> Religious organisations must stand against the suffering inflicted by medicine administered simply because it can be

NO HOLDS BARRED Margaret McCartney

The harms of futile medicine

Doctors are "murderers," the UK has "death panels," and the plight of Alfie Evans and his family shows why we need guns to protect us from the government. Social media in the age of fake news can be dangerous. This becomes more bizarre when tethered to the view, especially from the far right and self identified Christians in the US, that Alder Hey Hospital is committing a heinous crime. Catholicism in particular was behind pleas for more, non-palliative, intervention in the life of Alfie Evans, a baby with a fatal illness who has now died.

I went to a Catholic state school, a common destination for children my age brought up in Scotland. I clearly remember fund raising efforts to help open a hospice. It was clear that death was part of life, medicine can't make us immortal, and dying should have dignity. Indeed, Cicely Saunders, founder of the hospice movement, was Christian and used her values to create her legacy. Care of dying people has been a feature of many religions that acknowledge humans' impotence in our ultimate mortality—and our ability to care for each other despite it.

I'm an atheist, and I find the intersection between religion and day-to-day medical practice fascinating and troubling. Some patients and families are left believing that, unless they ask or plead for every possible intervention, their actions are somehow anti-religious and ungodly. I accepted an invitation to join the *Lancet*-Mario Negri-Vatican commission earlier this year because I believe that the intersection of faith and evidence based medicine could be much improved.

In end-of-life matters, many religions offer a far more reflective assessment than is commonly promulgated. For example, Pope Francis said in 2017, "And even if we know that we cannot always guarantee healing or a cure, we can and must always care for the living, without ourselves shortening their life, but also without futilely resisting their death. This approach is reflected in palliative care, which is proving most important in our culture, as it opposes what makes death most terrifying and unwelcome—pain and loneliness."

But this was not the message people heard from the Vatican. If religion meant that patients must take futile treatments and families should insist on them, not only would this become unethical for doctors—administering inappropriate interventions with a burden of treatment to be endured and no potential benefit—it would also mean that no one would be allowed to die peacefully. All would have to undergo ineffective cardiopulmonary resuscitation, chemotherapy, or surgery. It would be absurd and cruel.

Yet a US sect somehow thinks it righteous to instruct treatment beyond hope, while seeing a child not as an individual with rights distinct from the parents but as a conduit for the expression of a belief system.

We all come with biases, experiences, fears, and hopes. Religious faith clearly sustains and nourishes many people. But it can also, when misinterpreted, dressed up with fake news and social media hyperbole, create a climate where citizens think that religion justifies false hope and attacks on the families and staff caring for people at the end of life.

Religious organisations must stand against suffering inflicted by medicine administered simply because it can be. They should ensure their followers understand their message—and correct it vocally when they do not.

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THE BEST POLICY Nigel Edwards

Reducing outpatient activity does not cut hospital costs

This flawed approach has led to wasted effort in passing problems around the system

Each year in England there are more than 110 million outpatient appointments. The number has been rapidly growing, particularly since 2008.

Many of the NHS's sustainability and transformation plans, intended to transform health and care in 44 areas across England, have incredibly ambitious proposals to cut costs by reducing outpatient activity. Cheshire and Merseyside, for example, hopes to save £22.5m by reducing referrals by 20%. Leicester, Leicestershire, and Rutland intends to reduce all outpatient activity by 30% by moving services into the community, and Durham, Darlington, and Tees hopes to achieve a 20% cut. Such ambitions present several problems.

For instance, the prices quoted for outpatient activity (with new appointments ranging from £95 to almost £500) are a long way from the true cost. A significant but uncertain proportion of the total comprises overheads and other costs that are spread across all hospital activity but that still need to be paid even if the outpatient activity goes away.

Many of these costs are allocated on a formula basis, meaning that outpatient services attract a high proportion of them. Although the local clinical commissioning group may "save" £150 by preventing a new outpatient appointment, the hospital is likely to save almost nothing. This has led to wasted effort in passing financial problems around the system, rather than trying to work out the best and most cost effective way to provide a valuable service to patients.

An example of this flawed approach is the development of referral management centres. Although peer review and referral criteria and pathways are useful, putting an administrative layer between referrer and specialist does not seem to be effective. It almost certainly does not produce real savings and may introduce unnecessary or even hazardous delay. It also removes the chance to replace referral with email or telephone advice and other options.

Developing new and stronger relationships with GPs pays dividends

A further objection is that outpatient care covers a wide range of activities, and it is not appropriate to apply blanket assumptions about how to change them. The functions carried out by a clinic for psoriasis, for example, are very different from those for skin lesions or for post-procedure follow-up, and they need different designs.

Best innovation is clinician led

Much innovation is happening in outpatient care. The Nuffield Trust's upcoming review of outpatient

ACUTE PERSPECTIVE David Oliver

Learning from deaths in hospital

The secretary of state for health and social care, Jeremy Hunt, has spoken of "750 avoidable deaths in hospitals in England every month"—the equivalent of a passenger plane falling out of the sky each week. The source of this figure was a methodologically rigorous, peer reviewed study by a respected group, published in *The BMJ* in 2015.

