The adult social care workforce is ageing, low paid, and heavily reliant on immigration

Crisis in the supply of care homes

Care homes are a neglected area of public policy that we have to get right. Pressure on care home places is increasing, alongside huge recruitment and funding problems.

Last year Oxford Brookes University’s Institute of Public Care (IPC) studied data from the Care Quality Commission and found that, from April 2012 to April 2017, the number of care homes in England fell by 8%, from 17 801 to 16 392.

In the UK the term “care home” commonly refers both to residential care homes and nursing homes. While nursing homes employ registered nurses, care homes now increasingly care for older people with complex needs and physical dependence, disability, or cognitive impairment. The IPC found that the average size of newly opened care homes (37 places) was greater than in those that closed (29), so the number of places for older residents increased by 4%, from 387 485 to 404 163. Yet potential demand has outstripped this expansion, as the number of citizens aged over 85 increased by 16%.

Staffing these homes is also a challenge. Skills for Care has estimated 1.6 million jobs in adult social care, with annual turnover of 30%. Nearly half of these staff work in adult residential and nursing care, with vacancy rates of 11%. The workforce is ageing, low paid, and heavily reliant on immigration. The NHS, and less emotionally demanding and responsible industries, compete with the sector for staff, and recruitment and retention may be further harmed by visa restrictions and the impact of Brexit. Repeated cuts in local government funding (hence adult social care) have made the care home market ever more challenging for operators. The introduction of the national living wage has created further pressures.

I see no meaningful prospect of care homes no longer being required in my lifetime, no matter how much we invest in prevention and support at home. Modelling has shown that people living longer will lead to more years spent in high dependence. Even health systems lauded for their person centred processes and community approaches such as those in the Netherlands and Sweden still have significant per capita places in long term care homes, exceeding those in the UK.

England has serially slashed investment in public health. We’re building too few age friendly homes, including schemes such as sheltered accommodation or extra care housing for frail or dependent residents. Unpaid, informal family caregivers are already working flat out, at detriment to their own health. The recent national State of Caring survey by Carers UK portrayed a grim picture of poor support, inadequate information, and low morale.

With an ageing population and around three times as many people in care homes as in hospitals, and with many hospital patients unable to access community assessment or rehabilitation after acute illness or injury, the issue of care homes shouldn’t be treated by policy makers as invisible or relegated to the “too difficult” file. It deserves far more prominence and attention.

David Oliver is a consultant in geriatrics and acute general medicine, Berkshire  davidoliver372@googlemail.com

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**PERSONAL VIEW** Agnes Arnold-Forster

**Doctors’ wellbeing: learning from the past can improve the future**

Too much of the current focus on clinicians’ emotional health is caught up in piecemeal solutions

There has been much focus recently on doctors’ emotional health and the threat of burnout. There are campaigns to excise bullying from certain specialties, as well as research into wellbeing, institutional policy initiatives, and think pieces, all of which attest to this seemingly new concern.

Much of the conversation, however, is historically inaccurate and is coloured either by nostalgia for a fictitious past or is preoccupied with piecemeal initiatives that take little account of the structural, political, and historical context of the NHS.

In my current research, I conduct oral history interviews with practising and recently retired surgeons. I ask them to narrate their lives and we explore the emotions of their personal and professional experiences. When asked about the emotional cost of care and their working conditions, almost all hark back to an era before the introduction of the EU Working Time Directive. They reflect on the compassionate connections they could form with their patients when they were able to maintain continuity of care and talk about long working hours that were made bearable by the emotional support provided by the “firm.”

Histories of surgery and hospital care in the 1960s, 70s, and 80s reveal a different picture, however. They paint one of a hierarchical, male dominated, and exhausting system that relied on nepotism and bravado. They tell stories of male consultants who depended on their wives to perform the domestic labour and childcare that allowed them to work uninterrupted.

These histories also reveal a recurring pattern of initiatives that attempted to improve the emotional resources available to doctors.

Many recent schemes set up to improve the workplace cultures of the NHS position themselves as innovative and unprecedented, but history shows that this is not the case.

**Social spaces**

From the foundation of the NHS to the late 1970s, articles published in *The BMJ* repeatedly called for the preservation in hospitals of social spaces dedicated to doctors, the protection of surgeons’ lunch hours, and the provision of psychoanalytical and therapeutic support for staff.

None of this is to say, however, that those concerned about the emotional health of medical practitioners today have nothing to learn from the past. Indeed, the current conversation about the conditions of the NHS workforce is often trapped between

**Histories paint a picture of a hierarchical, male dominated, exhausting system that relied on nepotism and bravado**

**BMJ OPINION** Neal Russell, Sophie Windsor, Susan Bewley

**Effect of a “hostile environment” on maternal health**

A report released last month by Maternity Action reveals the experiences of women who are faced with NHS charges for accessing maternity care in England. It makes uncomfortable reading and should be a clarion call for change.

