

comment

Alcohol is now 60% more affordable than it was in 1980

ACUTE PERSPECTIVE David Oliver

Incoherent approach to alcohol harm

For at least a decade we've heard big government rhetoric on prevention of ill health, promotion of wellbeing, and "parity of esteem" for mental health. Speaking at last week's NHS Expo Conference, Public Health England's chief executive, Duncan Selbie, said that NHS England's 2014 *Five Year Forward View* had "told a fantastic story," yet its ambitions for prevention hadn't been implemented. With the upcoming 10 year plan, things had to change, he said.

The 2012 Health and Social Care Act shifted public health funding and provision to local authorities, ostensibly because they had influence over wider societal determinants of health, such as education, housing, and social care. But their budgets have been cut ever since, with public health hit hard. In 2012-13 the ringfence on council budgets for drug and alcohol services was lifted.

In 2017 UK Addiction Treatment Centres published a report based on replies from 118 English local councils to a freedom of information request. Their combined spending on services for drug and alcohol misuse from public health grants had fallen by 16% from £535m in 2013-14 to £452m in 2016-17. In two examples, Manchester had cut the proportion of its public health grant spent on drug and alcohol services from 30% to 16%, and Lancashire from 34% to 24%. Central government cut overall public health grants by more than £200m in 2016, so this is a smaller proportion of a smaller budget. In 2017 the Advisory Council on the Misuse of Drugs warned on the government's website that sustained cuts to funding for drug and alcohol services were "short sighted and a catalyst for disaster."

The Institute of Alcohol Studies has shown, based on the retail price index and real terms income, that alcohol is now 60% more affordable than it was in 1980. A 2017 systematic review of 33 studies concluded that price based policy interventions, including minimum unit



alcohol pricing, were likely to cut population alcohol consumption and related mortality and morbidity. Other expert groups, such as the Institute for Fiscal Studies, have argued that tax changes could have a similar effect on price, while generating revenue for the exchequer that could be ploughed back into prevention.

Scotland has enacted minimum unit pricing, and it is on the table in Wales. The failure to act in England seems to disregard the weight of evidence. Such is the reality of having a tax funded, politically accountable NHS while public policy relating to wider determinants of health rests elsewhere, Treasury included. The drinks industry has a powerful lobby.

Why does any of this matter? PHE estimates alcohol related harms cost the NHS around £3.5bn a year. NHS Digital reported 337 000 hospital admissions related primarily to alcohol, 5507 alcohol specific deaths, and 80 000 people receiving treatment for alcohol misuse or dependence in 2017-18. This is a small fraction of England's estimated 590 000 dependent drinkers. Alcohol is the biggest risk factor for death, ill health, and disability in adults younger than 49 and the fifth biggest across all ages. Dependent and hazardous drinking brings much wider harms, hence PHE's estimated cost to society beyond the NHS of around £21.5bn a year. Alcohol is heavily implicated in use of emergency services, attacks on their staff, and violent or motoring criminal offences.

NHS chief executive Simon Stevens said at the same conference last week that we needed to "get serious about new public health threats." I am sure he hasn't forgotten some of the older ones, such as alcohol. My concern is that however switched on our health service and public health leaders may be, the funding and the wider social policy rely on ministers, government communications teams, and the Treasury. These parties are late to the party.

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Breaking good news: an essential skill for avoiding too much medicine?

We need to improve how we train doctors to deliver positive results to patients to prevent overdiagnosis

“Unfortunately, your ultrasound scan is normal.” Watching a trainee’s video consultation I speculated about his next steps; my fears were realised. “So, we still do not know what is wrong with you, this means I need to refer you to a specialist and get some more tests done in the meantime.”

This negative view, of a result that is actually good news, led to a confused and frustrated doctor and patient. The patient had mild, colicky abdominal pains without other symptoms; physical examination was normal. The purpose of the scan was unclear and the result, although predictable, did not seem to help the situation. Yet, the referral and investigations came up with no specific answers either; a diagnosis of irritable bowel syndrome

was given, which worried the patient, although her symptoms had resolved before she went to the clinic. Excessive investigation and referral drives a lot of overdiagnosis. Is this partly driven by a lack of “breaking good news” skills?

Many patients consult a GP because they are worried about the meaning, rather than the intensity, of symptoms and hope for reassurance. The doctor walks a tightrope; all serious problems start with something, and that can be trivial. Serious disease must not be missed, yet non serious problems need to be handled in a way that encourages resolution and rehabilitation.

A further problem arises because medical schools teach about diagnosis as if there is pretty much always something to be identified. Even in secondary care this is only partially true. In every clinic there



Consultation skills can prevent the spiral of anxiety that can drive further investigations

are patients whose symptoms are not really explained by current disease models. Patients with such symptoms are common in primary care. Thus, clinicians have to explain normal tests in a way that is simultaneously reassuring, (“great stuff your scan is normal”), while leading to effective symptom control, (“this is what we can do to help”) and also allowing for the possibility of serious disease developing later (“Please come back if things get worse, do not go away”), also known as “safety netting.”