But the researchers who conducted the study had expressed caution about the limitations of their methods and baseline data, saying that their metric was no reliable indicator of the quality of care. They had reviewed 100 random sets of case notes from 34 hospitals, estimating that 3.6% of deaths had at least a 50% chance of being avoidable. The lead author said in an interview that, in many cases, it would require "the judgment of Solomon" to know whether a death had been avoidable.

There are deaths where no cause for concern arises, but hospitals still want to learn from them

In seeking to tackle avoidable deaths, Mr Hunt has understandably been influenced by high profile investigations such as those into Morecambe Bay maternity services or Southern Health NHS Foundation Trust and people with learning disability. He's also been influenced by the individual stories of bereaved people whose grief has sometimes been compounded by insensitive treatment, delays, obfuscation, and a lack of confidence that changes have been made to protect future patients. On the other hand, he has publicly committed to the need for an open, learning culture in the wake of the Bawa Garba case.

In December, Mr Hunt officially announced plans for the national mortality review programme. As part of this programme, from this year onwards, each hospital in England will publish a quarterly dashboard summary of what it's doing to review the case notes of patients who have died.

Each hospital will select some notes for deeper structured judgment reviews to identify potentially avoidable deaths and learning themes for improving practice. They will also have to set out plans

KUMAR SRISKANDAN/ALAMY

redesign, following an event held with clinical leaders who have transformed their services, shows that the most interesting and effective examples are not driven by top-down managerial planning but rather come from specialists and their teams working through solutions, running experiments, rethinking their processes, and carefully analysing the needs of patients and referrers.

One important insight is that for some specialists—those who deal with common chronic diseases, geriatric medicine, or paediatrics—developing new and stronger relationships with GPs pays dividends. One approach is to run multidisciplinary team sessions with groups of GPs and other staff to look at difficult clinical issues. As well as the educational benefits, this approach can bring a positive change in the relationship: GPs become more confident that they will get helpful advice, and specialists are happier to discharge patients back to GPs whom they know and trust.

Release consultants' time

Virtual clinics for conditions where there is a clear pathway can release consultants' time, particularly when this approach is combined with changes in skills mix to allow some tasks to be taken on by other staff. Using trained technicians or even surveys of patients to collect data and information on patients' conditions means consultants can ensure they see the most complex cases and use their time most efficiently.

Reducing follow up may be justified in many cases, but blanket reduction targets are not helpful. Alternatives such as telephone follow up, letting patients decide (perhaps with a decision tool) whether they want follow up, and "open return tickets" for more complex chronic conditions may be better.

Ultimately, any redesign of services needs to be appropriate to patients' needs and carried out by the clinicians responsible for delivering them.

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on how to involve bereaved people more in this process and to share information with them. In the first wave of quarterly dashboards very few "avoidable" deaths have been reported by trusts.

I support this initiative in principle, but I have some concerns. Firstly, the time taken by practising clinicians in reviewing these case notes could take them away from clinical care for the living. Secondly, it's important not to conflate issues across a whole range. NHS organisations have sometimes gravely mistreated bereaved families when care was often woefully substandard. Some families have raised complaints and concerns that have been investigated with varying degrees of speed, openness, and family involvement.

But there are also deaths where no cause for concern arises—yet hospitals still want to learn from them. Those lessons may have nothing to do with avoidable death or harm. They may relate to better organisation of services, better communication or palliative care, or perhaps avoidable admission to hospital of someone clearly near the end of life.

So, considering the political focus on public assurance, demonstrating decisive action, and showing bereaved people that meaningful action is being taken, let's not lose the other potential benefits of this work.

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BMJ OPINION Leone Ridsdale

Closing the gap between neurologists and GPs

The rising number of deaths from neurological disorders may be associated with rising numbers of neurologists (making diagnoses). It fits with the belief that neurologists enjoy diagnosis, but not so much management. But this old chestnut does not apply to many common conditions like migraine, epilepsy, or Parkinson's disease. And the potential of neurology to deliver on changing outcomes could go further if it was linked to primary care. This is particularly true for epilepsy.

In 2011 we published a paper based on a large sample of routine general practice and national data which pointed to a rise in deaths from epilepsy. This finding is confirmed by Public Health England data. We found that increased risk of death was associated with other risk factors routinely identifiable in general practice. Patients who have alcohol problems, who do not collect repeat prescriptions for anticonvulsant drugs, who have had recent injuries, or who had been treated for depression are at increased risk of death. Patients who are not seizure free in the prior 12 months are at a higher risk of death. The identification of this risk was possible because the Quality and Outcome Framework gave a limited amount of remuneration to GPs to create a register of people with epilepsy and record epilepsy control. In 2014 this was abandoned.

Increased risk of death was associated with other risk factors

It could be resuscitated and risk factors linked and stratified, just as they are for other conditions. Most of these risks are manageable. Depression requires identification, and can improve with antidepressants. However GPs may not use them in epilepsy because of side effect fears. Cognitive behaviour therapy works for both depression and anxiety which commonly co-occur in poorly controlled epilepsy. Smithson et al demonstrated that GPs can identify people who have not adhered to epilepsy medication and discuss this with them. Depression, non-adherence, and poor epilepsy control can combine to create a vicious cycle. Not identified or not managed, they account in part for the nearly three times risk of death in deprived areas.