Many comparable European countries offer free pregnancy care to undocumented migrant women regardless of immigration status, whereas the UK charges a disproportionate 150% of the NHS tariff. These regulations were reinforced in October 2017 when the government introduced a requirement (applying only in England, so far) to charge upfront, and withhold treatment from those unable to pay, unless the treatment is “urgent” or “immediately necessary.”

Pregnancy care is classed as “immediately necessary” and should always be provided without prior payment. The report makes clear, however, that fear of being charged—as well as threatening letters, phone calls, and debt collection practices—is having profoundly negative consequences for women. In addition, hospitals share patient details with the Home Office if bills are unpaid, effectively linking the search for healthcare with immigration enforcement—a practice still occurring despite the suspension of routine data sharing.

The policy is having a devastating effect on some of the most vulnerable pregnant women, raising serious concerns about the potential for poor health outcomes for women and their newborn babies.

The undocumented migrant women in the report, similar to previous studies, had generally been living in the UK for several years in
Effect of a “hostile environment” on maternal health

BMJ OPINION
Neal Russell, Sophie Windsor, Susan Bewley

It would be unethical, to wait for any independent inquiry into all charges, to suspensions of the charging regime. Mothers and newborns are facing deepening destitution. Women, new mothers, and babies are bearing the brunt of regulations now.

A third way
Instead, we need a third way. We need to work out what we did right, do away with programmes and policies that only place demands on individual doctors, and think about how we might adapt systems that have been successful in the past to a 21st century world and workforce.

Historical research has a place in policy debates about doctors’ mental and emotional health. It serves to inoculate discourse and decision making against nostalgia and helps us to ground programmes and innovations in their historical and structural contexts.

On its 70th birthday, the NHS deserves policies that protect the emotional health of its workforce and safeguard its future without harking back to a fictitious golden age of healthcare past.

Agnes Arnold-Forster is a postdoctoral research fellow, Wellcome Trust investigator award, University of Roehampton, London

Cite this as: BMJ 2018;363:k4101

Debates over NHS privatisation miss the bigger picture

One of the main concerns about the NHS, which has led to the formation of a number of pressure groups, is the worry that it’s slowly being privatised.

It would be safe to say that if there are plans to privatise the NHS, then they are being kept secret and their existence is repeatedly denied. Those who continue to believe there is an agenda for privatisation could be considered conspiracy theorists. I used to be one of them, but now I am much more agnostic about privatisation.

First, one needs to work out which definition of privatisation to use. Those who most fear its encroachment into the NHS could argue that the World Health Organization’s definition is appropriate: “a process in which non-government actors become increasingly involved in the financing or provision of healthcare services.”

Yet if one was to use WHO’s definition, then parts of the NHS are “private” already: general practice, retail pharmacists, opticians, dentists. Various parts of the NHS have been outsourced to businesses, or privatised depending on your interpretation, for many years. With the advent of the 2012 Health and Social Care Act the possibility of outsourcing more services was encouraged.

Privatisation of nationalised services in the UK has nearly always happened in a “big bang,” resulting in the sale of shares and transfer of asset liability. Yet the oft repeated fear for the NHS is that privatisation will happen by the backdoor. I would argue that piecemeal outsourcing of services by different clinical commissioning groups doesn’t reflect an underlying Machiavellian plan to undermine public ownership of the service, but these debates can risk blinding us to a bigger picture.

It is often said that the NHS is the one true religion of the UK—virtually everyone believes in and defends it. But it’s worth considering if this blind faith will serve our healthcare system and its future needs. We need a shift in the questions we ask of the NHS. We should be asking what type of service will give the country the best health outcomes.

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Privatisation of nationalised services in the UK has nearly always happened in a “big bang,” resulting in the sale of shares and transfer of asset liability. Yet the oft repeated fear for the NHS is that privatisation will happen by the backdoor. I would argue that piecemeal outsourcing of services by different clinical commissioning groups doesn’t reflect an underlying Machiavellian plan to undermine public ownership of the service, but these debates can risk blinding us to a bigger picture.

It is often said that the NHS is the one true religion of the UK—virtually everyone believes in and defends it. But it’s worth considering if this blind faith will serve our healthcare system and its future needs. We need a shift in the questions we ask of the NHS. We should be asking what type of service will give the country the best health outcomes.

Parts of the NHS have always been outsourced, and more parts are following that route. Instead of wasting energy on arguing whether this constitutes the slowest privatisation in the history of privatisations we should be working out if and how this affects health outcomes. Instead of yet more NHS reforms, what is needed is an NHS Reformation.

