> If it's not evidence based it might as well be homeopathy

NO HOLDS BARRED Margaret McCartney

What I've learnt in four and half years

1 Screening is only for people with no symptoms.
2 Screening is often counterintuitive. False positives rise when prevalence falls.
3 Inadequately tested tech can do as much harm as inadequately tested medicine.
4 The NHS is a pie: if you ask the NHS to do more but don't make the pie bigger, something else won't get done.
5 A system that uses blame to attempt improvement is likely to make good professionals miserable and leave.
6 Earlier isn't necessarily better. Lead time bias and overdiagnosis do harm.
7 If it's not evidence based it might as well be homeopathy.
8 Jeremy Hunt was not my favourite health secretary.
9 Poverty kills. Statins are not the solution to poverty.
10 Cycling and running are fantastic. Fresh air and trees are soul food.
11 Food should be pleasurable. Beware of people selling diet books.
12 Doctors should call out bollocksology when they see it.
13 Private companies promising fast access to GPs in exchange for discontinuity of care may result in the fulminant collapse of NHS general practice.
14 Humans make mistakes. Honesty breeds forgiveness.
15 Policy should require independent review by an "evidence desk" that stops avoidable errors. I make an ongoing offer to any government to staff that desk.
16 Keep your "thank you" cards.
17 We need to know absolute risk and all cause mortality. There's no use not dying from a disease if the treatment kills you.
18 Everyone in healthcare should make a public declaration of interests.
19 There's too much political in-fighting over the NHS. We should seek cross party cooperation, use evidence, and acknowledge uncertainty in decision making.
20 People should be offered interventions and be given help to make decisions. Doctors should not be paid for people making the "right" decision.
21 Financial incentives have caused a needless professional crisis in medicine.
22 Appraisal is bunk.
23 It's a disgrace that the GMC—a charity—pays for private health insurance and non-evidence based health screening for its staff.
24 False promise increases with the opportunity for profit.
25 Markets in medicine increase demand and make people into patients needlessly, while those who need to be patients can't access care: the patient paradox.
26 CPR isn't good treatment for many. Unless we opt out, we've been opted in.
27 Less treatment may be better treatment, but it can often feel risky to deprescribe.
28 More "resilience" will not make appalling workloads appealing or safe.
29 Medicine is a tough, unglamorous, difficult job which, with understaffing and austerity, often feels impossible to do well.
30 Medicine is an absolutely brilliant job, and having long term relationships with patients and families is one of its most joyous and fulfilling aspects.
31 Being a columnist has been great fun. The emails have (mostly) been a delight. But here I stop. Thank you to my editors, who are patient, kind, and clever; and thank you for reading.

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PERSONAL VIEW Giles Maskell

Think before you scan

The more radiologists image, the more we find. Some will help to advance the patient's health, but much of it won't

Who suffered the greater wrong? The patient who died after a false positive diagnosis or the one who died after a false negative

Two fictional friends in their mid-50s, Mick and Mack, underwent magnetic resonance imaging for back pain. Mick's scan showed a little "wear and tear" and a small disc prolapse but nothing warranting intervention.

Mack's scan showed similar findings, including a small disc prolapse, but he was also told he had a lump in his left kidney. After further scans, an inconclusive biopsy, and a lengthy discussion, he decided to have the kidney removed. The lump was an oncocytoma, a benign tumour often hard to distinguish from cancer. The surgery was complicated by a chest infection resulting in a prolonged stay on the intensive treatment unit, after which he developed chronic lung damage. Recuperation was slow, and in the following winters he had further severe chest infections, culminating in an episode of overwhelming sepsis from which he died, almost five years after his MRI scan.

While visiting Mack in hospital, Mick mentioned that his back pain, which had improved for a while, had come back with a vengeance. The MRI scan had shown a prolapsed disc, so he thought that was probably the explanation. Then one morning he couldn't move his legs. He had a tumour in his left kidney, which had spread to his spine, causing spinal cord compression. His cancer responded poorly to chemotherapy, and after a few weeks of treatment he had an episode of overwhelming sepsis, from which he died. Looking back at his original scan, the radiologist could identify the earliest signs of a tumour in his kidney. Colleagues discussed whether it could have been identified at the time.

Overdiagnosis and underdiagnosis are two sides of the same coin, an unavoidable trade-off. Perhaps an ethicist could decide which man suffered the greater wrong: the one who died after a false positive diagnosis or the one who died after a false negative. Having witnessed variants of both scenarios, I feel equally distraught in each case.

"Incidentalomas"

The term "incidentaloma" was coined to describe the rise of benign adrenal nodules, detected by increasingly advanced computed tomography. The term has come to imply that incidental findings are tiresome and generally harmless, but that is not always true. A common route to diagnosis of renal cancer is through an incidental

ACUTE PERSPECTIVE David Oliver

"Why did they put her on a geriatric ward?"

Geriatricians sometimes field formal complaints and informal calls for concern. Families can be unhappy that their loved one has been admitted or transferred to a geriatric medicine ward, whatever the quality of care or communication.