Definition of bad news

If we go back to one definition of bad news as “any information that... drastically alters the patient’s view of his or her future,” then it becomes clear that some good news may be experienced as bad news by a patient who may be expecting a specific

Five steps to cut preventable stillbirth rates in the UK

The low, featureless hum as the midwife moved the Doppler foetal monitor across my belly is a sound I wouldn’t wish on anyone. Heavy with meaning, it dragged my husband and me into an unimagined future. Our daughter, Ada, had died. The next morning I would be induced, and at 13:52 I’d give birth to her.

In the UK, 1 in every 225 births is a stillbirth—a baby born dead after 24 completed weeks of pregnancy. That’s around 3400 babies dying every year, or nine every day, on average. Twenty three high income countries have lower stillbirth rates than the UK. In high income countries, substandard care contributes to 20%



Every year around 3400 babies are born dead, or nine every day

to 30% of all stillbirths. The charities SANDS and Tommy’s work to improve these figures, and the experiences of bereaved parents. But clinical action, government investment, and further research is needed.

Here are some of the ways we can reduce stillbirths in the UK:

- 1 Identify and treat urinary tract infections. UTIs are common, affecting 8% of pregnant women, and have known risks. Screening in early pregnancy with the gold standard of cultured urine tests is routine, enabling prescription of antibiotics. But follow-up is needed.
- 2 Raise awareness among expectant mothers. It is vital to talk about

warning signs and symptoms, and the steps women can take to reduce their risk of stillbirth.

- 3 Monitor stillbirth rates. The UK conducts national audits on perinatal mortality. While these show that over the past four years the rate has started to fall, there was no improvement from 2015 to 2016, and substandard antepartum and intrapartum care is too often present when a stillbirth occurs. For example, improvements in care which may have made a difference to the outcome have been identified in 60% to 80% of babies who die at term.
- 4 Investigate stillbirths. All stillbirths deserve high quality investigation. In three quarters of cases, detailed



diagnosis, and even by a doctor, more familiar with disease than normality.

With this complexity, breaking good news might be even more difficult than breaking bad news, but there is far less attention paid to learning this important skill. The stakes can feel higher for good news breaking. Everyone knows someone who went to the doctor to be told all was well only to have a serious problem in the end.

First, doctors can only break good news, if they have genuinely good news to impart. A thoughtfully explored history, a proper examination and good clinical reasoning must precede any breaking of good news.

Moreover, the skills begin early in the consultation. The words used when exploring symptoms, and explaining examination findings, can be reassuring if stated in positive language. Saying “your chest sounds

healthy” is better than “there doesn't seem to be anything wrong.” The phrase “I can't find anything the matter,” may lead the patient to believe the problem is a hidden, more sinister one, whereas what the doctor really means is, “things are normal.”

Ruling out, or ruling in?

Furthermore, before any tests are performed, their purpose and expected results must be thought through and explained fully to the patient. Are the tests to rule out serious disease, or to rule in something? The potential for normal, reassuring results can be signalled at the start. This will begin to prevent the spiral of anxiety that can drive further investigations. Being able to break good news earlier, preventing a cascade of tests, saves time and effort; patients start their recovery more quickly when reassured.

Clearly, planning of tests with the patient may take time and is the opposite of dismissing the patient by “arranging some tests and seeing what comes up.” However, the prize is a good one; time and resources will be saved and anxiety reduced all round. Perhaps all clinicians should update their breaking good news skills.

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evaluation enables identification of probable or possible causes of death, compared with only about half when medical records alone are investigated. Bereaved parents should have access to a postmortem and placental histopathology, and the opportunity to discuss the death with their consultant in a timely, compassionate manner.

5 Tackle stigma and fatalism. In high income countries, about half of parents who have experienced a stillbirth feel they should not talk about their baby because it makes others feel uncomfortable, and two thirds of parents feel that the people around them believe most stillbirths are unavoidable. My interest in information about cause of death was interpreted by some as a desire for control over a sad but inevitable

situation, rather than a normal reaction to my child's death. Social perceptions and actions that dismiss the importance of a stillborn child or parental grief, or support the idea that a child was never “supposed” to live, not only harm bereaved parents, but also undermine efforts to reduce stillbirth rates.

Not all stillbirths are preventable, and we don't know with certainty that Ada's was. What is certain is that more must be done in the UK to reduce stillbirths—and the family devastation they bring—by ensuring excellence in the care of women during pregnancy and labour. Nine babies every day is just too many.

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BMJ OPINION Abraar Karan

Changing the way we communicate about patients

A 53 year old woman with right lower quadrant abdominal pain. A 36 year old acutely suicidal man off psych drugs. An 80 year old woman with chest pain. On a single shift, I regularly read through the “one liners” of more than two dozen patients. To keep track, I (and most of my colleagues) remember people by their presenting clinical symptom or main diagnosis. As clinically necessary as this is, what do we lose when we begin to think of patients in this way?



The risk of dehumanisation in medicine is a real one. Studies show that empathy systematically decreases over the course of residency, while burnout increases. As much as this is a product of challenging schedules and tough daily work, we contribute to this decline in many ways—notably through our routes of communication.