Variation in death rates between areas is a chance to improve outcomes. Enter the neurologist. Some deaths might be prevented by better neurological care. Such input would include diagnosis and drug reassessment, and some patients being referred for possible neurosurgery.

To achieve this, all neurology departments could appoint a neurologist to guide and support GPs to identify patients at higher risk. The lead would devise a local strategy whereby referred patients are triaged to a nurse specialist, neurologist, or other suitable expert.

Leone Ridsdale has worked as a GP and a neurologist, leading neurology teaching for medical students at King's College London

PROVOCATIONS

Neena Modi

A radical proposal

To protect children's health we should give them a vote

Adult health is in large part determined by child health, yet around the world policies directed at improving children's health remain inadequate.

For example, the UK government's response to the prevalence of overweight and obese children (a fifth of 5 year olds and one in three 10 year olds) has been criticised for being ineffective and too accommodating of commercial interests, although the vast majority of these children will go on to become obese adults.

All too often, governments listen only to a vocal electorate. This poses a problem for infants, children, and teenagers, almost a quarter of the UK population. Most have no vote and so are, in effect, denied their right to shape national destiny, despite their right to have their views and interests represented being enshrined in law.

Evolution of children's rights

For most of history children were considered the property of parents. It wasn't until 1989 that the UN adopted the Convention on the Rights of the Child, since ratified by 194 countries. The legally binding agreement sets out children's civil, political, economic, social, and cultural rights.

The consequence of children having no vote, and hence no voice, was brought into sharp focus by the realisation that the Brexit referendum might very likely have been different if the voting age had been lower. And of course it is the young who will be most affected by the consequences of that supposedly democratic decision.

The idea of parental proxy votes for their children is not new

The suggestion that parents could be provided with a proxy vote for each underage child is often met with bemusement, if not outright ridicule. Yet the default expectation of societies is that parents will act in the best interests of their children. In medical care when children are very young, parents give consent on their behalf, and it is assumed that decisions are made in their best interests. As they grow older, the expectation is for parental consent to be accompanied by child assent, until the child assumes responsibility for personal consent.

The idea of parental proxy votes for their children is not new and has been discussed in many countries.

When Eglantyne Jebb, founder of Save the Children, proposed in 1923 that children had rights, this was considered radical. So too when women argued for the right to vote. Think again then whether proxy votes for parents might provide the much needed 21st century stimulus to bring child friendly policies to political attention at long last.

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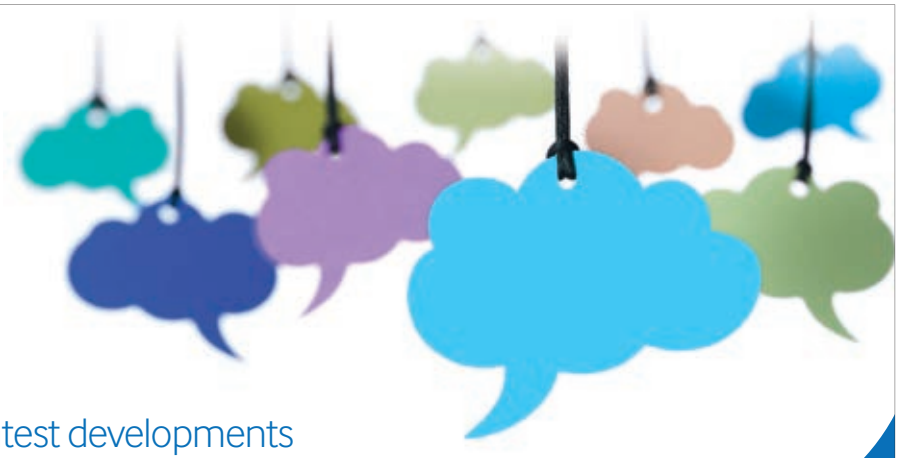

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ANALYSIS

Drug marketing ethics for the 21st century

Lisa Parker and colleagues call for updated WHO criteria to take account of changing industry practices

The World Health Organization has a long history of promoting the rational use of drugs with the aim of improving health. One element of its multipronged approach is to use its authority[1] to establish normative guidance on promotion. An early guidance document, drafted in 1968, focused on advertising of drugs. In 1988, it was updated in "Ethical criteria for medicinal drug promotion," which was endorsed through a resolution adopted by the World Health Assembly.[2] Recommendations endorsed by the WHA are among the strongest guidances produced by WHO.

The 1988 ethical criteria (box, overleaf) were intended as guidance for countries to use when developing their regulations and practices around medicinal drug promotion.[3 4] The document is still used by regulators, governments, and academics as a yardstick for measuring the acceptability of promotional activities.[5-8] The criteria have also been incorporated into curriculums for educating health professionals.[9] WHO guidance documents are particularly important in countries where local regulation is absent or insufficient. These countries are likely to receive increasing promotional attention from drug companies as the potential for market growth in high income countries shrinks.[10]

Social media enable advertising to consumers even in countries where it is illegal

The drug industry uses a variety of marketing strategies, implemented through a range of actors and tools and aimed at several targets (figure, overleaf).[11] It is important that health professionals and the public are educated about the promotional nature of industry activities, particularly those dressed up as research, education, or covert marketing through surrogates such as patient associations and key opinion leaders. The 1988 document covers a wide range of activities, but many new marketing strategies have since been introduced, including through social media. The WHO document therefore needs updating.[4 12]