Sometimes it isn't even a geriatric medicine ward. Fellow patients in 21st century acute medical units or wards are often older, frailer, or more cognitively impaired than the public might expect. For doctors who have devoted their professional career to the care of the oldest and most medically complex patients, and for the skilled multidisciplinary teams of nurses and allied health professionals we work closely with, such complaints can be unsettling.

The "G" word now has unfortunate, even comical connotations in wider society. People don't like it

Why are relatives, and sometimes patients who complain on their own account of being "with the old people," so aggrieved in these cases? You don't get patients with heart attacks, cancer, or fractures complaining because they're on a coronary care, oncology, or trauma ward or parents complaining that their child is on a paediatric ward. The animus against putting patients in a ward geared to their specific needs seems unique to geriatric medicine.

Strong evidence shows that specialist led, multidisciplinary comprehensive geriatric assessment (CGA) leads to better outcomes than "usual care" in services not equipped for older people's needs.

Stroke units have been proved to save lives and improve outcomes. In the UK their development, clinical leadership, and evidence base have been driven largely by geriatricians, and they effectively offer geriatrician led CGA for many patients. Older people often get a "right bed, wrong patient" raw deal when cared for on a ward where the staff don't have the training, values, or clinical leadership to focus on person centred, multidisciplinary care.

Although "geriatrics" describes a branch of medicine that has advocated tirelessly for older people's care, built an evidence base, and led clinical services, the "G" word now has unfortunate, even comical connotations in wider

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finding on imaging carried out for another purpose.

We radiologists in general have an ambivalent attitude to incidental findings, at least when we aren't directly incentivised to detect and report them. We know serious harm and even death can come to patients from pursuit of radiological abnormalities with a very small likelihood of affecting the patient's future health. But we also we pride ourselves on our ability to consider the whole image and not just the obvious findings.

The ability to identify incidental lung cancer on a radiograph showing a dislocated shoulder is one of the things that marks us apart from other healthcare professionals. Detecting the subtlest signs of pneumonia on the chest radiograph of a child with a fever is no big deal, but identifying the signs of aortic coarctation on the same image is the stuff of legend.

Muddy waters

But these are muddy waters. For something to be an incidental finding, the primary purpose of the examination must be clear, and this is often no longer the case. When the clinical question on a CT scan request form is succinctly phrased as "?pathology" (not uncommon) who's to say which findings are incidental and which are not?

Moreover, as we image more and more people, the value of "incidental" findings may start to exceed the value of the primary purpose, even when that primary purpose is made clear.

A truism in radiology is that the more we image, the more we will find. Some of it will help to advance the patient's health, but much won't. The general approach seems to be "Scan because you can"; I suggest a small amendment: "Think before you scan because you can."

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society. People don't like it; nor do they like "frailty" or being defined by age related health problems and functional or cognitive deficits.

We see ample evidence of age discrimination in society, the media, and even the caring professions. We tend to fear ageing or death and often don't want to identify ourselves as older or even to imagine entering the last phase of life and having the difficult conversations this may entail, even though we have excellent resources to help with this.

Yet around two thirds of NHS hospital bed days are taken up by people over 65; a quarter by people over 80. Many are admitted with or develop immobility, dependence, disability, dementia, delirium, incontinence, or sensory impairment. Patients may be near others who are close to death or who show confusion and behavioural symptoms, which can be disruptive or upsetting.

Well beyond the geriatric unit, the core business of modern acute healthcare is increasingly the care of vulnerable older people. In a universal health service with very high bed occupancy, open bays, and limited single rooms it's near certain that patients will be surrounded by others with age related problems. I'm not sure that we should be apologetic for this reality in responding to complaints, let alone the complaint that someone has been admitted to the specialist ward best able to help their specific needs.

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BMJ OPINION Samir Dawlatly

We need better ways to measure GP workload

Numbers are useful. Before proper numbers, perhaps primitive humans could count to 10 or show their fingers to represent those figures; anything larger was simply "a lot."

Doctors, and GPs in particular, have always been pretty vocal about how much their workload is. When asked, "How hard do you work?" they answer, "A lot!" or, if they are junior doctors, "A lot+++."

But how much is "a lot" in this case? Have doctors simply run out of numbers to quantify how hard they work, or do they not know? One thing that seems clear is that doctors' workload is more than before. How much more? Well, we can guess.

There are some measures of how much work doctors do. The number of patients who turn up or are taken to emergency departments is counted. This doesn't necessarily correlate directly to workload; it just counts the numbers of patients. It doesn't take into account their complexity, the staff skill mix present at the time, how dependent the patients are on having a member of staff with them, and so on. I imagine that someone working in resus could spend four hours with the same sick patient and have a higher workload than a colleague in minors dealing with "see and treat" patients. But at least the numbers are being counted and could be used to guide staffing levels.

Have doctors simply run out of numbers to quantify how hard they work?

The same can't be said about general practice. Nobody, it seems, is counting the numbers for general practice in a systematic way. A limited number of studies have shown a rise in consultations, prescriptions, and correspondence dealt with in primary care. Some GP surgeries endeavour to collect these data, mainly to monitor whether the interventions that they implement are having any effect on workload.