The way we currently communicate reinforces a culture in which people become another case of X disease. Our manner of speaking and writing about patients not only reflects but also impacts on how we feel about them. It can contribute to a steady loss of empathy and even, I'd argue, a deterioration in patient health outcomes.

There are many changes that we can make to improve how we communicate about patients. One of the easiest and most critical transformations is how we write

The risk of dehumanisation in medicine is a real one

medical notes. One of the best doctors I have worked with did exactly this. He systematically starts every note with the person's social history. This not just a lady with abdominal pain. She is a mother of three, a retired teacher, and an active cyclist. That is the first thing we read about her, and so when I enter her room, I can't help but see her this way rather than as a case of appendicitis.

This matters because patients deserve to be treated as people—a statement that's so obvious it shouldn't need to be said, but which physician behaviour doesn't always reflect. You wouldn't expect to know the most sensitive and vulnerable aspects of someone before even knowing their most basic background, yet we do this in medicine all the time. This is also important because it can provide critical information that helps deduce how they got sick, and why they may get sick again in the same way.

As practitioners, we are being trained to sift through large amounts of data to present and interpret relevant information quickly, and create safe and effective treatment plans. In many ways, our medical culture treats the social history and other “soft” data without regard. But by making this information a central part of how we write, speak, and engage, we will not only become more empathetic, but also provide better care for our patients.

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Forget the market: health systems should be publicly funded and provided

A private sector market in healthcare increases the likelihood of inequity and exploitation, with lower standards of care for both rich and poor, say **Neena Modi and colleagues**

In a publicly funded health system such as the NHS, does it matter whether care is provided publicly or privately? At the heart of the question of who should provide health services is their commodification, through the application of market mechanisms, so that healthcare is regarded as a product to be bought and sold.

Arguments about markets as a means of delivering healthcare were set out as long ago as 1963 by the Nobel laureate Kenneth Arrow.¹ In his landmark paper Arrow said the medical care market had failed because healthcare is not a simple product but is complex and subject to major information asymmetries as the health professional will usually know more than the patient.

This opens up the possibility of exploitation, with potential for adverse consequences, including iatrogenesis, as described by Ivan Illich² in relation to excessive or inappropriate use, and as set out by Julian Tudor Hart's "inverse care law": "The availability of good medical care tends to vary inversely with the need for it in the population served."³ The qualification that the law "operates more completely where medical care is most exposed to

Definitions

Publicly funded—paid for from the public purse

Publicly provided—delivered by a public sector workforce, in facilities that are managed and owned by public sector organisations

Privately funded—paid for directly via out-of-pocket payments, indirectly through insurance, or by charity

Privately provided—services that are managed and owned, or a workforce that is employed by, a for-profit organisation, not-for-profit social enterprise or charity; or a self employed workforce

Given the evidence against private providers, why is a marketised healthcare model being introduced progressively to the UK?

market forces, and less so where such exposure is reduced"⁴ is often omitted.

Patients and the public are vulnerable to offers of profitable, direct to consumer services that may be unnecessary, unhelpful, or even harmful by raising anxieties that provoke more investigation and greater expenditure.⁵⁻⁶ Margaret McCartney, a GP and former *BMJ* columnist, describes a "patient paradox" in which she finds it increasingly difficult to get necessary NHS care for her patients, while they are simultaneously exposed to advertisements for body scans, personal genome screening, and other unwarranted "health checks."⁷

Another effect of direct to consumer health services is the rise in multiple births as a consequence of poorly regulated private artificial reproductive treatments purchased abroad by UK citizens. A proportion of these result in the birth of extremely preterm babies who require prolonged, expensive, and often ultimately futile NHS care.⁸

The consequences of a marketised system are that both rich and poor people are vulnerable; the former to over investigation, unnecessary intervention, higher costs, and dubious treatments and the latter to lack of necessary care.⁹ The NHS lowered the likelihood of this divergent provision by creating a public sector workforce committed to a publicly funded system in which care is not only delivered according to need (rather than ability

to pay) but, importantly, without immediate benefit to health workers or their employers.

Effectiveness and efficiency

Arrow's work informed that of another Nobel laureate, Oliver Williamson, who drew attention to transaction costs and to the scope for opportunistic behaviour, especially when purchasing a product that is difficult to define. These are both conditions that apply to marketised healthcare.¹⁰

World Bank staff have developed these ideas, saying that, when the product is simple, the process clearly defined, and the outcomes easily measured, there may be a case for purchasing privately.¹¹ But they failed to consider the complex relations between components of healthcare provision; for example, purchasing radiology or pathology services from a private provider, often based elsewhere, possibly abroad, separates staff who report results from those who deliver care. The lack of clinical context and discussion can lower the quality of interpretation of almost all diagnostic tests; discussions between radiologist and referring clinician have been reported to change diagnosis and treatment in 50-60% of cases.¹²

Fragmentation of care also diminishes training opportunities.

