trial fibrillation is common, strokes resulting from it are often preventable, it’s often diagnosed coincidentally, and some people have the condition but no diagnosis. Screening for atrial fibrillation, therefore, should get under way without delay: on the face of it, like so much in medicine, such thinking seems to make sense.

After all, we have gadgets to make the diagnosis quickly and cheaply in primary care (or anywhere, if you have a smartphone). And a range of anticoagulants that don't require monitoring and are coming down in price.

This line of argument is also popular, especially with the political classes. As a result we see numerous “innovation” projects pushing screening, with few people standing in the way. NICE has proposed documenting pulse rhythm as a quality indicator in patients with conditions including hypertension and ischaemic heart disease. A report for the Scottish parliament’s cross party group on heart disease and stroke recommended “case finding” for at-risk groups, including all over 65s.

There’s a push to screen more people, through the academic health science networks (one of whose aims is “fostering opportunities for industry”), and pilot studies claim “lifesaving” pathways for atrial fibrillation screening in people attending pharmacies. But what might seem to make logical sense is challenged by evidence and the gaps in it.

For screening to be effective it’s important to know who will benefit from it. One needs to know the denominator when working out the chances of patients being harmed or deriving benefit. The lower the prevalence of a particular condition, the higher the risk of generating false positives—and the greater the harms generated become, relative to the benefits. Yet the populations examined in the various local pilots and experiments of atrial fibrillation screening vary widely. People visiting a supermarket are different from those attending a pharmacy, who in turn are different from those who have made an appointment to see their GP.

Population screening for atrial fibrillation is not recommended by the UK’s national screening committee. When the committee last deliberated on this in 2014 it was concerned whether screening asymptomatic people brought the same benefits as diagnosis in symptomatic groups and found a “paucity of evidence relevant to this question.” Some studies have investigated the comparative outcomes of symptomatic versus asymptomatic detection. But the results are mixed, and the studies are often poorly designed. They’re not often controlled, lead time bias is rampant, and they haven’t always categorised asymptomatic detection in terms of population risk.

The news of a large controlled study of screening over 65s in England is welcome—but it should also be a reason to stop the overfinanced “innovation” pilots that cannot hope to deliver the quality of evidence necessary to recommend themselves.

If screening is worth doing, it’s worth doing correctly. No amount of glossy reports or gadgets is a substitute for getting the evidence right to start with.

What dismays me most is the call for action, rather than for better evidence, from groups who really should know better.

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COULD YOU BE THE NEW MARGARET McCartney?

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Start-up e-cigarette aims to “improve smokers’ lives”

But the Juul “epidemic” in US schools is worrying

Great news: the prevalence of cigarette smoking continues to decline in the US, now down to about 14% of the population. Quite a change from 42% in the early 1960s. Furthermore, high school students’ cigarette smoking rate has declined to a new low of 9%.

These decreases may be, in part, because of the increased use of electronic nicotine delivery systems (ENDS), or e-cigarettes. And that, on the other hand, may not be good news, because e-cigarettes have become wildly popular with teenagers. As Time magazine recently said, “Vaping is the new smoking. Is that a good thing?”

The most popular US e-cigarette is a relatively new one called Juul. It has come out of nowhere to become the leading brand by far. Nielsen surveys show its market share in convenience store sales exceeded 50% in March this year.

Unlike the other leading e-cigarettes in the US (Vuse, MarkTen, Blu), Juul is not owned by a major tobacco company. Founded by two engineers who were former smokers, Juul has been run like a Silicon Valley start-up company, with offices in a renovated warehouse in San Francisco. Cleverly named to evoke precious jewels and energy promoting joules, Juul was designed to be an “un-cigarette.”

Unlike the industry standard “cigalikes” that are cigarette shaped tubes, Juul looks like a sleek, black USB drive. Rechargeable in your laptop, Juuls use small, colourful pods to supply nicotine “e-juice,” which comes in a choice of eight flavours. All this is packaged in beautifully spare, white boxes more befitting an iPhone than a lowly cigarette.

Nicotine salts
Juul’s success is not just down to great design and packaging, however. Its “biggest breakthrough was chemical.” It is the first e-cigarette to use nicotine salts, which better mimic the rapid “hit” of a cigarette when the vapour reaches the back of the throat. This may help explain its popularity and phenomenal growth rate.

The company denies marketing to teenagers and says its mission is “to improve the lives of the world’s one billion adult smokers.” It has pledged $30m (£23m) over the

Making less popular medical jobs more attractive

Medicine has an unwritten hierarchy of perceived glamour and prestige. This ends up having a real impact on patient care, as it affects who chooses to work in what specialty and which specialties struggle to recruit. Julian Simpson discussed this hierarchy in The BMJ on 2 June, when he highlighted the NHS’s reliance on overseas trained doctors from ethnic minorities for unpopular specialties in deprived or remote UK regions.