But, in general, GPs work a lot. And they work a lot more than they used to. A lot+++ more, in fact. The barometer of workforce level tells us this, but no one can quantify what isn't being counted. And because no one is counting, it means that we can't even begin to talk about the impact on workload of the increasingly multimorbid patients we try to squeeze into 10 minute appointments, as well as dealing with complex prescriptions, discharge summaries, and clinic letters.

And, if no one knows how much work is actually being done and the toll it takes, it becomes impossible to define how much of a workload is safe for a GP to do.

Samir Dawlatly is a GP partner at Jiggins Lane Medical Centre, Birmingham

ANALYSIS

What are the best investments society can make to improve people's health?

Healthcare alone cannot improve the wellbeing of the population. **Laura Webber and colleagues** advocate a "health in all policies" approach, with protected funding for preventive interventions

PRIYA SUNDRAM

The NHS has transformed medicine and improved lives.[1] But the ageing population along with the burden of non-communicable, mental, and neurological diseases have put its financial viability and sustainability into question. The next decade is projected to be the most financially austere in NHS history,[2] even if recent pledges materialise.

Reorienting the NHS to invest in cost effective disease prevention is essential if the health system is to be sustained. Disease prevention has four key benefits that show how cost effective it is both in and beyond the health and social care system (figure, right). We focus on the role of the NHS in disease prevention and the role of cross-government agencies in tackling the wider determinants of health.

Reorienting the NHS to invest in cost effective disease prevention is essential

KEY MESSAGES

- Investment in prevention is key if the NHS is to be sustainable
- A battery of preventive approaches is necessary—there is no silver bullet
- Times when national policies are under intense review—such as Brexit in the UK—offer the opportunity to take a "health in all policies" approach to public health
- Health in all policies should be the norm; we need a proactive solution ensuring that NHS funding protects preventative services and a level playing field for assessing preventive and curative interventions
- We recommend a national commission on health promoting fiscal policies, a guaranteed NHS health benefits package that includes prevention; and a NICE funding direction for public health interventions

Social determinants of health

Social and environmental influences are thought to contribute to around 50% of the variation in health status, indicating that access to universal healthcare alone is not sufficient to improve population health.[3] Strong preventive interventions tackling the social determinants of health often fall outside the usual scope of healthcare, yet accrue benefits for the sector.[4 5] Including health as a key outcome of policies and intersectoral governance on health is therefore an important step in improving population health and reducing health inequalities.[6]

The UK's recent industrial strategy acknowledges the importance that infrastructure investments can have on society, with a focus on how investment can support the needs of an ageing population.[7] The post-Brexit rewriting of laws and policies provides an opportunity for (public) health to be put at the centre of policy making[8] and for health to be embedded in new institutional norms.

Other policy making avenues provide similar opportunities, such as the ongoing changes to devolution and the movement of public health to local authorities in England.[9] We make the case for a "health in all policies" approach as the best investment for people's health and recommend that NHS funding protects preventive services (as promised in the *Five Year Forward View*).

Common risk factors and their costs

Preventing disease is key to reducing pressure on the NHS. In 2006-07, ill health related to poor diet cost the NHS £5.8bn.[10] The cost of physical inactivity was £0.9bn, smoking was £3.3bn, alcohol £3.3bn, and overweight and obesity cost £5.1bn.[10] Recent analysis quantified the NHS and social care (as opposed to broader societal) cost of pollutants nitrogen dioxide and fine particulate matter at £157.2m in 2017, increasing to a staggering £19bn cumulative cost by 2035.[11] Mental illness is estimated to cost £22.5bn a year (NHS, social care, and other agencies).[12] Obesity is projected to increase, and will likely drive further increases in non-communicable diseases.[13] Risk factors and non-communicable diseases tend to be more prevalent in the most deprived groups, with health inequalities estimated to cause over 700 000 deaths and 33 million cases of ill health in the EU as a whole in 2004, accounting for 20% of total healthcare costs and 1.4% of gross domestic product after lost productivity was taken into account.[55]

The wider social determinants of these risk behaviours—such as poverty, lack of adequate education, unemployment, austerity, inadequate social benefits, poor social housing, and poor public transport—are strong contributors to health inequalities and increased prevalence of mental and neurological diseases.[3] By reducing exposure to these determinants the disease burden can be reduced.

There is strong evidence globally that fiscal and pricing policies are a win-win for population health

Generating evidence for prevention: methods and means

Evidence for the effects of public health interventions on risk factors often relies on statistical modelling studies, as randomised controlled trials are not always feasible or ethical and frequently lack a commercial sponsor. Modelling is a crucial part of the decision making process, providing evidence for policy, as shown in the case of minimum unit pricing of alcohol[15 16] and the sugar sweetened beverage levy.[17 18]

Models are often complicated and led by assumptions, however, which makes leveraging policy change more difficult than when evidence is cited from traditional drug trials. Calls for guidelines to standardise reporting of public health modelling studies are therefore well warranted.[19]

The National Institute for Health and Care Excellence (NICE) is England and Wales's cost effectiveness watchdog, but its emphasis is typically on drugs and clinical services. Although NICE has enabled the development of public health guidance, some of this is now outdated and held "static."[20] Furthermore, NICE's decisions on technology adoption carry a funding direction that encourages the health service to invest in the latest drug.

