lived, when it became clear it would lose considerable amounts of funding.

He did more than anyone to raise the status of epidemiology and social medicine at a European level.

Influencing hospital design
The first part of Holland’s career focused on chronic disease and, in particular, respiratory disease in children. He took a hands-on approach, spending one evening a week visiting the families participating in his studies and analysing the data on the first primitive computers. In the mid-1960s his focus shifted. St Thomas’ was being rebuilt, and he was determined to ensure the new facility reflected the health needs of the local population in Lambeth. This led him to create the UK’s first health services research unit.

After his work on St Thomas’ he was invited to advise on other new hospitals, at Frimley Park and in Bury St Edmunds. Their designs were informed by a series of studies, ranging from epidemiological assessments of the health needs of the local population to a randomised controlled trial of early discharge. This work brought him into contact with the world of policy, but he carefully cultivated his links with civil servants, ensuring that evidence was at least heard, even if not always acted on.

Holland’s research on air pollution challenged the view that it was a major cause of chronic bronchitis at the levels seen in the 1970s. His trial of multiphasic health screening found major problems with a procedure that was thought to be beneficial, causing private health providers to become incandescent. BUPA was especially charged when he revealed that they were charging £75 for a suite of tests that cost them £12. Similarly, his work on the government’s resource allocation working party was very unpopular in the south London constituency where he lived, when it became clear it would lose considerable amounts of funding.

European collaboration
Unsurprisingly, given Holland’s personal history, he was committed to collaboration within Europe. His leadership of two editions of the European Community Atlas of Avoidable Mortality provided a graphic illustration of the natural laboratory provided by Europe’s diverse systems. Its findings stimulated numerous research questions and provided the basis for what is now a thriving European health services research community.

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Chair of the European Commission’s panel on epidemiology and social medicine from 1997 to 1994, he did more than anyone to raise the status of these disciplines at a European level. His leadership of two editions of the European Community Atlas of Avoidable Mortality provided a graphic illustration of the natural laboratory provided by Europe’s diverse systems. Its findings stimulated numerous research questions and provided the basis for what is now a thriving European health services research community.

Understandably, he was horrified by Brexit and the damage it is doing to his adopted country.

When Holland retired there were 27 senior academics around the world who had spent substantial time in his unit and another 43 who held senior posts in government departments or international organisations, such as the World Health Organization or the World Bank. He received many honours in the UK and internationally.

He leaves his wife, Fiona; three sons; and seven grandchildren.

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A research study this week (p 524) finds that importing off-patent prescription drugs from international sources could help manage shortages of these drugs and substantial price increases in the US.

In a linked podcast, Ravi Gupta, one of the authors and a resident at Johns Hopkins Hospital, Baltimore, discusses the effect of high drug prices on his patients: “I had the opportunity to work with patients that unfortunately find a lot of medicines prohibitively expensive, and they find it more difficult to balance the cost of those medicines with things like food and with rent. “I’ve had patients who have found medicines like insulin to be prohibitively expensive. There’s also the case where many patients struggle to afford their inhalers or various antibiotics that again have been around for a long time.”

However, he is hopeful the landscape is changing: “There is a higher and more robust level of discussion around drug prices. Polls show that patients are increasingly frustrated with price increases of drugs and how prohibitive purchasing of drugs has become.

“The FDA now should certainly take this proposal of importing drugs more seriously. They are very much committed to working on the affordability of drugs, particularly those that are off patent. I think they are trying to adopt strategies to set an increased level of competition.”

Effect of tai chi versus aerobic exercise for fibromyalgia

Sellu is cleared of medical misconduct

Could private top-up insurance help fund the NHS?