Many doctors, including me, actively choose disciplines that are generally (if often unfairly) seen as overstretched, less glamorous, struggling to fill posts, or with lower earning potential. I’ve never regretted being a geriatrician and general internal medicine physician. This is about trends, not absolutes.

But what makes a specialty seem more prestigious to potential applicants?

In my experience, terms such as teaching hospital, highly specialised, high tech, interventional, curative, physical health, younger, single organ system, and research active have too often trumped generalist, acute, unselected, older, mental health, long term conditions, district hospital, community, and primary. Workforce data, including surveys of recruitment to training posts, back this perception.

Geography also counts. Rural and remote or socioeconomically deprived areas can struggle the hardest to attract and retain staff or run viable services.

To study this phenomenon, in 2008 Album and Westin asked medical students and junior and senior doctors to rank 23 specialties and 38 medical conditions in order of perceived prestige. They found high prestige scores for “diseases and specialities associated with technologically sophisticated, immediate and invasive procedures in vital organs located in the upper parts of the body… especially where the typical patient is young or middle-aged.” Low scores were given to “diseases and specialities associated with chronic conditions located in the lower parts of the body or having no specific bodily location, with less visible treatment procedures, and with elderly patients.”

We currently find it hardest to recruit and retain doctors in primary or acute care—generalist disciplines with the most onsite working out of hours, the highest degree of risk, and the most patients. Doctors foresee a high potential for overwork, rushed care, disruption to family life, and complaints. Recruitment gaps create a vicious circle of overwork, making posts harder to fill.
Making less popular medical jobs more attractive

I’d suggest innovative, multipronged approaches to filling posts. (This list isn’t exhaustive, and I’d welcome more suggestions.) First, let’s ensure that, in the hardest to fill specialties and regions, we do more to allow for and support career breaks, less than full time training, and enhanced study leave, annual leave, sabbaticals, or opportunities for additional personal development or a portfolio career.

Second, we must train sufficient doctors or allow enough ethical recruitment of overseas graduates to fill all training, GP, and consultant posts across all disciplines, which will in turn help to staff those harder to fill roles. A slight apparent “oversupply” isn’t a disaster, given that one trained graduate doesn’t equate to one whole time equivalent practitioner in the long term.

Third, recognise the extra stress, responsibility, and night time or evening working in the busiest acute specialties, and increase pay in areas struggling the hardest to recruit or retain doctors. A salary uplift of, say, 15% above baseline would still be cheaper than employing locums, even if doctors who choose those disciplines haven’t picked them for money.

Finally, we all have a responsibility to celebrate the key contribution that the “engine room” specialties make to healthcare—even more so in regions that traditionally find it harder to recruit (yet where clinical practice can be hugely rewarding)—and we should resist any disparaging messages that these should be avoided or are a waste of talented doctors’ abilities. Good role models and training experiences enhance this.

Right now, I’d say that we have our priorities wrong.

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BMJ OPINION David Gilbert

A modern NHS needs patients around decision making tables

The story of the NHS can be recast as a narrative on power. Faced with the threat of a BMA strike, the founder of the NHS, Aneurin Bevan, conceded that GPs would retain the freedom to run their practices as small businesses. Consultants were given more money, and allowed to keep their private practices. In Bevan’s own words he “stuffed their mouths with gold.”

The battle between policy makers and medical professionals and institutions centres around notions of “accountability” (how money is spent) and “quality” (how care is delivered). Both managers and medics badge themselves as people’s sole advocates. Doctors claim to be advocates for patients and the government advocates for citizens.

As patients and citizens, we can speak for ourselves. Unfortunately, patient and public engagement is usually undertaken through two main approaches—feedback or representation. The former buffers patients from power as feedback focuses on people’s experiences of services, not what matters more widely, and professionals deciding what can be done. The latter relies on “representatives” being slotted into narrowly defined committees within institutions. The wisdom and insights of people experiencing illness and the healthcare system are then lost or undervalued. If the NHS is to survive, it needs new forms of collaborative leadership.

There are good examples of where patient leadership is beginning to work, and plenty of examples of patient partnership work in improvement. The BMJ has been ahead of the game. There is an emerging movement of patient leaders—entrepreneurs, activists, and digital pioneers—who are set to revolutionise healthcare. But there is still a long way to go.

Within NHS citadels these improvement efforts are not matched in terms of corporate practice, health economy decision making, or policy making power. Patients have been excluded from senior decision making roles in new models of care design and delivery, including sustainable transformation partnerships. Subsequently, matters that should be discussed openly with patients are happening behind closed doors.