The same does not apply to public health guidance, meaning that uptake of this guidance is largely voluntary. Recent empirical evidence shows that NICE's guidance on newer drugs receives a higher priority than good health practice already elsewhere in the system.[21]

Economic case for prevention and the reasons for inaction

Although the ultimate aim of prevention is not to save money, an increasing body of literature makes the economic case for prevention of ill health.[13-24] Despite this, just 3% of European health budgets are invested in public health.[25] Thus maintaining or reducing healthcare costs without negatively affecting health outcomes requires that cost effective prevention interventions are at the forefront of healthcare. Apprehension about the initial costs of disease prevention, combined with pressure on existing budgets, result in inaction while investment in ever increasing treatment costs continues.[26] Because the benefits of prevention are often long term and rarely show return on investment in the lifetime of a parliament or tenure of a minister of health, they must also overcome challenges to get political backing.

Best investments for society's health

Several reviews of the most effective, or cost effective, or both, interventions for society's health have been published, with sometimes contrasting results.[22-29]

In one review of more than 500 studies analysing primary or secondary prevention interventions, only two were cost saving: childhood immunisations and counselling adults on low dose aspirin.[29] An additional 15 were cost effective. But the included studies focused on clinical preventive services only, rather than prevention outside of the health system, and rarely considered non-healthcare costs.

A more recent review of return on investment for a broad range of public health interventions in developed countries with universal healthcare reported substantial cost saving.[27] In this context, cost saving refers to the overall social costs and benefits, including long term health benefits and government savings beyond the health system, rather than short term cashable savings to the NHS specifically.[30] Savings are therefore realised only after the increased pensions and social care costs owing to prolonged life expectancy without contraction of morbidity are factored in. National regulatory interventions produced the highest return on investment so are likely to be the best investment for population health, while also narrowing health inequalities.[31 32]

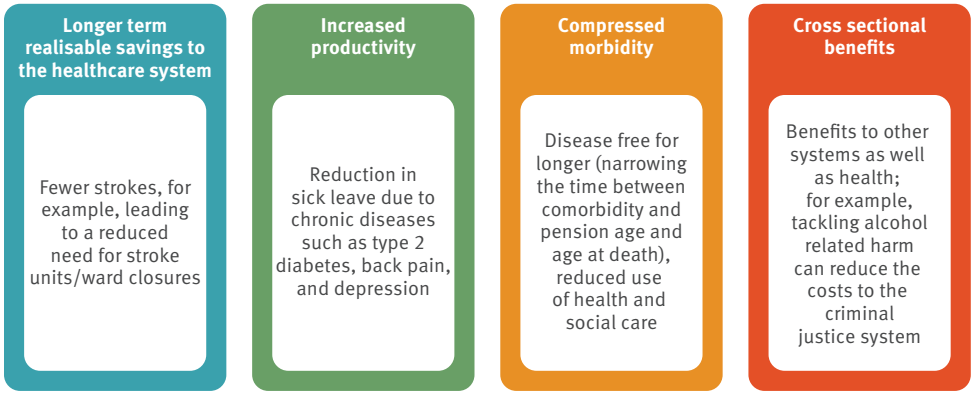
We explore some of the options for potentially cost saving interventions, outside of healthcare, yet argue that a combination of interventions is likely to be required for maximum effect.[33]

Fiscal and pricing policies

Price is a major determinant of consumption, and there is strong evidence globally that fiscal and pricing policies are a win-win for population health.[34] But pricing policies are underused, possibly owing to lack of political will, public acceptability, and conflicted interests (such as the tobacco, food, and alcohol industries opposing public health interventions for commercial reasons). Such policies have the dual benefit of generating revenue while reducing disease by disincentivising the consumption of unhealthy commodities and promoting healthy behaviour.[35]

An example of strong fiscal policy for health is tobacco tax. The UK has the highest pack price of any EU country (£9.91 for 20 cigarettes in 2017),[36] double the European average,[37] which has contributed to

The key benefits of disease prevention



decreasing tobacco consumption over the past three decades. Nevertheless, evidence shows that gains can still be made. Increasing the tobacco duty escalator to 5%, for example, is estimated to avoid 75 200 new cases of smoking related disease by 2035, saving £49m in NHS costs and £192m in societal costs in a single year.[38 39] Arguments against taxes as regressive are unfounded, as those in the lower income bracket tend to have more unhealthy behaviours and live in more polluted areas, so carry a disproportionately high disease burden. They have the most to benefit, especially in an NHS style system that is inherently equitable and serves as an "equaliser" moving resources from the rich to the poor and from the healthier to the sick.

UK fiscal policy around other behavioural risk factors lags behind that of tobacco, and trends in those risk factors reflect that. Obesity is one such example where prevalence has risen over the past 30 years, with predictions of nearly three in four people being overweight or obese by 2035.[13] The introduction of the sugar sweetened beverage levy in the UK represents progress, but swift and sustained action to make the leaps seen in tobacco control is crucial.