New tactics for drug promotion

Analyses of internal drug company documents,[31] testimonies from whistle blowers,[38] and transparency databases[39] have revealed new marketing strategies that are not sufficiently covered by the 1988 WHO ethical criteria. Drug companies are using health professionals in new ways, including honorary authorships of scientific papers, excessive financial remuneration for speaking at so called educational events, and generous stipends for advisory positions or other nominal services.[31] There are also new targets for promotional activities, including patient groups, which have become important power bases in health advocacy.[40]

Television based direct-to-consumer advertising in the US has substantially increased in recent years, at least partly because new regulations require advertisements to contain only a link to information about harms.[41] Social media enable advertising

KEY MESSAGES

- Medicinal drug promotion affects public health by facilitating overdiagnosis, inappropriate treatment, and inequality of drug access, and increasing healthcare costs
- Many new methods contravene standards of honesty and transparency, compromising professional integrity, and undermining the scientific evidence base
- Existing WHO guidance on promotion needs revising to take into account new marketing methods
- Guidance should also be strengthened by including ethical justifications for the standards

BELLE MELLOR

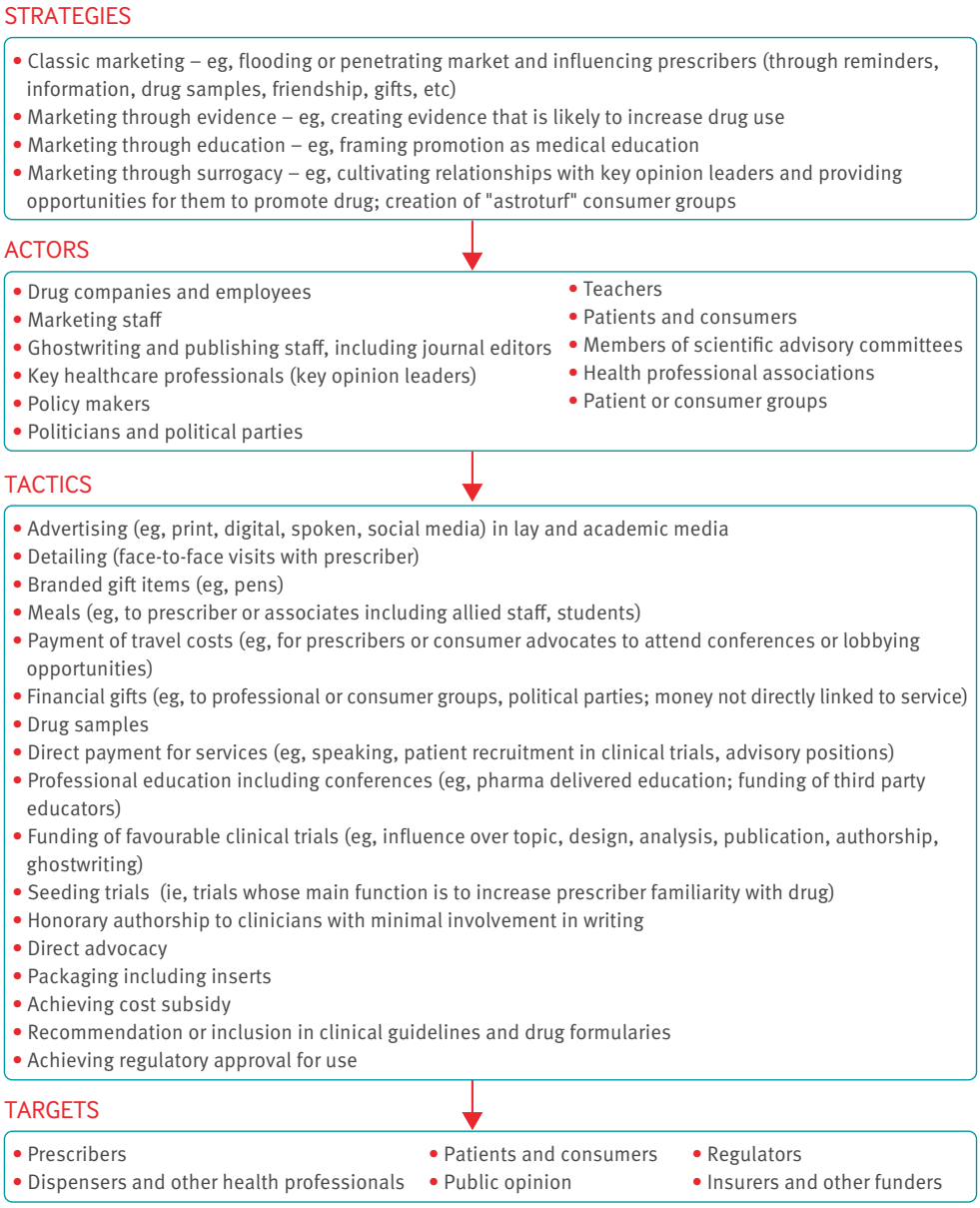
to consumers even in countries where it is illegal.[42]

Awareness has also increased of the marketing nature of certain activities conducted in the name of research. For example, there is increased recognition of seeding trials, such as the ADVANTAGE[32] and STEPS[31] studies. Seeding trials are promotional activities whose main aim is to increase prescriber familiarity with the drug rather than contribute to scientific evidence.[33] A Cochrane review shows that industry funded clinical research is more likely to deliver publications that are in favour of the funder's product.[43] The literature is skewed towards favourable results in several ways, including deliberate suppression of unfavourable results.[31-44]

Why and how should we judge medicinal drug promotion?