The NHS has changed in 70 years. Now, it has to change again to adapt to the rising patient and citizen movement. I don’t want to save the NHS if saving it means preserving the status quo. I don’t think Bevan—always for the people—would have wanted it that way.

David Gilbert, patient director, Sussex MSK Partnership (Central). This opinion piece was written in a personal capacity.
Nutritional approaches for patients with, or at risk of, type 2 diabetes

Our food series continues with Nita G Forouhi and colleagues, who find common ground on dietary programmes for the prevention, management, and potential remission of the condition.

The importance of nutrition in the management and prevention of type 2 diabetes through its effect on weight and metabolic control is clear. However, nutrition is also one of the most controversial and difficult aspects of the management of type 2 diabetes.

The idea of being on a “diet” for a chronic lifelong condition like diabetes is enough to put many people off as knowing what to eat and maintaining an optimal eating pattern are challenging. Most physicians are not trained in nutrition interventions and this is a barrier to counselling patients. Moreover, talking to patients about nutrition is time consuming.

Progress has been made in understanding the best dietary advice for diabetes but broader problems exist. For instance, increasing vegetable and fruit intake is recommended by most dietary guidelines but their cost is prohibitively high in many settings. An expensive market of foods labelled for use by people with diabetes also exists, with products often being no healthier, and sometimes less healthy, than regular foods.

Principles of current dietary guidelines

In some countries, dietary guidelines for the management of diabetes have evolved from a focus on a low fat diet to the recognition that more important considerations are macronutrient quality (that is, the type versus the quantity of macronutrient), avoidance of processed foods (particularly processed starches and sugars), and overall dietary patterns.

It is now recognised that dietary advice for both the prevention and management of type 2 diabetes should converge (figure overleaf). However, in those with type 2 diabetes, the degree of glycaemic control and type and dose of diabetes medication should be coordinated with dietary intake. With some dietary interventions, such as very low calorie or low carbohydrate diets, people with diabetes would usually stop or reduce their diabetes medication and be monitored closely.

There is also now greater understanding of the multiple pathways through which dietary factors exert health effects through both obesity dependent and obesity independent mechanisms. The influence of diet on weight, glycaemia, and glucose-insulin homeostasis is directly relevant to glycaemic control in diabetes, while other outcomes such as cardiovascular complications are further influenced by the effect of diet on blood lipids, apolipoproteins, blood pressure, endothelial function, thrombosis, coagulation, systemic inflammation, and vascular adhesion.

Areas of consensus in guidelines

Weight management

Type 2 diabetes is most commonly associated with overweight or obesity and insulin resistance. Therefore, reducing weight and maintaining a healthy weight is a core part of clinical management. Weight loss is also linked to improvements in glycaemia, blood pressure, and lipids and hence can delay or prevent complications, particularly cardiovascular events.

Dietary patterns

The evidence points to promoting patterns of food intake that are high in vegetables, fruit, whole grains, legumes, nuts, and dairy products such as yoghurt but with some cautions. Firstly, some dietary approaches (eg, low carbohydrate diets) recommend restricting the intake of fruits, whole grains, and legumes because of their sugar or starch content. For fruit intake, particularly among those with diabetes, opinion is divided. Many guidelines continue to recommend fruit, however, on the basis that fructose intake from fruits is preferable to isocaloric intake of sucrose or starch because of the additional micronutrient, phytochemical, and fibre content of fruit. Secondly, despite evidence from randomised controlled trials and prospective studies that nuts may help prevent type 2 diabetes,

**KEY MESSAGES**

- Considerable evidence supports a common set of dietary approaches for the prevention and management of type 2 diabetes, but uncertainties remain
- Weight management is a cornerstone of metabolic health but diet quality is also important
- Low carbohydrate diets as the preferred choice in type 2 diabetes is controversial
- The quality of carbohydrates such as refined versus whole grain sources is important
- Recognition is increasing that dietary advice should focus on foods and healthy eating patterns rather than on nutrients
Moreover, many guidelines also highlight the importance of reducing the intake of foods high in sodium and trans fat because of the relevance of these for cardiovascular health.