Policy regressions have led to alcohol duty as a share of total tax receipts dropping to just over half what it was in 1978,[40] further compounded by the alcohol duty escalator freeze and the coalition government's change of direction on minimum unit pricing of alcohol in 2013 in England.[41 42] Nevertheless, Scotland's success in implementing minimum unit pricing this year, after extensive legal challenge, is a key turning point in getting alcohol policy back on the agenda. Such policies are crucial given the UK's large increases in liver disease over the past 40 years, largely as a result of alcohol consumption and obesity.[43]

More broadly, the effect of investments in wider social infrastructure (such as social policy and education) on health shouldn't be undermined. Fuel duty is an important policy outside of health that could incentivise people towards active

travel. Policy decisions to freeze rates of fuel duties since 2011 have been estimated to cost the exchequer about £5.4bn a year in 2017-18 terms.[44] This freeze has incentivised inactive travel (driving) and has cost a substantial amount that could otherwise have been allocated to improving active travel infrastructure. Car ownership and use is skewed towards higher income groups, so tackling subsidies would help reduce inequalities.[45]

Increased social welfare spending is correlated with reductions in mortality

Promoting physical activity

Changes to the built environment have repeatedly been shown to be cost effective. Recent NICE economic modelling showed that changes to transport infrastructure, frequency of and access to public transport, and open space access are highly cost effective ways to improve health, even if generating only a modest increase in physical activity.[46]

The guidance noted that the effects of infrastructure interventions would not necessarily decay, unlike behavioural interventions, and could increase over time. This is a good example of a "health in all policies" approach, where town planning and transport policy can include effect on health as a primary policy outcome.

Investing in social welfare

Evidence from several countries shows that increased social welfare spending is correlated with reductions in mortality, but healthcare spending is not.[47] This emphasises the need to maintain and improve investment in social welfare programmes as a key determinant of population health.

Public Health England commissioned evidence reviews around effective interventions for improving social determinants of health. These covered education, early intervention, employment, ensuring a health living standard for all, and healthy environment, providing a 12 step plan for action.[48] Examples include parenting programmes such as An Equal Start[49]; Adult Education Gloucestershire, which reported improvements in wellbeing and reduced stress[50]; and placement support schemes that integrated employment specialists into community mental health teams to support individuals into employment, education, or training.[51 52]

NHS England's Healthy New Towns project works with 10 housing developments to shape the health of communities and consider new ways of health services delivery.[53] It is a welcome example of joined up cross-government action on upstream determinants of health.

Future options

We present some options for investing in society's health. We need a broader approach that focuses on maintaining people's health rather than on the consequences of disease. Evidence calls for a "health in all policies" approach as the norm. We think that NHS funding for prevention should be protected and extended through a guaranteed benefits package,[54] to include prevention, a national commission for health promoting fiscal policies, and a NICE funding direction for public health interventions. We need rigorous, validated, and comprehensible epidemiological and economic modelling to inform policy reliably on the best investments for society's health.

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NHS HIT LIST

Pulling the plug on elective surgery

All healthcare runs the risk of being unsuccessful and therefore ineffective (Too Much Medicine, 14 July). But many of the procedures the NHS considers ineffective, such as carpal tunnel decompression, are for debilitating conditions, treatment of which is associated with a high rate of satisfaction. Moreover, the preferred treatment methods, such as unicompartmental knee replacement for osteoarthritis, are arguably more likely to be ineffective than the listed procedures. They are, however, less expensive up front.

By restricting procedures to patients who apply for exceptional funding, the NHS may restrict care to those with GPs who have the time, education, and resources to make an application. This is clearly contrary to the NHS constitution, which states that "everyone counts" and that it will provide a comprehensive service regardless of demographic.

A more accurate title for the article could be "NHS England's plan to pull the plug on elective surgery."

John R Kiely, plastic surgery registrar, Cambridge

Cite this as: *BMJ* 2018;362:k3706

I accuse NHS England of a lack of transparency

Robinson says, "You can't accuse NHS England of a lack of transparency" (Too Much Medicine, 14 July). But policy makers use elusive phrases like "not routinely funded." My interpretation is: "not available on the NHS."

The NHS constitution states the right to "a comprehensive service, available to all." This means no exclusions.

An honest approach would mark the treatments and drugs as not funded by the NHS—no ifs, no buts. This would remove the inherent inequity of the current system, where procedures and drugs are funded for the savvy and affluent but denied to vulnerable patients.

Individual funding requests are an immoral method of denying access to care. The NHS promises a comprehensive service in return for a premium deducted at source. It should provide the same cover to all, not just to those who can put together a request and know how to manipulate the system.

Hendrik J Beerstecher, GP, Sittingbourne

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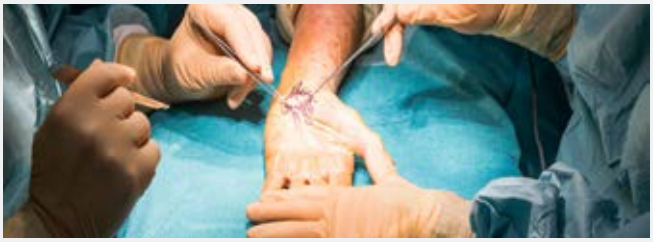

LETTER OF THE WEEK

Selective use of poor quality studies by NHS

NHS England plans to restrict funding for procedures that it considers unnecessary (This Week, 7 July), supposedly based on the best clinical evidence and endorsed by NICE and the Academy of Medical Royal Colleges.