Samir Dawlatly is a GP partner at Jiggins Lane Medical Centre, Birmingham
Improving cities for global health

Majid Ezzati and colleagues call for greater action to reduce health inequalities in urban areas

The number of people, and proportion of the world population, living in cities has increased steadily, with 4.2 billion urban residents now accounting for 55% of the world’s population (fig 1). That urban living influences health is well recognised and increasingly included in broader discussions about cities and sustainable human development. The general tone of such discourse, however, tends towards the negative aspects of infectious outbreaks, vehicular pollution, waste disposal, and unhealthy lifestyles rather than the positive and progressive aspects of cities.

Empirical evidence strongly points to urban residents having better health than their rural counterparts since at least the early to mid 20th century, in high income as well as low and middle income countries. The health advantages of urban living, however, are unevenly distributed in cities, with massive inequalities existing over short distances (fig 2). Reducing inequalities is fundamental because population health suffers where inequalities are larger.

The urban health literature commonly uses the “healthy city” concept to frame discussions. The idealised healthy city, although aspirational, can easily be disconnected from the complex dynamics of urban development, in which cities’ demographies and social, natural, built, and food environments are constantly changing through interactions between individual, corporate, and public actions. Limited attention has also been given to the essential role of urban services, including healthcare, childcare, and public safety.

The policy challenge for improving health in cities, first laid out a century ago by Chapin, remains—to identify and implement institutional and technical innovations in every sector that form transition pathways to better health, taking into account the contemporary local social, demographic, and economic conditions. We discuss a set of themes in which municipal governments and administrators (referred to as “cities” hereafter) can foster innovation in technology and practice, and achieve economies of scale in services that improve the health of residents and benefit a wider geography, with emphasis on reducing health inequalities.

Defining the role of cities in global health

Environment

The infrastructures, technologies, and regulations that provide clean sanitation and water have been a cornerstone of health improvement in cities for centuries.

Although much recent attention has been on water quality, many cities face severe water shortages due to inefficient management and unfavourable natural or human induced hydrological cycles. Shortages have led to rationing and rising costs, disproportionately affecting poor people.

Other urban environmental factors that affect health include air and noise pollution, green space, and the overwhelming volume of general solid waste, as well as electronic, battery, industrial, and other toxic waste.

Cities can reduce pollution through infrastructure planning and regulations that change energy or transport technologies and behaviours. But the inequality challenge remains, as poorer areas are often designated to accommodate waste from richer areas of the same city or even from other locations.

Housing

Housing affects health through both social (interaction versus isolation) and physical (temperature, moisture, mould, pollutants, sunlight, and crowding) environments.

The agglomeration benefits that attract people to cities inevitably create higher living densities and housing costs, which in

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Fig 2 | Life expectancy at birth in 2012 in London’s local authorities. Data are from Bennett et al"
larger cities are exacerbated by the presence of highly paid expatriate staff employed by multinational corporations. The high cost of housing leads to inequalities in housing quality and neighbourhood conditions (fig 3). It also reduces the income that people have available for food, healthcare, energy, education, and leisure or limits the time that people can spend on these because they commute longer distances.

More broadly, cities can tackle housing challenges through high quality state owned social housing and through fiscal policies and regulation that incentivise housing associations, public-private partnerships, or private entities to develop safe and healthy housing that operates at low cost and in the interest of low income people.

Addiction
Cities provide a focal point for the distribution and consumption of addictive substances (tobacco, alcohol, and illicit drugs). Both commercial and informal suppliers typically target poor and vulnerable communities.

Cities have an important role in tackling addiction and its health consequences; they can, for example, levy additional taxes beyond national or provincial dues; restrict the locations and opening times of alcohol and tobacco outlets through licensing; regulate product advertising; legislate smoke-free areas; raise the minimum legal age for sales; institute sobriety checkpoints and random breath testing; implement designated driver campaigns; sanction the use of currently illicit substances in monitored locations for harm reduction; and provide addiction counselling and treatment services.

Universal health coverage
Universal health coverage has emerged as a priority for national and international health agencies. Although financial protection and limiting out-of-pocket payments often comes under national or provincial jurisdiction, some cities provide additional safety nets for those without insurance coverage.

More importantly, health services in cities both provide care to their own residents and act as referral hubs for rural residents who need specialist care because the higher population density and reduced distances in cities facilitates regular and frequent interaction with primary health services, and provides economies of scale for secondary and tertiary care.

City living might isolate vulnerable groups, including elderly people, and limit or delay their use of health services. Compensating mechanisms include an integrated primary health and social care system and combining new sensing and communication technologies with key health workers to ensure interactions are made in time to prevent severe declines in health.

Public safety and emergency response
Public safety and emergency response are essential city functions that, under normal conditions, can contribute to health through prevention (enhanced neighbourhood and traffic safety and crime reduction) and through mitigating adverse outcomes from acute events (faster response to heart attacks, road traffic accidents, and fires).