Areas of uncertainty in guidelines
Optimal macronutrient composition
One of the most contentious issues about the management of type 2 diabetes has been on the best macronutrient composition of the diet. Some guidelines continue to advise macronutrient quantity goals, such as the European or Canadian recommendation of 45–60% of total energy as carbohydrate, 10–20% as protein, and less than 35% as fat.13,20 By contrast, the most recent nutritional guideline from the American Diabetes Association concluded that there is no ideal mix of macronutrients for all people with diabetes and recommended individually tailored goals.22 A low carbohydrate diet for weight and glycaemic control has gained popularity among some experts, clinicians, and the public (see below). Others conclude that a low carbohydrate diet combined with low saturated fat intake is best.22

For weight loss, trials point to potentially greater benefits from a low carbohydrate than a low fat diet, but the difference in weight loss between diets is modest.23 A comparison of named diet programmes with different macronutrient composition highlighted that the critical factor in effectiveness for weight loss was the level of adherence to the diet over time.24 The quality of the diet in low carbohydrate or low fat diets is also important.25,26

Research on weight or metabolic outcomes in diabetes is complicated by the use of different definitions. For instance, the definition of a low carbohydrate diet has ranged from 4% of daily energy intake from carbohydrates (promoting nutritional ketosis) to 40%.15 Similarly, low fat diets have been defined as fat intake less than 30% of daily energy intake or substantially lower. Given these limitations, the best current approach may be an emphasis on the use of individual assessment for dietary advice and a focus on the pattern of eating that most readily allows the individual to limit calorie intake and improve macronutrient quality (such as avoiding refined carbohydrates).

Reversing type 2 diabetes through diet
Type 2 diabetes was once thought to be irreversible and progressive after diagnosis, but much interest has arisen about the potential for remission. Consensus on the definition of remission is a sign of progress: glucose levels lower than the diagnostic level for diabetes in the absence of medications for hyperglycaemia for a period (often proposed to be at least one year).33,34 However, the predominant role of energy deficit versus macronutrient composition of the diet in achieving remission is still controversial.

Remission through a low calorie energy deficit diet
Low calorie diets have been used as a tool to study the mechanisms involved in the rapid normalisation of fasting plasma glucose after bariatric surgery. In one study fasting plasma glucose normalised within seven days of following a low calorie diet.37 This normalisation through diet occurred despite simultaneous withdrawal of metformin therapy. Gradually over eight weeks, glucose stimulated insulin secretion returned to normal.37

The critical aspect is when there is a gap between energy required and taken in. Because of this deficit, the body must use previously stored energy. Intrahepatic fat is used first, and the 30% decrease in hepatic fat in the first seven days appears sufficient to normalise the insulin sensitivity of the liver.37 In addition, pancreatic fat content fell over eight weeks and beta cell function improved. This is because insulin secretory function was regained by rerifferentiation after fat removal.38

The permanence of these changes was tested by a nutritional and behavioural approach to achieve long term isocaloric eating after the acute weight loss phase.39 It was successful in keeping weight steady over the next six months. Calorie restriction was associated with both hepatic and pancreatic fat content remaining at the low levels achieved.
The initial remission of type 2 diabetes was closely associated with duration of diabetes, and people with type 2 diabetes of shorter duration who achieved normal levels of blood glucose maintained normal physiology during the six month follow-up. Recently, 46% of a UK primary care cohort remained free of diabetes at one year during a structured low calorie weight loss programme (the DiRECT trial). These results are convincing, and four years of follow-up are planned. Considerable interest has arisen about whether low calorie diets associated with diabetes remission can also help to prevent diabetic complications. Evidence is sparse because of the lack of long term follow-up studies but the existing research is promising.

Management or remission through a low carbohydrate diet
Carbohydrate restriction for the treatment of type 2 diabetes has been an area of intense interest because, of all the macronutrients, carbohydrates have the greatest effect on blood glucose and insulin levels. A review by the American Diabetes Association identified 11 trials of low carbohydrate (less than 40% of calories) diets published from 2001 to 2010. Eight were randomised and about half reported greater improvement in HbA1c on the low carbohydrate diet than the comparison diet (usually a low fat diet), and a greater reduction in the use of medicines to lower glucose. Notably, calorie reduction coincided with carbohydrate restriction in many of the studies, even though it was not often specified in the dietary counselling.

For glycaemia, reviews of evidence from randomised trials in people with type 2 diabetes have varying conclusions. Some concluded that low carbohydrate diets were superior to other diets for glycaemic control or that a dose-response relation existed, with stricter low carbohydrate restriction resulting in greater reductions in glycaemia. Others cautioned about short term beneficial effects not being sustained in the longer term, or found no overall advantage over the comparison diet. Narrative reviews have emphasised other benefits of low carbohydrate diets, including increased satiety, and highlight the advantages for weight loss and metabolic indicators.

Concerns about potential detrimental effects on cardiovascular health have been raised as low carbohydrate diets are usually high in dietary fat. Several studies found greater improvements in high density lipoprotein cholesterol and triglyceride levels with no relative worsening of low density lipoprotein cholesterol in patients with type 2 diabetes following carbohydrate restriction. Low density lipoprotein cholesterol tends to decline more, however, with a low fat diet.