A related argument is that private services are more efficient, but the available evidence challenges this. A systematic review of hospital performance in the EU found that "most evidence suggests that public hospitals are at least as efficient as or are more efficient than private hospitals."¹³ Insurance based systems provide little incentive to limit tests and investigations but ample motive to recommend more, necessitating initiatives such as Choosing Wisely, which originated in the US.¹⁴

KEY MESSAGES

- The UK is best served by a health service that is predominantly publicly funded and predominantly publicly provided
- Non-public providers should be confined to a minor contribution
- Evidence shows that major non-public sector provision impedes monitoring of quality and effectiveness and leads to inequity and exploitation, with suboptimal care for rich and poor
- This contributes to progressive destabilisation of the public sector, poor cost efficiency, loss of focus on population health, and damage to the wider national economy

Employment market dynamics

Employment conditions also feature in the public versus private debate. But this complex factor differs across the variety of roles in a health service.

For some senior doctors, the opportunity to work independently in the private sector carries professional advantages, such as increased autonomy, higher income, and time to provide a more personal and responsive service. These latter characteristics are likely to appeal to patients seeking rapid access to an experienced doctor. Notably, however, the NHS has a majority medical workforce proud to work in the public sector and eschewing opportunities for private practice.

The dynamics of the employment market may have destabilising consequences for the public sector. In a labour intensive sector such as healthcare, the scope for substantial efficiency gains is limited. So, to achieve “efficiencies” private employers contracted to provide NHS services often bear down on terms and conditions, especially of non-medical staff.^{15,16} At scale, differential contractual arrangements may result in cuts to overall staffing, employment of less skilled workers, and poorer, inconsistent conditions in the NHS.

These circumstances pose major risks to workforce morale and patient wellbeing. Where cleaning services have been contracted out, for example, staff numbers are lower and hospital infections more common¹⁷; contracted out services have also been known to engage in “gaming” to misrepresent performance.¹⁸ When morale suffers, staff leave, as shown by the 100 000 vacant full time posts across the NHS at the start of 2018¹⁹ and by the rate of junior doctors choosing to move into specialist training being only 43% in 2017.²⁰ The sustainability of high quality, publicly provided healthcare may therefore depend in large part on the ability of the NHS to attract, harness, and retain those with highly marketable skills and expertise.²¹

Reducing public sector burden

Many commentators have argued that purchasing from private providers will reduce the strain on NHS services, but



The consequences of a marketised system are that both rich and poor people are vulnerable

other countries' experiences do not support this. Even when the healthcare procedure is clearly definable (such as a hip operation) and has an easily measured outcome (such as survival), the creation of a parallel private sector reduces the number of staff available to work in the public sector and their training opportunities. Public health systems, such as those in Chile²² and Brazil,²³ are chronically short of staff and getting progressively more limited in what they can provide as a result of a parallel private sector, a situation that is now emerging in the UK.²⁴

High throughput NHS theatre lists may offer advantages over outsourcing to the private sector—surgery delivered according to need, assessed using consistent criteria, supervised training opportunities, and carrying negligible transaction costs. Instead, the emerging situation is that the public sector deals with complex cases, chronic conditions, and complications, and invests in staff training, while the private sector cherry-picks simple cases and rarely provides training. Private maternity providers, for example, charge large sums for overseeing normal deliveries in healthy women but transfer very preterm or sick babies to the NHS.²⁵ The Care Quality Commission has noted the reliance

of the private sector on the NHS as a concern²⁶ and the destabilising effect on NHS general practice of online private consultation services that accept only healthy patients.²⁷

Size, power, and influence

The relative size, power, and influence of providers is a further consideration. Those for and against markets tend to conflate all private providers, whether small social enterprises and charities or global corporations. Yet they are entirely different. The former tend to occupy specialist niches for universal benefit. The latter are positioned to take a dominant position in a system that allows them to set the rules in their favour.²⁸ Independent sector treatment centres (ISTCs) are private sector providers contracted to treat NHS patients. ISTC contracts are designated “commercially confidential,” thereby outside the Freedom of Information Act. One study of a Scottish ISTC indicated that large payments were being made for patients who were not actually treated.²⁹ ISTCs have also been shown to engage in “up-coding,” where patients are categorised with more severe conditions to charge higher payments.³⁰

The involvement of large private corporations in the NHS, many of which are household names, has other implications for the public purse, including costly and protracted litigation. Several providers have challenged, or threatened to challenge, the NHS when not awarded contracts and have received substantial sums of public monies in recompense.^{31 32}

Quality of care

Quality, efficiency, and effectiveness are important for any health system. A recent overview of systematic reviews concluded that, in general, outcomes are worse in private-for-profit hospitals than in others hospitals.³³ In the UK, some ISTCs achieved better outcomes than NHS facilities for elective surgery, but the differences were marginal despite having healthier, more affluent patients.³⁴ Moreover, outcomes were not adjusted for key influences such as BMI.³⁵ ISTCs also provide poorer training environments,³⁶ reduce communication across institutional boundaries,³⁷ and, in an example where surgery was transferred from a NHS hospital to a nearby ISTC, reduce overall activity.³⁸

Private providers can also exempt themselves from certain evaluations; for example, no private provider of neonatal services in the UK is evaluated through national audit.³⁹ The Centre for Health and the Public Interest (a non-party think tank) identified several systemic safety risks specific to the private hospital sector such as inadequate medical cover and poor ability to deal with patients with serious complications.⁴⁰

The NHS is facing major challenges from the fragmentation of patient care pathways across the multiple care providers that have emerged after the 2012 Health and Social Care Act. Knowing where responsibility and accountability lie in a fragmented system is difficult. The addition of private providers, the incentives and values of which are not necessarily aligned with public care providers, risks worsening this situation.