Achieving these objectives requires sustained investment in infrastructure and personnel, including street lighting, fire services, ambulances, police, and paramedics, as well as training and oversight to ensure equal treatment of citizens. Extreme events can overwhelm services and require an agreed contingency plan that includes a well rehearsed command structure, a communications strategy, recovery management, and a good understanding of the role of government agencies and civil society, which should all be established before the crisis arises.

Infectious disease outbreaks
Because of their population concentration and connectivity, cities are a rate enhancing or rate limiting gateway to infectious disease transmission, with consequences that extend beyond health, as seen recently with Ebola. This makes detection and control of epidemics a direct function of cities, which requires robust outbreak surveillance, detection, and control systems that are coordinated between neighbouring municipalities.

Non-drug interventions are often the first—and sometimes the only (especially in resource poor settings)—line of defence against outbreaks. Quarantine, isolation, and contact tracing are almost always carried out by municipal public health authorities.

Cities also have a major role in the distribution of antiviral drugs, for prophylaxis and for treatment, and vaccination campaigns, both of which featured prominently in the 2009 H1N1 pandemic.

Finally, an important route for introduction of infections in cities is when infectious agents cross the species barrier in wholesale and retail markets, initiating a cascade of events that ultimately seed an epidemic.

Limiting such events requires a “one health” approach that recognises the critical interface between animal and human health and extends to agriculture, aquaculture, and animal husbandry practices.

Smart cities and emerging economies
Advances in sensing, computing, and communication technologies are creating...
unprecedented opportunities, as well as challenges, to improving urban health and reducing inequalities.

Examples include the use of digital footprints for tracking disease and mobile phones for health information and alerts; distributed sensor technologies to detect water and air pollution, mould, traffic flows, and crime; better monitoring of, and response to, health of newborns and elderly people through personalised sensing; better nutrition through online shopping and home delivery; and more active or more efficient transportation through bicycles and car sharing and eventually autonomous vehicles. Such technologies also have the potential to worsen health and widen inequalities.

Sharing systems like Airbnb may be affecting the limited housing supply in cities, and the gig economy may be worsening social inequalities by reducing wages and job security. Home delivery of goods and services and diversion of traffic to reduce congestion could increase air pollution and the risk of traffic related injuries in residential areas, and reliance on online shopping may increase social isolation. Individual cities cannot stop such trends but will need to carefully monitor their penetration and impact and be prepared to intervene through agile legislative, regulatory, and fiscal policies to maximise benefits and minimise harms, especially in terms of inequalities.

Nutrition

Although urban living is often taken as a proxy for unhealthy eating, cities provide opportunities for better nutrition. Infrastructures such as roads and electricity facilitate the trade, transport, and storage of food, which can reduce the effect of agricultural shocks and seasonality and can enhance dietary diversity. At the same time, the commercial nature of food provision can raise the cost of healthy foods and enable transnational and local food industries to market unhealthy foods. This is especially true in poor and marginalised communities (fig 4), where a combination of cost and limited time and space for cooking healthy meals leads to poor nutrition.

Cities can leverage the benefits of food trade and sales through food hygiene laws and inspections and through healthy food programmes that support poor people, such as school meals, food stamps, requiring the availability of healthy foods such as fruits in grocery stores, and restricting the marketing and sales of unhealthy foods. Cities can also use their planning and zoning powers to facilitate access to land and water for urban agriculture, which can improve food security and nutrition.

Migrant, transient, and peri-urban populations

Cities around the world are home to tens of millions of refugees, asylum seekers, undocumented migrants, and internally displaced persons. City boundaries and residents are also increasingly blurred by large groups of transient populations who seek jobs in cities, even in tightly controlled systems such as the Chinese “hukou” (household registration) system, and by large peri-urban communities.

These groups and areas are functionally part of the city but are often administratively hidden and not entitled to full land and residency rights or to services such as waste collection, water connections, social insurance, and healthcare, which worsens social and health inequalities in cities.

Agricultural based industries and off-farm activities that generate sustainable income and better rural infrastructure and services can slow the rural-urban migration. But overcoming these inequalities in cities can be achieved only by administrations acknowledging the presence, contributions, and needs of migrant, transient, and peri-urban populations and by providing equitable access to quality healthcare and promotion of rights to safe accommodation and working environment.

Conclusions

The concentration of knowledge, innovation, economic activity, healthcare, education, and other public services endows cities with the potential to deliver substantial improvements to the health and wellbeing of their residents and those of other parts of the country.

Further, local politics in cities, whereby politicians and citizens live side by side as members of the same community, provide an opportunity to avoid and resist the exclusionary and austerity trends seen in national politics and economics around the world and to make health inequalities the central focus of urban health policies.