Low carbohydrate intake can lower the more atherogenic small, dense low density lipoprotein particles. Another concern is the effect of the potentially higher protein content of low carbohydrate diets on renal function. Patients with type 2 diabetes with normal baseline renal function have not shown worsening renal function at one year, but no research has been reported in patients with more severely impaired renal function. Other potential side effects of a very low carbohydrate diet include headache, fatigue, and muscle cramping, but these can be avoided by adequate fluid and sodium intake, particularly in the first week or two after starting the diet when diuresis is greatest. Concern about urinary calcium loss and a possible contribution to increased future risk of kidney stones or osteoporosis have not been verified but evidence is sparse.

Dietary advice for different populations for the prevention and management of type 2 diabetes

In all populations
- Manage weight
- Foods/overall diet quantity matters quality is relevant
- Focus on foods, not isolated nutrients
- Consider overall eating patterns
- Non-dietary factors are also important (eg, physical activity, smoking, other lifestyle factors)

Specific considerations in management of type 2 diabetes
- Coordinate dietary intake with type and dose of medication
- In specific approaches such as low carbohydrate nutrition or very low calorie diets, monitor glycaemic control and adjust (or stop) medication to minimise hypoglycaemia

46% of a UK primary care cohort remained free of diabetes at one year during a structured low calorie weight loss programme

Given the hypoglycaemic effect of carbohydrate restriction, patients with diabetes who adopt low carbohydrate diets must understand how to avoid hypoglycaemia by appropriately reducing glucose lowering medications.

Finally, low carbohydrate diets can restrict whole grain intake, and the fibre and micronutrients they contain may be harder to replace with other foods. This has led some experts to emphasise restricting refined starches and sugars but retaining whole grains.

Conclusion
Despite the challenges of nutritional research, considerable progress has been made in formulating evidence based dietary guidance and some common principles can be agreed that should be helpful to clinicians, patients, and the public. While adherence to dietary advice is an important challenge, weight management is still a cornerstone in diabetes management, supplemented with new developments, including the potential for the remission of type 2 diabetes through diet.

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OVERCOMING OVERUSE

Persuading the public that less is more

Woloshin and Schwartz, among others, place great faith in sharing decisions in the fight against overdiagnosis (Essay, 26 May), but I am less optimistic. Should clinicians be spending time sharing decisions about tests that have no benefits but have substantial harms from overdiagnosis and overtreatment?

The authors state: “Hype is hype, whether for more or for less care.” I disagree. If our goal is to change behaviour, how might we do this without some hype, persuasion, or at least a nudge in the “right” direction?

When it comes to popular but useless tests and treatments, will it be enough to simply notify the public of the (uncertain) magnitude of benefit compared with the (uncertain) magnitude of harms? Our culture has deep seated beliefs that more is better. Should we draw the line at promoting informed choice? Or should we consider more persuasive approaches that improve health but risk undermining public trust?

Adrian C Traeger, NHMRC early career research fellow, Sydney

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Shared decision making won’t reduce uncertainty

The views expressed in The BMJ do not offer a clear way forward (Essay, 26 May). Experienced doctors have always been aware of the trade-off between overdiagnosis and underdiagnosis, overtreatment and undertreatment. The eternal problem is “too much uncertainty” when trying to predict outcomes. Sharing decisions with patients is clearly important but will not reduce uncertainty.

Evidence based medicine currently assesses tests by their ability to predict the results of “gold standard” diagnostic tests. These gold standards are also used to recruit patients to randomised controlled trials (RCTs). The problem is that they are adopted without any real supporting evidence for their predictive value. Assuming constant relative risk reduction and extrapolating risk over time also undermine the interpretation of RCTs as they only provide approximations for low probabilities found in epidemiology.

We need a more sophisticated understanding of the diagnostic and prognostic processes and better directed research.

Huw Llewelyn, hospital physician, Aberystwyth

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LETTER OF THE WEEK

Racial prejudice persists in the NHS

Menon’s article reminded me of my late father’s experiences as an ENT registrar in the 1970s and an inner city GP in the 80s (Commentary, 2 June). The “local candidate” trope was so frequently used as justification for not appointing black and minority ethnic (BME) clinicians that it ceased being a euphemism.

When I applied to medical school in the 90s, these experiences shaped his advice to me; societal attitudes to race may have progressed, but I would still need to be twice as good as any white student.

Overt racial abuse is perhaps less common today, but prejudice has mutated surreptitiously. Disparities in healthcare access, experience, and outcomes persist for ethnic minority patients, and BME representation in NHS leadership is minimal. BME NHS staff report increased rates of harassment, and the national climate does not foster equal opportunities for minorities (Bawa-Garba, Windrush, the “hostile environment”).

Can the NHS at 70 accept that disparity is a problem and provide a catalyst for change? The catalyst won’t be another policy paper, a quango without any real reach, or tokenistic BME appointments to fill quotas.