A healthcare market increases the likelihood of inequity

Collateral effects

The wider economy is affected by a nation's health system choices. The 2012 Health and Social Care Act removed the duty of the health secretary to "provide" a comprehensive service; this was a shift in the primary responsibility of government from population health to population (universal) health coverage. Additionally, when profit is the primary goal, efforts to tackle the wider determinants of health are likely to be disadvantaged. Current efforts to curb the power of the junk food industries are a case in point. Although a government "obesity strategy" has been published, it has been widely criticised for being weak and overly accommodating, while obesity related conditions impose annual costs of more than £6bn on the NHS and around £27bn on the wider economy.⁴¹

We must again differentiate between small and large private providers. Small providers support local economies and are likely to pay their taxes. Some large provider corporations pay virtually no UK taxes.⁴² All for-profit providers must produce a return on capital to investors. Those driven by short term gain have an incentive to strip assets; those with a longer term perspective may engage in predatory pricing to capture market share and drive out the public sector. The consequences can be seen in the failure of several for-profit organisations (such as Serco) to fulfil contractual obligations after taking over NHS services,^{43 44} inflicting further damage on the public purse.

Size also matters for charities and non-profit social enterprises. Some

of the largest pay extremely high executive salaries, thus reducing funds available for frontline care. The top three highest paid charity executives in the UK in 2014 were in the independent health sector.⁴⁵

Evidence, not ideology

The evidence available does not support a substantial role for the private sector in healthcare. Where non-public sector provision is used, it should be limited to small and medium enterprises and to minor contributions. This has wider implications for the UK, with a case for bringing general practice fully into the state sector.

Given the evidence against private providers, why is a marketised healthcare model being introduced progressively to the UK? The legalised opening up of the NHS to private sector providers through the 2012 act has given rise to all of the consequences described.⁴⁶ We suggest the only plausible explanations are lack of understanding of the empirical evidence, self interest, or ideological belief. If the UK is to retain a high quality, efficient, effective, equitable health service, the evidence and implications of the current route must be widely understood and acted on.

Conclusions

Debate centred on a simple public-private dichotomy is unhelpful, but there are multiple, cogent reasons why the UK is best served by a health service that is both predominantly publicly funded and provided.

A healthcare market increases the likelihood of inequity and exploitation, with suboptimal care for both rich and poor. The creation of complex, fragmented provider networks impedes attempts to monitor quality, patient outcomes, and other measures of effectiveness.

The public sector is progressively destabilised as private providers offer higher pay and select easier cases but contribute little to training. Cost efficiency is compromised by the rise in transactional costs, public monies being diverted to profit, and public sector bail out when things go wrong.

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SURGE IN SURGERY REFUSALS

Patients should not be denied hip surgery

It is concerning that patients are having to apply for exceptional funding when referred for hip surgery, which is increasingly refused (This Week, 21-28 July).

Although many patients with hip arthritis are successfully managed conservatively, symptoms worsen with compromised function and increasing pain. Prolonged waiting times lead to worsening deformity, muscle wasting, and bone loss. Timing of referral is critical.

We must be honest and upfront. I see patients who have been told that they are too young, that hips only last five years, or that they can have only one replacement. Such negative information can be used to justify what are, as Thorman and Nanu say, financial reasons to limit referral. Patients should not be denied access to such a cost effective and reliable intervention.

Hip replacement is inextricably linked to the 70 year old NHS. If that link is to be maintained, orthopaedic surgeons must accept responsibilities to the wider healthcare economy, being cost effective and evidence based in their decisions and fastidious in their surgery.

Andrew Manktelow, president, British Hip Society

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Rationing policy will do far more harm than good

NHS England's list of restricted procedures normalises denying patients effective treatments. Shifting between pretexts of "clinically obsolete" and "too expensive," it is the antithesis of a sensible, pragmatic response to planning provision.

The example of Doncaster shows how this rationing is both clinically inappropriate and negatively cost effective. Most of the 24 out of 25 patients being



A crowd in Dublin celebrates the result of the Irish abortion referendum in May

LETTER OF THE WEEK

Students get inadequate abortion training

Goldbeck-Wood et al call for the government to update the UK's abortion laws (Editorial, 21-28 July). As a medical student, I am concerned that induced abortion is covered only in the personal and professional development component of the undergraduate medical curriculum. This component helps students reflect on their own views and the perspectives of others by debating controversial topics.

Considering one in three women in the UK will have an abortion, I am shocked that we are not taught the basics of managing an unwanted pregnancy. As with other health matters taught at medical school, the subject requires a holistic approach, considering appropriate counselling and support, medical and surgical management, alternative options, and complications.