A challenge to this, described a century ago by Chapin and equally relevant today, is the fragmented administrative and technocratic systems in cities. Harnessing the health enhancing potential of cities requires using the cross sectoral roles of mayors and city councils to build health and health equity in all policies. Beyond individual cities, global and regional city networks (such as United Cities and Local Governments https://www.uclg.org/ and the C40 network https://www.c40.org/) provide an opportunity for shared learning and coordinated experimentation of innovative policies and how these can be adapted to contemporary local social, demographic, and economic conditions.

Building on this thinking, The BMJ is launching a series of articles on important themes in urban health, such as emerging economies and technologies; extreme events and emergencies; housing; migration; and water resource management. The series will focus on actions cities can take to reduce health inequalities and deliver on their potential to create better and healthier lives for all.

Majid Ezzati, professor of global environmental health, School of Public Health, Imperial College London majid.ezzati@imperial.ac.uk

Christopher J Webster, dean and chair professor of urban planning and development economics, The University of Hong Kong

Yvonne G Doyle, director for London, Public Health England

Sabina Rashid, dean and professor, James P Grant School of Public Health, BRAC University, Dhaka, Bangladesh

George Owusu, professor and director, University of Ghana, Accra, Ghana

Gabriel M Leung, dean and chair professor of public health medicine, LKS Faculty of Medicine, The University of Hong Kong

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Fig 4 The association between deprivation and density of fast food outlets across England’s local authorities (source: Public Health England)
Who will the rehabilitation centre rehabilitate?

The Defence and National Rehabilitation Centre was recently opened with 200 beds, 80 reserved for "seriously wounded soldiers" (Military Medicine, February 2010). It seems destined to fill a non-existent need.

Government figures show that, from 2014 to 2017 (inclusive), only one member of the armed forces was killed by "hostile action." With a working ratio of 10 injured for every fatality, this leaves very few physically injured soldiers to fill the 80 beds.

By contrast, substantial numbers of service personnel acquire occupational medical conditions. These include post-traumatic stress disorder (with a prevalence of 4.8%) and alcohol misuse (18%). Both of these conditions are treatable by modern methods, as recommended by NICE.

Perhaps the military authorities could use the new rehabilitation centre to provide effective treatment to military personnel with non-physical conditions before they return to civilian life.

J Wilson Carswell, retired surgeon, Rickmansworth

Cite this as: BMJ 2018;363:k4110

BAWA-GARBA CASE

GMC failed as a regulator

Hadiza Bawa-Garba has won the right to practise medicine again (This Week, 18-25 August). This is a landmark moment in patient care, and the GMC needs to state what it will do now in the same circumstances.

Doctors would be less likely to be honest about their mistakes and senior doctors like me would have been looking to retire early.

When making potentially career-ending decisions like this, the GMC should have someone in the room who understands the word "enalapril." It didn't when it made the decision to appeal the MPT's decision. In that, it failed the Adcock family, Bawa-Garba, and the public.

Saying sorry is not sufficient; the GMC needs to state what it would do now in the same circumstances. And we need a public inquiry or, at the very least, a detailed analysis by the health select committee on why it took its actions.

David J Nicholl, consultant neurologist, Birmingham

Cite this as: BMJ 2018;363:k4111

Educating the public about medical errors

Doctors around the world have reacted strongly to the Bawa-Garba case because they know what it is like to be forced to cover more than they are supposed to; they understand how disabling it is for IT systems to go down; and they know how not eating, drinking, or resting for 10 hours can affect their focus and thinking. But patients cannot be expected to automatically empathise with doctors.

We need a new generation of doctors to give society an insight into practising medicine under such circumstances. Waiting until something goes seriously wrong will not help the public to understand the effects of context on our performance.

I propose the Bawa-Garba principle for medical error: When an otherwise competent doctor is given an increasing clinical workload in situations of inadequate support or systemic failure, or both, at some point medical error becomes inevitable.

Deen M Mirza, GP, Croydon

Cite this as: BMJ 2018;363:k4112

Helping clinicians complain about system failures

Frontline medical staff have made clear their fear that they are increasingly acting as scapegoats for services that are inadequately resourced.

In child and adolescent mental health, we have seen a rise in complaints made against psychiatrists. Families may criticise the psychiatrist’s care of their child when the heart of the matter lies in the family context. The projection of the parents’ feelings on to the psychiatrist or clinician can feel persecuting. The way in which NHS trusts respond to this type of complaint may be similar to what happened to Bawa-Garba.

We need a new generation of doctors to give society an insight into practising medicine under such circumstances. Waiting until something goes seriously wrong will not help the public to understand the effects of context on our performance.

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Deen M Mirza, GP, Croydon

Cite this as: BMJ 2018;363:k4112

Continued overleaf
this imbalance and empowering clinicians is essential to ensure the longevity and strength of the profession.