Those of us who identify as BME have a duty to call out overt, structural, or implicit racism. We must mentor the next generation of healthcare professionals to do the same and provide the positive role models that the previous generation lacked.

Partha Das, Harkness fellow in healthcare policy and practice, Cambridge, USA

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LONELINESS

Tackling loneliness with local communities

The Royal College of General Practitioners’ action plan on tackling loneliness is a positive move (This Week in Medicine, 2 June).

The crucial point is that effective social prescribing requires effective community development. Local people should be supported to develop and maintain initiatives offering social interaction. This should be driven by the ideas and experience of local people. Professionals should support and facilitate—not define and direct.

This needs to be done at scale. For too long, public health improvement work has viewed community development as a “side salad” to the “main course” of interventionist, treatment based programmes.

So yes, let’s raise awareness of loneliness, offer social prescribing, and better engage GPs on the issue. But this will fail if we haven’t also worked with local people.

We can create a transformational improvement in loneliness and social isolation if we remember to do it with communities rather than to them.

Lisa McNally, director of public health, Bracknell

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MIGRANT CARE LAW

NHS must tackle inequality in staffing

Simpson’s essay is a surreal biography of my own life (Essay, 2 June). As the son of two doctors recruited from outside Europe in the 1960s, the reality of how they were treated is ingrained in my earliest memories.

Perhaps the greatest irony is that, having seen doctors who were the “backbone of the NHS” being treated like second class citizens, I chose what remains a shortage specialty—psychiatry.

As training programme director of one of the largest training schemes in psychiatry, I introduced a fair, objective, and transparent interview process, where international medical graduates could compete on a level playing field. This model was used as the basis for national recruitment by the Royal College of Psychiatrists.

If the NHS is to survive, it must tackle inequality in medical staffing. Until it extols the many virtues of psychiatry, geriatrics, and general practice, we remain in the 1960s.

Rahul Tony Rao, consultant old age psychiatrist, London

Cite this as: BMJ 2018;362:k2949
Sophie Louise Ellis

General practitioner and associate medical director NHS England Central Midlands (b 1971; q Royal London Hospital 1995; DCH, DRCOG, MRCP), d 5 November 2017

Sophie Louise Ellis (née Bassindale) joined the Oxford general practitioner scheme. She moved to Milton Keynes and worked in primary care roles including as GP partner and clinical assistant in diabetes. She contributed to the wider system as GP facilitator for Quality: MK and local representative to the Royal College of GPs. Appraisal became Sophie’s passion, and she worked as appraiser and senior appraiser. In her final role she was associate medical director of NHS England Central Midlands. Sophie presented her contemporary appraisal model at a national leadership conference just five days before her death. She leaves her husband, Jonathan; three children; and her parents, siblings, and wider family.

Jonathan Ellis
Cite this as: BMJ 2018;361:k2651

Gerald Ernest Moore

Oral surgeon (b 1926; q Dublin 1954; MGDS RCS Eng, LDS, MSc (Med)), died from old age on 25 March 2018

Before turning to medicine and dentistry, Gerald Ernest Moore had enjoyed a promising career as a child actor. He was a published poet and author as well as a prolific painter, artist, and sculptor, with many exhibitions in the UK and in Europe. In 1963 Gerald and his first wife, Irene, purchased Heathfield Park in Heathfield, East Sussex, and moved in two years later with their three young sons. They opened the gardens of the house to the public, set up a riding school, restored the Gibraltar Tower, established a wildlife park, and had a car museum. After Irene’s death in 1992, Gerald sold Heathfield Park, and in 1993 he retired to Devon. Predeceased by his youngest son and both his wives, he leaves two sons from his first marriage.

Adrian Moore
Cite this as: BMJ 2018;361:k2494

Alastair James Watt

Consultant in diabetes and endocrinology, obesity, and acute medicine North Devon Healthcare NHS Trust (b 1971; q St Bartholomew’s Hospital Medical School 1996; BMedSci, DTM&H, MRCP), took his own life while off sick with work related stress on 13 December 2017

As a junior doctor, Alastair James Watt had a reputation—despite a fear of the sight of blood—for being the best at fitting central lines outside intensive care. As a consultant at Barnstaple, he found that the small rural community of north Devon suited his patient oriented, community focused approach to diabetes. Having no consultant colleague in the latter four years, he relied on his excellent team of nurses to deliver diabetes care in the hospital and the community, and his obesity team had some of the best outcomes from bariatric surgery in the south west. Alastair leaves his wife, Ruth Taylor, and their 12 year old twins.