Carpal tunnel syndrome, Dupuytren disease, and trigger finger are common and have substantial detrimental effects on quality of life. Timely surgery is effective in relieving symptoms and preventing irreversible loss of function. Extensive published data show the efficacy, success, and cost effectiveness of these treatments, which should not be described as "procedures of limited clinical effectiveness."

Carpal tunnel release costs £1280 per quality adjusted life year, well below the £30 000 threshold NICE uses to guide commissioning. This makes it one of the most cost effective interventions performed by the NHS, with similar evidence for trigger finger release and fasciectomy.

We are disappointed that the research evidence used in the consultation document has been inadequately examined and is extensively misquoted. None of the available high quality reviews is included, and literature is used selectively to support a bias against surgical intervention.

The British Society for Surgery of the Hand welcomes efforts to improve patient care and supports using research evidence to deliver the most cost effective care. But this should include a systematic review of all available evidence, rather than selective use of poor quality studies to support a predetermined view.

David Shewring, consultant hand surgeon and president; Jonathan Hobby, consultant hand and orthopaedic surgeon and honorary secretary; David Warwick, consultant hand surgeon and president elect; Tim Davis, consultant hand surgeon and chair research committee, British Society for Surgery of the Hand

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Service expansion can also be cost effective

NHS England's recommendations on restricting access to some currently routine interventions (Too Much Medicine, 14 July) is reminiscent of the in vitro fertilisation (IVF) situation. These services continually come under fire from clinical commissioning groups looking to save money.

Evidence shows that fully funding three cycles of IVF would lower the multiple birth rates caused by patients paying for their own treatment and requesting multiple embryo transfer, believing it to be more successful.

IVF on the NHS reduces harm to women and has reduced costs by reducing multiple pregnancy rates. If NHS England wants to stand by its "hierarchy of goals," it needs to acknowledge that it can be used by others to argue for an expansion of services that have already begun to suffer from cuts.

Daniel J Short, obstetrics and gynaecology specialty trainee, Glasgow

Cite this as: *BMJ* 2018;362:k3708

ADOLESCENT MENTAL HEALTH

Mental health care into young adulthood

Understanding the risk factors influencing the mental health of adolescents (Editorial, 7 July) should be extended to emerging adults (18-25 years). The extended period of transition to adulthood is critical for the development of potentially chronic adult mental disorders.

A paediatric-adult model for mental healthcare is not only developmentally inappropriate but creates a dangerous discontinuity of service at the epicentre of greatest need. From developmental, biological, and socioeconomic perspectives, "adolescence" limits our understanding of current generations of young people.

A new, long term framework for youth mental health that includes preventive and early intervention strategies is crucial. But focusing on risk factors is merely one part. Urgent reform and redesign of systems of care are equally critical. We need new models of care that are evidence based, culturally appropriate, and codesigned by young people and families.

Patrick D McGorry, professor of youth mental health; Cristina Mei, research fellow, National Centre of Excellence in Youth Mental Health, Melbourne

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Maurice William Beaver

Director of public health for Nottinghamshire (b 1930; q London 1955; DPH, FFPH, FRSPH), died after a period of illness after a stroke on 23 April 2018

Maurice William Beaver was diagnosed with TB in 1958, which prompted him to change his career plans. In 1968 he became deputy county medical officer of health for Nottinghamshire. In 1974 he was promoted to area medical health officer for south Yorkshire, and in 1979 he returned to Nottingham as special adviser for the East Midlands and senior lecturer in public health medicine at the university's medical school. In the late 1980s he built a team to pilot the use of information technology in the NHS. In the last years of his career, he was director of public health for Nottinghamshire. He published widely and was much in demand as a special adviser. Maurice leaves his widow, Marian; three daughters; and three granddaughters.

Rosemary Beaver, Rachel Beaver, Ruth Beaver

Cite this as: *BMJ* 2018;362:k3408

Henry Teuton Burrowes Beers

Consultant anaesthetist Laganvalley Hospital (b 1952; q Queen's University Belfast 1976; MD, FFA RCS), died from small cell carcinoma of the oesophagus on 2 May 2018

Harry Teuton Burrowes Beers endured a gruelling houseman's year in the Waveney Hospital. He started training in anaesthetics the following year. For many years he worked on a rota of one in two, with responsibility for the maternity unit, the accident and emergency department, the surgical unit, and any "crash call" in the hospital, including newborns. As joint medical director, he was respected and valued by his colleagues. He retired in the summer of 2010. In his scarce free time, he loved golf and developed a phenomenal knowledge of football. He was diagnosed with small cell carcinoma of the oesophagus in early 2017. He leaves Stephanie, his wife of 40 years and a general practitioner; two children; and a granddaughter.