The current abortion laws are complicated and, as described by the authors, encourage "clinical contortion." Consequently, the current legal framework hinders the integration of abortion teaching into the undergraduate gynaecology programme and undermines the importance of a reproductive rights based approach to women's health education. Future clinicians may be misinformed and underequipped with the knowledge to manage an unwanted pregnancy. This may contribute to the current shortage of trained medical personnel working in abortion services, leading to long and variable waiting lists.

Decriminalising abortion is the necessary way for the UK to ensure women and girls receive high quality, safe abortion care and will enable medical students to receive adequate teaching on this subject.

Rachel Burton, medical student, Liverpool

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refused knee replacements will probably end up having them anyway. This is doubly detrimental: to the patient left with progressive disability and pain, and who may come to further harm from falls or medications, and to the NHS, which incurs clinical and administrative costs—perhaps even litigation—as a result of the delays.

This is an insidious rationing policy that will do far more harm than good. Unnecessary and neither clinically nor cost effective, it deprofessionalises doctors, places conflicts in the doctor-patient relationship,

prevents doctors from acting in each patient's best interests, and creates a societal pressure for patients to pay for this care.

Nick Mann, GP, London

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Individual funding request process is bad for everyone

The individual funding request process is detrimental to doctors as well as patients.

In 2005 I had difficulty accessing a course of manual lymphatic drainage for midline lymphoedema that was caused by NHS cancer treatment.

Eventually the primary care trust commissioned an intensive course at a hospital that usually treated only arm lymphoedema.

Treatment benefits lasted years. Then my usual clinic said it would treat only new patients. I moved to a hospice based clinic that could not afford to offer intensive manual lymphatic drainage, so my GP applied through the individual funding request process. I was denied.

The knowledge of the CCG seemed limited; it suggested I apply to the hospital that had already refused further treatment, then to the clinic from which I had been discharged, and finally, to the hospice clinic that could not afford to treat me.

Thanks to this process, there is no NHS for a condition induced by NHS treatment.

Mitzi A J Blennerhassett, *BMJ* patient reviewer, York

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WELLBEING

Tackling burnout in trainee doctors is vital to the NHS

The findings of the GMC's survey on burnout raise concerns about patient care (Seven Days in Medicine, 14 July). In a recent meta-analysis we found that the association between burnout and low professionalism was two times higher in trainee and early career doctors than in more experienced doctors. As such, tackling burnout in trainee doctors has strategic importance for the provision of safe, high quality patient care.

We have recently piloted the delivery of well received resilience training intervention to obstetric and gynaecological registrar doctors and mindfulness courses to foundation year doctors. Although such programmes should be accompanied by organisational improvements, these early findings are encouraging.

Judith Johnson, lecturer, Leeds; Chris Bu, foundation doctor year 2, Liverpool; Maria Panagioti, senior research fellow, Manchester

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OBITUARIES

Denis Anthony Mitchison

Emeritus professor of bacteriology (b 1919; q 1943; FRCP, FRCPath), died from a heart attack on 2 July 2018

Denis Anthony Mitchison was born in Oxford into a family

of scientific and scholarly distinction. Throughout his academic life, Mitchison had a major role in the treatment of tuberculosis. His most important contribution, together with colleagues, was identifying combinations of different drugs that shortened the duration of treatment for TB from 18 months to six months. Such short course regimens are the basis of current standard therapy worldwide. At the time he finally retired in 1995, he was engaged in work that may eventually lead to treatment reduction to four, or even three, months. He was the author of more than 300 scientific papers and received many awards. His work has saved vast numbers of lives. Denis Mitchison leaves two children, four grandchildren, and two great grandchildren.

Amina Jindani

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Gwyn Howells

General practitioner (b 1932; q Welsh National School of Medicine, Cardiff, 1954; RD, FRCGP, DCH), died from metastatic colon cancer and aortic stenosis on 29 November 2017

In 1957 Gwyn Howells joined the St Helen's Road practice in Swansea, where he stayed until his retirement. He took an active interest in medical politics and was a founder member of the South Wales Faculty of the Royal College of GPs. As medical officer to the local training centre Gwyn became interested in the care of people with learning difficulties; his paper in 1986—"Are the needs of mentally handicapped adults being met?"—reflected his belief that general medical skills could be used more effectively. Gwyn's ideas, later adopted throughout the UK, had substantial input into the Welsh strategy for the community of those with learning difficulties. Gwyn leaves Enid, his wife of 61 years; two sons; and five grandchildren.

David Horsman, Enid Howells

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William Dewi Rees

General practitioner and palliative care medical director (b 1929; q St Thomas' Hospital, 1956; MD, FRCGP), died after a stroke on 5 May 2018

Having worked in Canada and Wales, William Dewi Rees ("Dewi") became a GP in Warwickshire. From 1980 until he retired in 1990 he was medical director of St Mary's Hospice in Birmingham. In 1968 he published a paper in *The BMJ* on fatal agricultural tractor accidents, which led to Parliament passing a bill requiring tractors to be fitted with a protective safety cab. His subsequent research was in bereavement and care of the dying. His work on hallucinations of widowhood, also published in *The BMJ*, gained him an MD from the University of London. He published more than 20 papers and wrote four books. Dewi held a strong Christian faith and was interested in comparative religion. His wife, Valerie, predeceased him in 2006. He leaves three children.