Ruth Taylor
Cite this as: BMJ 2018;361:k2571

Lorna Creighton Kinloch

General practitioner (b 1928; q Glasgow 1951), died from a stroke on 22 May 2018

Lorna Creighton Kinloch lived in Moscow between 1953 and 1955, where her husband, Peter, was medical officer to the British Embassy. She returned to work on Merseyside as a rheumatology clinical assistant in 1961 and became a part time GP in 1967. She became a partner in her husband’s practice in Halewood in 1973. She was a keen GP trainer and became a magistrate in 1981. Peter and Lorna were joined in the practice by their son Tom in 1985 and retired together in 1989. In her retirement Lorna enjoyed travel and golf. In her later years Lorna had a stroke, which made it hard for her to speak, but she soldiered on. She enjoyed life to the full until she had another stroke, from which she subsequently died. She leaves her two sons and their families.

Tom Kinloch
Cite this as: BMJ 2018;361:k2589

Stewart Oliver

General practitioner, Hamilton, New Zealand (b 1960; q Dundee 1987; DA, FRNZCGP), died unexpectedly as a result of complications during surgery on 19 June 2017

Paisley born Stewart Oliver was a GP in New Zealand, having moved there with his young family in 2005 from Scotland. After GP training in Oban, he worked on the Orkney Islands and in Polmont, Scotland. He loved being a GP in New Zealand and offered the continuity of care that he had delivered in Scotland, including visiting elderly and terminally ill patients at home. He had an interest in palliative care and was known for his humour and compassion. With his family he enjoyed the outdoor life that New Zealand had to offer. He balanced this well with his love of general practice, and would go out of his way to support patients and colleagues. He leaves his wife, Helen, and two children.

Janice Oliver
Cite this as: BMJ 2018;361:k2652

Michael Opitz

Consultant orthopaedic surgeon (b 1955; q University of Cape Town 1978; FCS (Orth) SA), died from blunt force trauma to the chest on being swept to sea by a wave on 14 April 2018

Michael Opitz (“Mike”) was born in Riyadh, Saudi Arabia, and grew up in Namibia. He married Deborah Appanna, a nurse in the intensive care unit at Cape Town’s Groote Schuur Hospital, in 1987. After specialising Mike and his family (which by then included three children) moved to Windhoek, Namibia. For the next 20 years he worked as an orthopaedic surgeon, which included locum work at the Royal Bournemouth Hospital in the UK. From 2009 until 2018 he worked in Dubai. He retired in March 2018 and had just moved to Cape Town to start the next phase of his life, but within a month, he died in a freak accident. He leaves Deborah and three children.

Taiacre Abdulwahab, Michaela Opitz
Cite this as: BMJ 2018;361:k2549
T Berry Brazelton

The “Baby Whisperer”

T Berry Brazelton (b 1918; q Columbia University College of Physicians and Surgeons, New York City, 1943), died at home from congestive heart failure on 13 March 2018

Even as a child, T Berry Brazelton possessed an extraordinary ability to mentally connect and communicate with babies. Later this earned him the nickname “the Baby Whisperer.” He once said: “I can look at a child, a newborn, and tell you just what he is trying to say without words.” That ability, combined with his keen observational skills, provided Brazelton with an illuminating insight into the mind of the baby, which led to development of the neonatal behavioural assessment scale (NBAS), considered by many to be his most important contribution.

The scale, published in 1973 and revised in the mid-1980s and again in the mid-1990s, is now used by physicians and researchers around the world to evaluate physical and neurological responses of newborn babies and their emotional wellbeing and differences.

Barry M Lester, director of the Centre for the Study of Children at Risk at Brown University in Providence, Rhode Island, says Brazelton’s work triggered a paradigm shift in our understanding of child development similar to the “Copernican revolution” in the 16th century, by placing the baby at the centre of the universe of the science of child development and revolutionised how we think about, understand, and study children.

“Touchpoints” model

The second most important of Brazelton’s contributions was his “Touchpoints” model of development: the idea, as Lester explains, “that development is not linear, that there are fits and spurts and upheavals in development, that regressions are normal, and if you know them they can be anticipated and disruptions in the mother-infant relationship can be prevented.”

Thomas Berry Brazelton Jr was born on 10 May 1918 in Waco, Texas, into—in his own words—a very privileged family.” He followed family tradition and enrolled at Princeton University in New Jersey, where he was known as a gifted actor, singer, and dancer. He graduated in 1940 and then moved to New York City to study medicine at Columbia University College of Physicians and Surgeons, where he qualified in 1943. After completing an internship at Roosevelt Hospital, he served in the US Navy until 1945. He then trained for the next five years in Boston at Massachusetts General Hospital and Boston Children’s Hospital. He also trained in child psychiatry at the James Jackson Putnam Children’s Center and was a research fellow in child psychiatry at Harvard Medical School.