The 1988 document is functionally a code of conduct. It provides granular detail and judgment of drug promotion activities but does not underpin this with a cohesive ethical framework. WHO recognises that drug promotion is a public health concern.[45] As such, we advocate incorporating public health ethical principles[46] into an updated WHO document. This will provide justification for the guidance contained within the document and improve accountability by enabling scrutiny of underlying values. It can also stimulate new approaches—ethical principles can provide a new model for thinking about drug promotion outside the traditional activities listed in the 1988 document. This can trigger different kinds of question and enhance awareness of research gaps (table). New ideas can then be cross checked against existing advice to inform and strengthen guidance for strategies and tactics.

Review of scientific evidence is an important part of answering questions triggered by ethical inquiry; conversely, questions raised by relevant ethical values can guide future research agendas.



Model of drug promotion activities.[11] A company's strategy directs its choice of actors and tactics

Summary of WHO ethical criteria for medicinal drug promotion, 1988[2]

Aim

Improving health through the rational use of drugs, using the ethical foundation of truthfulness and righteousness.

Definitions

Promotion All activities by manufacturers and distributers that induce prescription, supply, purchase and/or use of drugs

Drugs All products that are promoted as a medicine, including prescription drugs, non-prescription (over-the-counter) drugs, and traditional medicines

Intended audience

Industry, prescribers, dispensers, governments, teachers, professional and consumer associations, media

Sections

Advertising Guidance on content, types of drug for which advertising to the public is acceptable

Medical representatives Guidance on staff training, personal qualities, activities, sales commissions

Medication samples guidance on free samples for prescribers and the public

Promotional symposiums—Guidance on focus (science/marketing), sponsorship transparency and limits

Industry funded research—Guidance on data sharing, reporting of hazards, research-as-promotion

Packaging, labelling, and other patient information Guidance on content, authorship, location of information (eg, package inserts, leaflets), style; relevant to drugs produced for both domestic and export use; drug information template provided

Public health ethics for drug promotion

Relevant ethical values	Sample questions to determine whether drug promotion strategies and tools support or contravene these values	Suggestions for ethical policy and practice
Maximising health benefits	Is this marketing activity likely to contribute towards the welfare of individuals or society? How? (eg, does it increase access to appropriate therapies, contribute to useful knowledge?)	Independent body disseminating information about new medicines Better review processes for detecting/rejecting biased industry funded research Prohibit seeding trials without scientific merit (eg, through the ethics review system) Provide adequate non-industry funding for research
Minimising harms	Is this likely to deliver harm to individuals or society? (eg, by contributing to drug overuse, contributing to overdiagnosis, increasing use of inadequately tested drugs, or drugs with a worse side effect profile)	Prohibit industry funded gifts, meals, payment of travel costs, political donations Strict controls on promotion of antimicrobials and drugs associated with overdiagnosis Prohibit digital direct-to-consumer advertising that is easily transmitted beyond country borders Eliminate industry funding of medical education unless money goes anonymously into a central fund
Maintaining cost efficiency	Is this an efficient way to deliver healthcare benefit compared with other healthcare interventions?	Cap marketing spending for new drugs when acceptable options already exist
Respecting, supporting, or enhancing autonomy	Does this support people to make and act on their personal (adequately and correctly informed) choices about their health?	Prohibit direct-to-consumer advertising (especially if it does not inform about negative effects of drug use)
Distributing benefits and harms in a just manner	Is this likely to deliver benefits or harms unevenly across the population? If so, is this justifiable?	Prohibit free drug samples
Communicating honestly	Is relevant information (within or about the promotional activity) fully communicated honestly, focusing on truth and accuracy rather than on unfounded appeals to emotion?	Replace face-to-face detailing with more transparent drug promotion activities Tighten regulation of content in advertising to physicians and consumers Penalties for failure to disclose industry funding among clinicians, researchers, and educators (eg, moratorium on publication)
Making policy decisions with a fair, honest and transparent process	Is this likely to bias or unduly influence related policy decisions? Is this covert?	Prohibit those with industry funding from advising on or participating in policy making
Upholding reciprocal obligations	Does this contravene the company's obligations? (eg, obligation to avoid compromising the integrity of clinicians or introduce bias into medical research because of industry advantage from a scientifically robust healthcare system)	Prohibit ghostwriting and honorary authorship for scientific papers (and penalise those who transgress) Limit industry ties with researchers—eg, caps on research funding per company, exempting anonymous contributions to a pooled industry research fund Prohibit industry funded gifts to clinicians and researchers, including meals, travel costs Prohibit industry ties with journal editors
Respecting and facilitating connections between community members	Does this interfere with the presence of solidarity between the public and the medical profession, where everyone is pulling towards the same healthcare goals?	Prohibit or severely limit financial reimbursement to practising clinicians or researchers for services rendered to industry

What needs to happen next?