David Jones, Peter McNamee

Cite this as: *BMJ* 2018;362:k3370

John Duncan Holden

General practitioner (b 1953; q Birmingham 1976; MD, FRCGP), died in a fall on 15 July 2018

John Duncan Holden had strong links to the Royal College of General Practitioners. He achieved his MD when he was 50 and worked on research projects. He was a trainer and chair of the St Helens and Knowsley Multidisciplinary Audit Advisory Group, and as a GP tutor, he brought awareness of quality improvement in patient care to many in local practices before it was a mainstream activity. John helped develop the virtual ward frailty service Eldercare in St Helens and published more than 100 articles and two Cochrane reviews. John Holden died in a fall while attempting to complete the Josh Naylor Challenge, a 24 hour, 48 mile, 17 000 feet total climb via a series of peaks in the Lakes, from Pooley Bridge to Ennerdale. He leaves his wife, Alyson, and three daughters.

Steve Cox

Cite this as: *BMJ* 2018;362:k3367

Barry John Cooper

Director of health and biomedical information World Health Organization (b 1932; q Birmingham 1961; DPH, MFCM), died from leiomyosarcoma on 5 March 2018

Barry John Cooper left the UK in 1972 to work in publications at the World Health Organization in Geneva. He spent the rest of his career at WHO, as principal editor and director of health and biomedical information. He travelled for work, not frequently but over the years to Russia, Kuwait, India, China, the Philippines, and Mexico. He knew many languages and liked to surprise people of other nationalities by addressing them in their own tongue. He often returned to England to see his family, and he was assiduous in attending the five yearly Birmingham medical school reunions. Barry remained well until the age of 82, when his leiomyosarcoma was diagnosed. He leaves Barbara, his wife of 51 years; two children; and three grandchildren.

Louise Cooper

Cite this as: *BMJ* 2018;362:k3376

Margaret Kathleen Douglas

General practitioner Chatham (b 1925; q London 1949), died from a chest infection on 1 January 2018

Margaret Kathleen Douglas ("Peggy") grew up in Chatham, where her father, a general practitioner, practised from home. During the war she was moved from school to school in various parts of the country. She studied at Edinburgh University as an external student of London University. After house officer posts in Chatham's hospitals, and finding it difficult to obtain a permanent post in Chatham, Peggy restarted a singlehanded general practice in the home where her deceased father had previously practised. She established a much respected and thriving practice, took on a partner (the author of this obituary) in 1980, and remained there until she retired in 1990. Outside medicine her great love was her garden. She never married, but leaves nephews, a niece, and friends.

Jill Cohen

Cite this as: *BMJ* 2018;362:k3374

Stephen William Valentine Coppinger

Consultant urological surgeon (b 1953; q Middlesex Hospital Medical School, University of London, 1979; FRCS Eng, MS), died after an intracerebral haemorrhage on 29 April 2018

Stephen William Valentine Coppinger ("Steve") was born and educated in Canada. In 1974 he started at the Middlesex Hospital Medical School. After consultant appointments at hospitals in the Midlands, Steve moved to New Zealand in 2011, where he was a consultant urological surgeon at Palmerston North Hospital until he retired in 2015. His many interests outside medicine included model making, photography, wine, and live music. He became unwell while doing what he loved: visiting an art show with his camera, before going on to listen to live music. Steve leaves his wife, Carole; two sons from his second marriage; a stepson; and two siblings.

Christopher Mitchell

Cite this as: *BMJ* 2018;362:k3378

Michael Rosen

Anaesthetist who championed patients' rights to pain relief

Michael Rosen (b 1927, q St Andrews 1949; CBE, FRCA, FROG, FRCS (Eng)), died from complications of Parkinson's disease on 2 May 2018

Michael Rosen was a pioneer of individualised postsurgical pain relief. In the 1960s and 1970s, patients were routinely suffering. Pain relief was poorly managed, leading to pathological consequences such as chest infections, prolonged hospital stays, thromboembolism, and the development of crippling chronic pain syndromes.

Funded by a Medical Research Council grant, Rosen developed the Cardiff palliator, the first commercial PCA machine. It allowed patients to trigger delivery of a morphine bolus directly into the bloodstream, while using technology—sophisticated at the time—to keep them safe while they did so.

Patient controlled analgesia is now used worldwide to provide effective and safe postoperative pain relief.

Rosen followed this landmark work by playing a leading part in the establishment of pain teams in hospitals. He also established a training programme for operating department assistants.

At the time Rosen started working, there were no standards in place for medical suction—used to clear surgical fields and the airways of unconscious patients—and failure of suction was common and sometimes fatal. His earliest work in 1960 tackled this "so successfully, that all in the profession now take effective suction completely for granted," says David Bogod, consultant anaesthetist and past vice president of the Association of Anaesthetists of Great Britain and Ireland.

Patient safety

Rosen was also a persistent and vocal champion of maternal safety. Bogod says, "He argued strongly—and very much against the fashionable views of the time—that small obstetric units were an inefficient use of resources and were inherently unsafe, since those who worked in them didn't encounter rare but life threatening conditions sufficiently frequently to maintain their skills."