Brazelton opened a private paediatric practice in 1950, when many believed that newborn babies were not able to use their senses. “We still didn’t think they could see or hear in the 1950s, can you believe it?” Brazelton exclaimed in a 1997 interview, adding: “You know, it became obvious to me that we didn’t think they could see or hear or do anything because we’d never treated them as people.”

Brazelton admired the work of Benjamin Spock, who had a huge impact on parenting in the “baby boom” years of postwar America. But Brazelton said that both Spock and he were influenced by English paediatrician and psychiatrist Donald W Winnicott. “A wonderful, wonderful man,” Brazelton said of Winnicott. “Every paediatrician ought to read his stuff.”

In 1953 Brazelton was appointed as an instructor in paediatrics at Harvard, where he remained affiliated for the rest of his life as emeritus professor of paediatrics. In 1972 he established the child development unit at Harvard’s Boston Children’s Hospital, and in 1996 he founded the Brazelton Touchpoints Center at the same hospital. During his career he was also a professor of psychiatry and human development at Brown University.

Despite his academic affiliations, much of Brazelton’s research was based on his observations of babies in his private practice and his chats with their parents.

Prominent public figure

Brazelton first shot to prominence in 1969 with the publication of a book for a general audience: Infants and Mothers: Differences in Development. The book sold more than a million copies and was translated into nearly two dozen languages.

Brazelton wrote more than 30 books for the general public, as well as more than 200 academic papers and chapters. From 1984 to 1995 he hosted his own television show, What Every Baby Knows, which won an Emmy award in 1994. He also wrote various columns.

In 2013 he was awarded the US Presidential Citizens Medal, the nation’s second highest civilian honour. Predeceased by Christina Lowell, his wife of 66 years, in 2015, he leaves four children and five grandchildren.
The brutality of football

World Cup fever draws to a close this weekend, after having gripped fans for the past few weeks. To the editors of The BMJ in September 1894, however, “the commencement of the football season” was a cause for alarm (Br Med J 1894;2:601), drawing “attention afresh to the danger of the game as at present played” and “the very serious list of casualties which each season brings.” The BMJ had already expressed this opinion some years earlier and been taken to task for it by readers (Br Med J 1886;2:1008). A Howard Lowe contended that “football supplies a much needed opportunity for vigorous exercise and affords a powerful counter attraction to the pleasures of town life.” While WS Godfrey read the journal’s argument “with some amount of indignation.” “That football is a somewhat dangerous game I do not deny,” he wrote, “but I do deny that it is more dangerous than hunting and can say, without fear of contradiction, that there is little to choose between the dangers of football and cricket.” The BMJ stood firm, however, in expressing the opinion that “football is not a pastime which tends to polish the manners of young men.” “If the constituted authorities of football cannot draw up and enforce good rules,” wrote the journal (Br Med J 1886;2:1106), then “public opinion will be justified in demanding that football played in public . . . should be subject to ordinary police regulations.”

FROM THE ARCHIVE

WHAT YOU’RE TWEETING ABOUT

Should doctors go to patients’ funerals?

Last week Margaret McCartney (BMJ 2018;362:k2865) confessed that for years she thought it “was a definite ‘no’” as to whether doctors should ever attend the funerals of patients, but that she now wondered if the feeling of community it formed could bring “solace” to doctors. Here’s what you were saying on Twitter:

I have known nursing staff and care home staff attend my family’s funerals. The local pharmacy also sent flowers to my mum. The GP called her. This was all really appreciated.

Janice Mills @citzgirl

After 12 years of hospital medicine I ended up going to a patient’s funeral. It is not something I intend to repeat but it was the right thing to do at the time . . . However too frequent an experience and I think it will take its toll.

Ben Burrows @DrBennyB

I believe it depends on why you are going and the families’ wishes. Healthcare is only a small part of most people’s lives. It should be an exception in practice rather than the rule.

kate Yeo @Yeo_kat

I do, when I can, mostly on days off. It’s a way [of] caring for the rest of the family, of showing respect, and saying “this person mattered.” Am I hopelessly old fashioned?

Dr Helen Salisbury @HelenS_NHA

I attend my long term dialysis patients’ funeral. It is really overwhelming when the whole family thank us for doing our job.

Vijayan Suresh @VijayanSureshDr

As a patient I’d say yes if the relationship suggested that was the right thing to do. It can be the last duty of care a medic can show.

Andrew Corbett-Nolan @acorbettn

It’s not a chore. It’s a meaningful way to know the story of the patient.

Dr Brian Goldman @NightShiftMD

When the funeral is a community event and the doctors are part of the community then I think it’s wholly appropriate.

Welliesandseaweed @welliesandseaweed