Katherine Hall, core trainee in psychiatry; Clare Short, consultant child and adolescent psychiatrist; Katrina Graham, specialist registrar in child and adolescent psychiatry; Priya Rajayaguru, specialist registrar in child and adolescent psychiatry, Brently

Cite this as: BMJ 2018;363:k4113

EBM AND CLINICAL JUDGMENT

Evidence based medicine is a double edged sword

Evidence based medicine does protect patients from harms, but it can also adversely affect clinical judgment if used only as a tool for defensive medicine (Head to Head, 4-11 August).

Some clinicians simply regurgitate what the guidelines say, without trying to understand the rationale behind them. Why do physicians learn critical thinking and literature appraisal in medical schools, if they don’t apply those skills at work?

Perhaps, in clinical settings, you can win an argument by saying “the guidelines said” rather than showing your deductive reasoning skills and acting in patients' best interests.

So, does evidence based medicine adversely affect clinical judgment? This is like asking, “Is a double edged sword dangerous?”

Yes, if you are not using it properly.

Eugene Y H Yeung, physician, Lancaster

Cite this as: BMJ 2018;363:k4114

Tailoring population derived data to individuals

The process of generating “evidence” has an element of chance built into it. The problem of reproducibility of results is well known across the scientific disciplines, including medicine. Biological systems have endless layers of complexity, with the current best evidence being merely reflective of the limitation of computational power and statistical, as well as measurement, tools.

We have no way of knowing how a given medicine behaves in a specific patient, despite having the highest level of population derived evidence supporting its use.

As clinicians, we work with individual patients, so the evidence generated should be tailored to this requirement. Evidence produced should take into account the known variability that exists.

Precision medicine initiatives like the N-of-1 trial are one way of bridging the gap between population derived, evidence based medicine and personalised clinical judgment. Hopefully, it will empower individual patients and their clinicians to jointly explore what works best for them.

Balasubramanaya Seetharama Rao, consultant in pharmaceutical medicine, Orion Pharma (UK)

Cite this as: BMJ 2018;363:k4115

RESPONSE

Thomas Breuer and colleagues at GlaxoSmithKline respond to Peter Doshi

We are writing to respond to The BMJ’s feature article about the Pandemrix vaccine (Feature, p 12). Our response focuses on some of the statements in the article as well as the methodology on which the major premise of the article is based.

The statement by The BMJ that the available safety data were not disclosed to the public by the authorities or by GlaxoSmithKline is incorrect. During the pandemic, safety data available to GSK and the company’s analyses of those data were shared regularly with the authorities through weekly teleconferences and monthly written periodic safety update reports. Summaries of the information relating to all pandemic vaccines used in Europe were made available to the public weekly on the European Medicines Agency website.

The above disclosures were made in addition to the routine safety oversight processes established by the authorities for medicinal products, which include the independent assessment of available safety data by experts in regulatory authorities and public health institutes. These processes ensure that changes in the safety profiles of vaccines are communicated to the public either directly by manufacturers such as GSK or through healthcare professionals.

Despite the author acknowledging that the data were insufficient to make conclusions about cause and effect, The BMJ’s article draws conclusions using scientifically inappropriate methodology. Pandemrix and Arepanrix were used in different countries and different regions (mostly Europe for Pandemrix; Brazil, Canada, Malaysia, Mexico, and Turkey for Arepanrix).

As experts and regulatory authorities agree, comparing reporting rates of adverse events between products distributed across different geographies, using different surveillance systems, is prone to inaccuracy and likely to result in false alerts. Moreover, the Brazilian authorities report adverse events to drug companies like GSK in batches with a time delay, and the reporting systems of the other listed countries have other particularities, all of which led to an under-representation of adverse events from those countries relative to the in-stream reporting systems in Europe.

By relying solely on a few data points, which were accessible to the journal, the conclusion of The BMJ’s analysis is based on incomplete data, which do not account for significant under-reporting of events relating to Arepanrix.

Furthermore, the analysis in The BMJ itself shows that the disparity in adverse event reporting rates between the two vaccines was very similar across several types of adverse events, which is a further indication that the reporting rates do not reflect differences between the two vaccines but rather different reporting intensities in the various countries and regions.

In contrast to the underlying premise of The BMJ’s article, analyses of all available safety data conducted by GSK and independently by the authorities both during and since the pandemic have concluded that the benefit and risk profiles of Pandemrix and Arepanrix were positive.

In summary, the article’s conclusion that the difference in reporting rates should have been used for making choices between the vaccines is not only methodologically flawed but also, if followed, would have led to unsound public health practice.

We are concerned that reports such as the one in The BMJ could generate undue concern and negatively influence trust in vaccines and vaccination. GSK remains firmly committed to transparency of safety information but calls upon the scientific community, including the publications that serve that community, to ensure that the disclosure of such information is driven by scientific responsibility and integrity.