Michael Millar-Craig

Cite this as: *BMJ* 2018;362:k3511



Alan Patterson

Consultant ophthalmologist (b 1933; q Liverpool 1956; MD, DO, FRCS, FRCOph), died from old age on 23 November 2017

Alan Patterson was a consultant

ophthalmologist at St Paul's Eye Hospital and Alder Hey Children's Hospital in Liverpool. He was also director of ophthalmic studies at the University of Liverpool from 1968 to 1998. He studied ophthalmology at Moorfields Eye Hospital and specialised on the anterior segment of the eye. He published important scientific papers, and his work on herpetic infections of the cornea underpins clinical practice today. Alan established the excimer laser and refractive eye service at St Paul's eye unit. He developed eye problems late in life and commented, "I am now a patient and have learned that when the instruction 'Read the chart from the top, please' applies to you, life is very different indeed." He leaves his wife, Flo; three children; and five grandchildren.

Stephen Kaye

Cite this as: *BMJ* 2018;362:k3515



Darrel Orlando Ho-Yen

Consultant microbiologist and honorary senior lecturer Raigmore Hospital, Inverness (b 1948; q Dundee 1974; DSc, MD; MRCPPath; MRCP (Hon)), died from a myocardial infarction on 31 October 2017

Darrel Orlando Ho-Yen came to London from British Guyana in 1962 and secured a place at Dundee medical school in 1968. He took up his consultant post in the department of microbiology at Raigmore Hospital in 1987 and stayed until he retired in 2011. He maintained the toxoplasmosis reference laboratory status and later established a new testing service for Lyme disease. He published more than 100 peer reviewed articles over his medical career, completed his DSc in 2001, and wrote several book chapters and books. Darrel will perhaps be most fondly remembered for his desire to get the most out of those around him. He leaves his two children, Gregory and Colan.

Colan Maxwell Ho-Yen, Gregory Orlando Ho-Yen

Cite this as: *BMJ* 2018;362:k3520



William Tong

Consultant virologist Barts Health NHS Trust and honorary reader Queen Mary University (b 1958; q University of Hong Kong 1983; MSc, FRCPath, MD, FRCP), died from a subarachnoid haemorrhage on 2 May 2018

William Tong came to the UK in 1990 and in 1992 was appointed to the University of Liverpool and Royal Liverpool Hospital. In 2000 he moved south, and in 2013 he started at Barts Health NHS Trust and Queen Mary University. He contributed to service development, infection control, research, teaching, training, and examining. His clinical and research focus was on bloodborne viruses, sexually transmitted infections, HIV and AIDS, transplant infections, enteroviruses, rhinoviruses, novel diagnostics, and emerging infections. His particular interest was in emerging infections and infection control. William's work was underpinned by his strong Christian faith. He leaves his wife, Pandora, and two daughters.

Eithne MacMahon

Cite this as: *BMJ* 2018;362:k3505



Ogobara Doumbo

Malaria researcher who was committed to improving research and healthcare in Africa

Ogobara Doumbo (b mid-1950s; q National School of Medicine and Pharmacy, Bamako, Mali, 1979), died from complications of surgery on 9 June 2018 at a hospital in Marseilles, France

The unexpected death of Ogobara Doumbo in a hospital in Marseilles, France, was a shock to his friends and colleagues around the world. An official cause of his death was not publicly announced. French news reports said, however, that he had experienced complications from an operation performed in Mali and was flown in a critical condition to Marseilles for treatment. After his death, members of his family, including sons, daughters, and grandchildren, collected his body and returned to Mali, where Doumbo was honoured with a state funeral in Bamako on 16 June.

Life and career

Born in Mali in the mid-1950s, Doumbo did not know the exact date of his birth, as there was no health post in his village to make a legal record. His birthday is normally listed as 1 January 1955, but in some cases 1 January 1956. French news reports about his death listed his age as 63.

His village—which had no electricity—was in Dogon country, a region of long history, magnificent landscapes, and rich culture that is a designated Unesco world heritage site. Doumbo was known to be extremely proud of his heritage. His father was a traditional healer, as was his grandfather, who was well known as a healer of pharyngitis and breast tumours and infections. Doumbo sometimes accompanied his grandfather on trips to other villages to treat patients.

By the age of 10 Doumbo had decided he wanted to be a doctor. Seven years later he started studying medicine at the National School of Medicine and Pharmacy in Bamako, where during his second year he came under the influence of French internist

Bernard Duflo. After graduating in 1979, he spent two years at Point G hospital in Bamako, training in internal medicine. He then was appointed as a rural district medical officer based in Selingué. In addition to general medicine, he also performed surgeries and delivered babies, some by caesarean section. His patients included people with river blindness, schistosomiasis, and malaria.