The existing WHO document on ethical criteria for drug promotion needs to be strengthened. The section on ethics should be expanded to include a broader range of ethical values than truthfulness and righteousness.

Each listed value should be annotated with notes on how to interpret and act on the abstract concepts (table). The concrete guidance about specific promotional strategies and tools should also be extended to reflect new evidence and ideas—for example, restricting interactions between industry and prescribers or surrogate marketers, including prohibiting industry gifts to individuals or groups as well as meals, travel costs, and political donations[47]; banning free samples of prescription medicines; reducing or banning industry sponsorship of specific educational events or scientific studies[48]; restricting industry links with journal editors[34]; and encouraging the creation of independent detailing, education, and research.

The document should have sections providing guidance about important new aspects of drug promotion—for example, banning promotion of antimicrobials; mandating transparent reporting of all industry promotional costs; and prohibiting industry funded individuals from participating in policy.

The revision requires broad and intensive consultation with independent experts from the health professions and academia as well as representatives of consumer groups. The members of the group writing the guidance in the revised document should have no financial conflicts of interest. It may be helpful to include experts in public health ethics to facilitate conversations about relevant principles and their application in the context of drug promotion.[49] Members of the drug industry and other interested parties could participate in open consultations on the document. It will be important to get industry support for the document, and industry groups could be encouraged, along with WHO member states, to adapt the revised document to their own situation.

Promotion of drugs is harming public health, and drug companies will continue to come up with new marketing strategies. To support countries to respond, we advocate the revision of WHO's ethical criteria for drug promotion to incorporate a public health ethics justification that can be extended to other situations. We also urge communities and governments to enact stricter policies that enforce change.

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OBITUARIES

Gordon E Anderson

Consultant in obstetrics and gynaecology Dryburn Hospital, Durham (b 1938; q Glasgow 1964; FRCOG), died from bronchopneumonia secondary to multiple strokes on 28 October 2017

Gordon E Anderson was initially interested in engineering but changed his career plans when diagnosed with tuberculosis at age 18. He was appointed consultant in obstetrics and gynaecology at Dryburn Hospital, Durham, in 1974. His main interests were in the training of medical and nursing staff and in the development of obstetric ultrasound. He campaigned to raise funding for state of the art equipment for his department. Gordon's career came to an end in 1998, when he had a stroke from which recovery seemed unlikely. Superb medical and nursing care and his wife, Margaret, ensured that he was able to spend the next 19 years with a quality of life that, although restricted by his disability, was full. He leaves Margaret, a son, and two grandchildren.

David W Herring

Cite this as: *BMJ* 2018;361:k1441

Gavin Cranston Arneil

Professor of child health University of Glasgow (b 1923; q Glasgow 1945; MD, DCH, PhD, FRCP), developed complications after being run over by a lorry in 2014 and died from these on 21 January 2018

Gavin Cranston Arneil was appointed as consultant to the Royal Hospital for Sick Children, Glasgow, and rapidly developed a special interest in kidney disease. His research led to a better understanding of the underlying pathology of kidney disease by his promotion of the use of kidney biopsy. Arneil was a founding member of the British Association of Paediatric Nephrology and a leading figure in the establishment of the European and international associations. He joined forces with John Forfar from Edinburgh in 1974 to produce *Forfar and Arneil's Textbook of Pediatrics*, now in its 8th edition, as the only non-American major textbook of paediatrics. He leaves his wife, June; a daughter, and two grandchildren.

Alan Craft, Heather Maxwell

Cite this as: *BMJ* 2018;361:k1438

Henry Hollis

General practitioner Melton Mowbray, Leicestershire (b 1923; q 1948; DTM&H), died from old age on 28 February 2018

Born in Thistleton, Rutland, Henry Hollis attended the King's School in Grantham and the London Hospital Medical College during the war. In lieu of national service he spent five years in the Royal Navy in the south Atlantic and the Admiralty Experimental Diving Unit in Portsmouth, where he contributed to work on new diving tables. After getting married he worked in Ghana and Sierra Leone as a mine surgeon until 1960, when he became a GP in Melton Mowbray, where he worked for 33 years. Described by former patients as "one of life's gentlemen," he was renowned for his bow ties, kindness, and good humour, and for always having time for his patients. Predeceased by his wife, Pauline, and later by his companion, Jean, he leaves two sons and six grandchildren.

Chris Hollis, Nick Hollis

Cite this as: *BMJ* 2018;361:k1444

John Sloan McLintock

Chief medical officer National Coal Board (b 1919; q Glasgow 1942; DPH, FFOM, FRCP (Glas), CSt J), died after a brief illness on 25 October 2017

John Sloan McLintock joined the Royal Army Medical Corps after qualifying and was posted to south London and then to Normandy. He returned to Scotland and married Betty. Subsequently, he served in India and Malaya. By 1950 the communist insurgency prompted him to take his growing family to the UK. He decided to enter the specialty of public health, joined the National Coal Board, and rose to be chief medical officer. In this position he was involved in the discussions that led to the setting up of the European Coal and Steel Federation, a precursor of the EU. He was, for a time, president of the British Occupational Hygiene Society. He leaves his second wife, Rosalind; four children; eight grandchildren; and four great grandchildren.