Thomas Breuer, chief medical officer; Vincent Bauchau, director, clinical safety and pharmacovigilance; Tatjana Poplazarova, head of medical governance, bioethics, and scientific publications; Jens-Ulrich Stegmann, head of clinical safety and pharmacovigilance, GSK Vaccines

Cite this as: BMJ 2018;363:k4116

See Feature, p14
OBITUARIES

William Masson
General practitioner, consultant paediatrician
Royal Army Medical Corps (b 1931; q Aberdeen 1952; FRCP), died from bowel obstruction on 17 March 2018

After leaving the military, William Masson (“Bill”) worked as a singlehanded general practitioner in Ardnamurchan for over 20 years. He loved his job and provided continuity of care, offering 24 hour availability to his patients. He left general practice because of ill health. He had his first myocardial infarction at the age of 39. He had two coronary artery bypass grafts and chronic inflammatory demyelinating polyneuropathy, but he remained active and was a renowned, genial host. An erudite conversationalist, Bill had diverse interests, including fishing, photography, music, and reading. Despite his medical conditions he enjoyed life to the full. Predeceased by his wife, Jean, he leaves two children.

Derek McCormack

Cite this as: BMJ 2018;361:k3674

David Walmsley
Consultant physician in diabetes and endocrinology
University Hospitals of Morecambe Bay NHS Trust (b 1956; q Cambridge/Westminster 1981; FRCP; MD), died from complications of vascular disease on 26 April 2018

In 1995 David Walmsley became consultant physician at the University Hospitals of Morecambe Bay NHS Trust, where he was the first specialist appointment in diabetes and endocrinology. He implemented many changes to provision for patients with diabetes. He had type 1 diabetes himself, and many of the patients valued the experience he could share with them. David took early retirement in 2016 and then threw himself into work on his village’s neighbourhood plan, the Lune Rivers Trust. He also enjoyed cycling, gardening, and birdwatching. He died suddenly while out cycling in the Forest of Bowland. He leaves his wife, Jenny, and two sons.

Paul Smith

Cite this as: BMJ 2018;362:k3679

David Robertson
Consultant anaesthetist
Sheffield hospitals (b 1934; q Guy’s Hospital Medical School 1956), died from complications of vascular disease on 26 April 2018

David Robertson (“Dai”) was in the middle of three generations that trained in medicine and allied health professions at Guy’s Hospital. All his anaesthetic training took place at Guy’s, apart from national service in the Royal Army Medical Corps, which took him to Aldershot. The late 1950s and early 60s were times of pioneering work in cardiothoracic surgery at Guy’s. David developed a special interest in this area and in 1963 was headhunted to join a new team being put together to start a cardiothoracic service in Sheffield. On retiring in 1994, David and his wife, Anne, moved from Sheffield to Wiltshire to be nearer their daughters and their families. He leaves Anne, four daughters, 14 grandchildren, and three great grandchildren.

Ian Renwick, Colin Renwick

Cite this as: BMJ 2018;362:k3682

Richard Emmott Shaw
Consulting surgeon
Coventry Group of Hospitals (b 1916; q Leeds 1940; FRCS), died from old age on 24 April 2018

After national service in Kenya, Richard Emmott Shaw was appointed chief assistant in surgery to the West Middlesex Hospital. In 1951 he joined the surgical staff of the Coventry hospitals as a general surgeon. He was an early member of the British Association of Urological Surgeons and increasingly specialised in urology. In 1968 Walsgrave General Hospital opened in Coventry, and, thanks to Richard’s work, a urology department was established. Richard served in professional societies and the BMA. He maintained an interest in clinical research and teaching. Away from his professional life he had a happy life with Jean and their three children. Jean predeceased him by four years, but in 2016 Richard celebrated his 100th birthday with all his children, seven grandchildren, and six great grandchildren.

Rob Blacklock

Cite this as: BMJ 2018;362:k3681

Michael Kenneth Weaver
Consultant anaesthetist
Newcastle upon Tyne Hospitals Foundation Trust (b 1958; q Cambridge/Newcastle upon Tyne 1983; MA, FRCA), died suddenly after a successful mitral valve repair on 8 October 2017

Michael Kenneth Weaver (“Mike”) became consultant at the Queen Elizabeth Hospital in Gateshead in 1996 and moved to the Newcastle upon Tyne Hospitals Foundation Trust in 2002, where he pursued his interest in paediatric anaesthesia. Involved in airway management, he set up an airway database of difficult intubations. He became fascinated by medical error and human factors. His impact on anaesthetic training in the region will continue for years to come. He was passionate about music, a keen accordion player, and known for introducing people to music they had never heard before and possibly would not listen to again. He leaves his wife and three children.