In 1984 he moved to France, first studying parasitology and immunology in Marseilles. Here he started working on a research project with parasitologist Philippe Ranque, who also held an appointment at Point G hospital in Bamako. In Marseilles, Doumbo also studied medical anthropology at Aix-Marseille University, receiving a masters degree in 1987. He then moved to the University of Montpellier to focus on parasitology, receiving a PhD in 1992. He later studied in the US, receiving certificates in biostatistics and epidemiology from Johns Hopkins University and in international research ethics from Harvard University.

Malaria research

During his seven years in France, he returned home to Mali during breaks to maintain contact with villagers. On one visit home Doumbo, who was addressed as “Ogo” by his friends and colleagues, met malaria expert Louis H Miller from the US National Institute of Health’s National Institute of Allergy and Infectious Diseases (NIH-NIAID), who wanted to expand research capacity in Africa. With guidance from Miller and the support of NIH-NIAID, Doumbo and his colleague Yeya Touré in 1992 founded the Malaria Research and Training Centre at the University of Science Techniques and Technologies. The centre is based in Bamako, but includes a research network spread across Mali. Additional support for the centre later came from WHO, the government of Mali, and the Rockefeller Foundation.



He was involved in dozens of Mali based and global projects in all areas of malaria research

Over the years, Doumbo was involved in dozens of local and global projects in all areas of malaria research, including drug and vaccine trials. Miller said that Doumbo was part of an extremely important project that helped “develop the evidence for the parasite gene that caused chloroquine resistance, the most important problem for malaria that increased death from *Plasmodium falciparum* malaria.” The project yielded several key papers.

Doumbo’s work also includes key contributions in the development of seasonal malaria chemoprevention strategies for pregnant women and children younger than 5 years. The strategies were endorsed by WHO in 2011 and 2012. In recognition of his contributions, the French National Institute of Health and Medical Research in 2013 awarded Doumbo its international prize, one of his many honours and prizes.

Doumbo mentored more than 60 doctoral candidates and postdoctoral trainees, several now in leadership positions in Mali and dozens working in Africa, Europe, and the US.

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Cite this as: *BMJ* 2018;362:k3125

 **WHAT YOU'RE TWEETING ABOUT**

Communicating about patients

Abraar Karan calls for doctors to communicate about patients in ways that are more person centred on page 317 of this week's issue. Here's what readers on Twitter said the article meant to them:

I'd really like to stop referring to human beings by their bed numbers please...
#hellomynameis Segun @iceman_ex

This resonated with me... asking "if I had met you before you were unwell, tell me about yourself then" helps personalise my consultations
Catriona Mayland @CattyRM

In the emergency department it can be difficult to get a full social history on every patient, but I usually find the information helps establish a trusting patient-doctor relationship and can be helpful in diagnosis... Patients like it too
Nick Sawyer @NickSawyerMD

We ask new patients to write "goals/questions for the visit"... these identify patient



priorities not what you think they should be
Terri Armstrong @Tsarmstrong01

Can't imagine how less interesting my day would be if I didn't have proper conversations with the patients I see, and get to know them as people. Last week I found out about GCSE grades, career plans, and Paw Patrol
Amit Bali @amitkbali

One of the things I really love about being a #geriatrician and a #palliativecare specialist is that to do my job well, knowing my patients' human stories is just as important as knowing their medical histories
Dr. Clairebear @dr_clairebear

This is just one of the reasons for the past 20 years I send a copy of my clinic letters to the patient. It changes how we write about them. It helps me remember what's important to them. I much prefer recalling details about people rather than diseases
Peter Martin @petermartinsept

I would add—it's not just how physicians talk about their patients, but how we talk with them: rather than starting with "so, what brings you in...?", instead: "tell me about yourself..." My most meaningful interactions with my patients start with *knowing* them
stephen kriegler @SKrieglerMD

MOST READ ONLINE

Margaret McCartney: A summary of four and a half years of columns in one column

 • [BMJ 2018;362:k3745](#)

Statins for primary prevention of cardiovascular events and mortality in old and very old adults with and without type 2 diabetes
 • [BMJ 2018;362:k3359](#)



Diclofenac use and cardiovascular risks
 • [BMJ 2018;362:k3426](#)

GP is struck off after being jailed for human trafficking
 • [BMJ 2018;362:k3665](#)

Pay rise for doctors in England is announced
 • [BMJ 2018;362:k3236](#)

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NEW BMJ PODCAST

Nutritional science—is quality more important than quantity?

"We've been focusing for 30 years on trying to reduce obesity by telling people to eat less and I don't think we need to do that. I think that's the wrong approach. We need to tell people to eat better and in fact eat more of the healthy foods... and so I think it's about quality, not quantity."

Dariusz Mozaffarian, dean of the Friedman School of Nutrition Science and Policy at Tufts University, Massachusetts, discusses quality as the driver of a good diet in this latest

podcast, which is part of an ongoing series on food and nutrition. The study of nutritional science contains many areas of disagreement, but one thing that is widely agreed on is that food quality matters. This podcast explores what quality is; how the industrialisation of our food has changed quality over time; and how we conceptualise quality, including the rise of the clean eating movement.

 Listen to this podcast at http://bit.ly/diet_quality_quantity