Derek McLintock

Cite this as: *BMJ* 2018;361:k1447

Thomas Martin Richards

General practitioner Haslemere (b 1925; q St Thomas' Hospital Medical School 1954; DObst RCOG), died after several years with dementia on 8 August 2017

Thomas Martin Richards ("Tom") was born near Vienna. He was sent to school in England at a young age, learnt the language, and developed the desire to help others. At medical school, he regularly played hockey, tennis, and squash, which stood him in good stead when he started looking for a place to settle and become a town GP. He had also been in the army and a ship's surgeon. Like many doctors he did locum work in various places in England and abroad, and Haslemere in Surrey was where he settled. As he had specialised in obstetrics and gynaecology, he became the "go to" doctor for deliveries. He retired from general practice in 1990. He leaves his wife, Ruth; two children; and five grandchildren.

Keith Richards, Sara Richards

Cite this as: *BMJ* 2018;361:k1443

John Weston Smith

General practitioner (b 1922; q Birmingham 1949; MFARCS), died from a heart attack on 1 January 2018

John Weston Smith worked in a practice in Tamworth, Staffordshire, from 1949 to 1982. He also worked as a GP anaesthetist in hospitals in the area. Because of workload pressures, made worse by a measles epidemic, the practice decided to employ a practice nurse. This was pioneering work and resulted in a paper entitled "Extended use of nursing services in general practice," which attracted interest from the national media. The team was interviewed by Cliff Michelmore on *24 Hours*, a BBC late news programme, on 15 December 1967. Several other publications followed. Macular degeneration resulted in blindness for the last four years of John's life. Predeceased by his wife in 2002 and by their only daughter in 2004, John leaves five sons, 21 grandchildren, and six great grandchildren.

Paul Weston Smith

Cite this as: *BMJ* 2018;361:k1434

Maura Lynch

Fistula fighter and nun

Maura Lynch (b 1938; q Dublin 1964; FRCOG, FRCSI), sustained a fracture after a fall. She developed complications after surgery and died unexpectedly on 9 December 2017

When Maura Lynch entered the order of the Medical Missionaries of Mary two days before her 18th birthday, she was hoping to spend her life serving poor populations in Africa. By the time of her death at the age of 79 in Kampala, Uganda, the surgeon-nun had spent 50 years on the continent, and the past three decades setting up and running an obstetric fistula clinic in Kitovu Hospital, Masaka. She rejoiced in restoring to health women who were often shunned by their families because of incontinence, and she was particularly fond of quoting the case of an 85 year old woman who underwent successful surgery after 40 years with incontinence. "Afterwards we danced," said Lynch. "As a ministry, I think it beats all. It's so worth while."

Between 1993 and 2007 Lynch did more than 1000 repair operations. She was honoured by the Ugandan government, and on a state visit to Dublin in 2003 president Yoweri Museveni requested her presence at a reception to thank her for her contribution to medical services in Uganda.

The 28 bed unit and dedicated operating theatre Lynch set up in the mission hospital provides 250 operations a year, many done by surgeons from overseas. Women, alerted to the clinic by announcements on Ugandan radio, are treated free and then offered free antenatal care and caesarean delivery if they go on to have a baby.

The unit is supported by the UK's Royal College of Obstetricians and Gynaecologists, which granted Lynch honorary fellowship in 2013.

Commitment to human dignity

While Lynch had no misgivings about her career—"She had lived her vision and had no regrets about her choices," according to her sister, Breda Rogers—she was saddened by the persistence of a preventable injury.

In Uganda alone, she said, an estimated 192 000 women were still affected by obstetric fistula, and she called for better education of girls and more medical staff to carry out free operations. According to the World Health Organization, between 50 000 and 100 000 women worldwide are affected by obstetric fistula every year, which is directly linked to obstructed labour, often resulting in the death of the baby.

Maura Lynch was born in Youghal, County Cork, the fourth of nine children of Patrick, who worked for the Irish postal service, and his wife Jane, a former teacher. The family spoke Irish at home.

After school at Laurel Hill College, Limerick, and having become a nun, Lynch studied medicine at University College Dublin, one of the top three students in her year to graduate. After a two year internship at Our Lady of Lourdes Hospital, she studied Portuguese in Lisbon and in 1967 moved to Angola for her first overseas assignment. She worked at the 200 bed Chiulo mission hospital, where, with only one other medical sister, she treated the wounded of both sides during the civil war and cared for large numbers of patients with tuberculosis and leprosy. "When it came to surgery, she was fearless and ready to treat whoever came through the door, but always started each operation with a prayer," her sister Breda recalled.

At the age of 46, she interrupted her missionary work and returned to Dublin for further surgical training and was awarded the fellowship of the Royal College of Surgeons in Ireland in 1985.

Kitovu Hospital

In 1987 she was assigned to Uganda, as consultant surgeon and obstetrician to the 200 bed Kitovu Hospital, where she pioneered the fistula repair service, establishing a dedicated ward and operating theatre, and fundraising for many years to ensure a free service.