Rosen's strong opinions placed him at odds with those who favoured a more personalised and local environment for childbirth. After the introduction of epidural pain relief in labour, he collated a series of more than 200 000 uses of the technique in major hospitals without permanent complication, and identified the full time presence of an obstetric anaesthetist as an essential safety feature when epidurals were used.

"This emphasis has led to a permanent anaesthetic presence in delivery units and has been a major contributor to the remarkable fall in anaesthetic related maternal mortality in the UK," says Bogod.

Rosen was consultant anaesthetist at Cardiff Royal Infirmary and University Hospital of Wales, from 1961 to 1993. He was made an honorary professor in 1984 by the University of Wales College of Medicine. Trainee anaesthetists came from all over the world to visit Cardiff for sabbatical and research purposes.

An active medical politician, Rosen became successively secretary, treasurer, and then president of the Association of Anaesthetists of Great Britain and Ireland.

The Royal College of Anaesthetists said that Rosen was instrumental in the development of the specialty. He was a member of the Confidential Enquiry into Stillbirths and Deaths in Infancy from 1992 to 1996. In 1996 he was awarded an honorary doctor of laws by the University of Dundee. He was awarded gold medals by both the Association of Anaesthetists of Great Britain and Ireland and the Obstetric Anaesthetists' Association.

Later years

In his later years, Rosen focused his attention on achieving standards for pain relief for babies undergoing ritual circumcision. His Jewish faith, although never in the foreground, was an important and abiding comfort to him, friends say.

He argued strongly that small obstetric units were inherently unsafe

He eventually developed Parkinson's disease and family members say they particularly want it to be known how he dealt with his illness and approaching death.

As his own health deteriorated, he knew that his wife, Sally, was also dying. They had married in their 20s and been together for 62 years. "He was staying alive to support her," says Rosen's daughter, Amanda Kirby, a former GP and specialist in developmental disorders.

When Sally died, Rosen wanted to be able, while still cognisant, to determine how his own life would end. Kirby says, "I think he felt he'd done his lot for his family and professionally, and had to basically stop eating to die. That, to me, was a sad choice to have to make, especially when his dying seemed too slow. He suggested being taken to Zurich for an assisted death but it was too late then. He said, 'I've messed up the timing.'"

Michael Rosen leaves three children and eight grandchildren.

Matthew Limb, London, UK
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Cite this as: *BMJ* 2018;362:k2894

GETTY IMAGES

FROM THE ARCHIVE

The art of taking holidays

Holiday season is coming to an end and many have now returned to work and the rhythm of everyday life. Nearly 100 years ago, Sir Humphry Rolleston, then president of the Royal College of Physicians, had some apt thoughts (*Br Med J* 1925;2:100) on the importance of the emerging tradition of the "prolonged summer holiday," which was becoming "a much more established article of faith than it was fifty or sixty years ago."

"Work and holidays are the natural complements of each other, and there should not be any workers without their holidays," said Rolleston, who gives his thoughts on where, when, and how to take a holiday to the best advantage. After all, "skilled medical advice might effect a good deal in obviating failure in holidays."

For starters, when deciding on the length of holiday, Rolleston thought this varied with the individual. "Some people are slow starters and take about two weeks to get into the holiday frame of mind and body, and therefore need a more generous vacation than others."

Rolleston thought it important, however, that all holidays contain elements of recreation and of rest and repair. "Recreation consists in change, distraction, and activity of a pleasant nature in a direction other than that of ordinary routine life. It is mainly a psychological remedy, as shown by the good effect of switching off from one line of work to another."

Meanwhile, an important point in the rest factor of a holiday "is to secure complete change of environment . . . to get away from him or herself." "Respite from soul destroying routine and worry should be continuous and complete during the holiday," insists Rolleston, and "for this reason a holiday at home has distinct drawbacks." In this point, holidays abroad have an advantage, since "calls, consultations, and certificates are not so likely to reach their intended recipient and as a rule correspondents cease from troubling."

He notes, however, that "an uncongenial holiday would be worse than useless," and suggests that "the worries attendant on a long journey, with the rush of getting off and to care of children and luggage, may be minimised if the anxious mother and the irritable father take a sedative dose of bromide to render them philosophic, cheerful, and less prone to a train headache."

As to his observations on doctors' preferred choice of holiday, he notes that "as a complete change from the saving of life, medical men not uncommonly seek a holiday in stalking, shooting, or fishing, while others, tired of percussing the chest, obtain relief in driving golf balls over, or even into, bunkers."

NEW BMJ PODCAST

What opened your eyes to overdiagnosis?

The concept of overdiagnosis can be hard to get—especially if you've been educated in a paradigm that says medicine has the answers, and it's only ever a positive intervention in someone's life. The journey to understanding the flip side—that sometimes medicine can harm—often takes what Stacy Carter, director of research for social change at Wollongong University, described in a previous BMJ podcast as a "moral shock."

At this year's Preventing Overdiagnosis conference, we asked some of the leaders in the subject to describe what it was that opened their eyes to overdiagnosis and overtreatment.

You can listen to their answers in this podcast http://bit.ly/open_eyes_overdiagnosis

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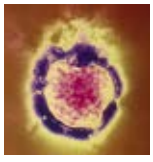

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