Maura Lynch was saddened by the persistence of a preventable injury

"Maura was practical, pragmatic, enormous fun, and a natural doctor," said Mhairi Collie, consultant colorectal surgeon at Western General Hospital, Edinburgh, who made four working visits to the Kitovu unit in recent years. "When I last saw her in 2017, she had just been on call for two weeks—quite something in your late 70s," said Collie. "Always full of energy and enthusiasm, she took enormous interest in training staff as well as in the patients themselves. She loved people and put great efforts into getting sponsorship."

In 2013 Lynch took part in a six mile sponsored run in Dublin to raise €5000 for an overhead lamp for the operating theatre. Her surgery practice was restricted 10 years ago by a detached retina, which proved inoperable. But she still attended operations and supervised staff. When a fellow sister suggested her partial loss of sight must be frustrating, Lynch said: "I don't think what I can't do. I just think of what I can still do."

Predeceased by three brothers and a sister, Maura Lynch leaves three brothers and a sister.

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NEW DRUGS: HOPE OR HARM?

Shining a light on "hidden patients"

Like O'Dowd, I also was intrigued to see two *Times* articles reflecting opposing views of what the NHS should provide (Medicine and the Media, 31 March-7 April). I agree with Appleby that mixed messages are emerging from national health policy. Presenting case studies of patients who would benefit from drugs is easier than presenting those of patients who may be harmed by health pounds being diverted to new cost ineffective interventions. In the same issue of *The BMJ*, Wise (whose sister has cystic fibrosis) describes the call by MPs for NICE to change its decision that funding Orkambi is not cost effective.

I have been exploring how we can focus attention on "hidden patients" who do not make the headlines using stories and films. I have created a website to encourage the public to share how they have been affected by or have participated in difficult healthcare prioritisation decisions (https://people4health.com).

Peter Littlejohns, professor of public health, London

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FIVE NEW MEDICAL SCHOOLS

A decline in standards is inevitable

I am concerned about the government's plan to create five new medical schools (News, 31 March-7 April). Its top priority should be to reform the NHS to relieve stressful working conditions and stop experienced doctors leaving to work overseas.

Increasing the numbers of medical students has profound implications for the quality of training. Where will the teachers be found? Most of the schools are being established in areas where there is difficulty in recruitment and already understaffing. Can Health Education England give sound figures on the manpower requirements of its proposals?

I am also concerned about the staffing implications of more places in existing medical schools. How are large student numbers to achieve competence in examining patients? Practising on dummies, using simulations, and watching videos are not sufficient. A decline in standards is inevitable.

Finally, I have misgivings about the capability of the GMC's quality control groups to manage so many schools.

Philip F Harris, retired and part time university teacher, Nottingham

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Existing schools need support

Rather than creating new medical schools, we should give existing schools the support mechanisms to reduce the number of students who drop out. These are extremely intelligent and highly motivated individuals who go through an extensive selection process. Most have thought long and hard about becoming medical students, and the dropout rate should be low.

Mayur Shah, retired general medical practitioner, Milton Keynes

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LETTER OF THE WEEK

Resource allocation based on cost effectiveness

What underlies the criticism of NICE's appraisal system after its non-approval of the cystic fibrosis drug Orkambi on the grounds of cost effectiveness (News Analysis, 31 March-7 April)?

NICE's approach is utilitarian, allocating healthcare resources across the population to maximise aggregate health gain (allocative efficiency). It distributes resources to people who have conditions that are treatable with the most cost effectiveness interventions. Thus, NICE excludes people who are not cost effective for treatment. These are often people with life threatening or other serious diseases who could benefit from higher cost interventions. This approach contrasts with that of health workers, who start with patients and then look for cost effective interventions to treat them (productive efficiency).

To estimate allocative efficiency the cost effectiveness of interventions is compared across different conditions, which requires a generic measure of health gain. NICE uses quality adjusted life years. This metric combines the outcomes of death and estimated quality of life, which are qualitatively different and incommensurable. The compression of frequently multidimensional health outcomes into a single, objectively unmeasurable number is insufficient for making life or death resource allocations.

Decision making on health resources requires a balance between affordability, clinical effectiveness, equity, and efficiency. The principles are a matter of social policy and require informed political debate and open public consultation. This is not a question of economics but of political choice.

Malcolm Segall, retired paediatrician, Tunbridge Wells

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Reducing medical school dropouts

I agree with Shah (previous letter) that we should reduce dropouts to increase the number of local graduates. Rather than purely expanding the numbers in medical schools, should some funding be used to help struggling students pass their exams and remediate their training? Should educators spend more time helping these students finish their programmes? We must debate these points.

Eugene Y H Yeung, medical doctor, Lancaster

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DANDRUFF

Ending prescriptions affects the poorest

Ending prescriptions for conditions such as dandruff (Sixty Seconds On. . . , 14 April), athlete's foot, and mouth ulcers because people can buy them over the counter may seem like an easy win. But not everyone can buy them readily. Universal credit amounts to less than £75 a week. Are we really going to force the very poorest in society to give up a substantial amount of their limited income or expect them to live with flaky scalps and itching toes? Even £5 is a lot for such people. Those who pay prescription charges in England will buy over the counter because it is cheaper. The poor are exempt from these charges. This seems a sensible way to keep things.

Simon Stevens, chief executive of NHS England, says that we should "think like a patient, act like a taxpayer." We should also think with some humanity.

Brian McKinstry, professor of primary care ehealth, Edinburgh

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