Denise Adams, Nicola Hirschauer, David Mayne

Cite this as: BMJ 2018;362:k3677

Peter John Donald Whittaker
General practitioner
Chichester (b 1951; q Cambridge/Westminster 1975; DRCOG, DCH, MRCGP), died from adenocarcinoma of the terminal ileum on 2 August 2018

Peter John Donald Whittaker and his wife, Bryony, started working as GPs at the Lavant Road Surgery in Chichester in 1980, where he practised until 2016. Peter brought an analytical approach to GP work and firmly believed that continuity of care was what mattered to patients, doctors, and the NHS. He supported the local postgraduate centre, sat on the hospital ethics group, and was a member of the local treatment guidelines and therapeutics committee. After retiring from full time work, he returned to do locums until 2016 while undertaking Open University courses to keep his brain active. Eventually his illness overcame him, and he died peacefully at home. He leaves Bryony, two children, and four grandchildren.

Grant Kelly, Sara Kelly

Cite this as: BMJ 2018;362:k3676
Chris Burns-Cox became a driving force in the promotion of altruistic kidney donation after donating a kidney to a stranger in 2010, when aged 72. He was convinced it was “the most useful thing” he could do to “convert somebody’s life from major misery and early death to normal again.”

He wrote, “I had been a doctor for 50 years and was aware how enormously fortunate I had been in my own good health. And I just came to the conclusion that I didn’t need two kidneys.”

Patients typically live 10 to 15 years longer with a kidney transplant than if they are kept on dialysis. For Burns-Cox it was a tragedy that hundreds of those on the transplant waiting list died each year, and he wanted more people to know they could give a kidney safely.

**Give a Kidney**

Burns-Cox helped to set up the charity Give a Kidney, which he chaired from 2012 to 2016. He thought that once the public realised that “donation is no big deal for the donor—but a really enormous one for the recipient,” many would join the altruistic donors’ club.

They did. Altruistic kidney donations rose from 15 in 2009-10 to 118 within five years. Initially, however, not everyone in the medical establishment was convinced that altruistic or non-directed kidney donation was a good thing. For a time, the BMA said it could not wholeheartedly endorse patients having procedures they did not need.

Annabel Ferriman, a former news editor with *The BMJ*, whose article about her own kidney donation ([www. bmj.com/content/336/7657/1374](http://www.bmj.com/content/336/7657/1374)) caught Burns-Cox’s attention and led him to launch the charity with her in 2011, says he was hugely influential in changing minds. “He had a wonderfully optimistic view of human nature and such were his persuasive powers that everyone he approached just fell into line,” she says.

**“Missionary zeal”**

Burns-Cox had what colleagues describe as a “missionary zeal,” a passionate belief in the need to help fellow human beings. His winning—some say eccentric—way of expressing it rallied collaborators, making them feel inspired rather than preached at or guilt tripped, say friends.

Throughout his training, his near 30 year career as a general physician at Frenchay Hospital in Bristol, and after he retired, he found energy for numerous causes and lent his wide medical expertise to several developing countries.

Burns-Cox joined the World Health Organization’s programme to eradicate smallpox in Bangladesh, worked alongside Palestinians to improve health and battle injustice there, and provided treatment for the inhabitants of St Helena, a British dependency.

He taught medical students at the University of Malaya in Kuala Lumpur and the University of Kumasi in Ghana, and he also worked in Uganda and Anguilla. With his informed interest in tropical medicine, he was an active participant with Eldryd Parry in the early days of the Tropical Health and Education Trust.

**Early life and career**

Born in Hove, East Sussex, Burns-Cox won a scholarship to Marlborough school in Wiltshire and studied medicine at the Middlesex Hospital.

He held house jobs at Ipswich Hospital and became a medical officer in the former British colony of Sabah in north Borneo, helping to set up family planning and vaccination services, before returning to London as a senior registrar.

He was a consultant general physician at Frenchay Hospital from 1971 to 1999. He helped to develop innovative services in neurorehabilitation and palliative care at Cossingham Hospital in Bristol and raised money to set up a centre where patients were able to find information about their illnesses.

Burns-Cox worked to improve palliative care and pursued legal cases on behalf of patients who were seeking a right to die.

His support for human rights in Palestine was one of his biggest passions, and he was vocal in opposing Israel’s bombing of Gaza in 2009. He taught medical students there from 1990 until 2012 and was planning to do so again this year before he became ill.

He was interested in the natural world, too, and planted some 70 different cultivars of oak tree next to his Gloucestershire home.

Later on, he would have a spell in charge of Dr Jenner’s House, Museum, and Garden, the museum in Gloucestershire that honours Edward Jenner, the vaccination pioneer.

Burns-Cox said that he did not know who received his kidney and didn’t want to know, unless the knowledge might help the recipient. Within an hour of his operation at Southmead Hospital, the Bristol transplant unit, he was amazed to be told by the surgeon that his kidney was working very well in someone else.

He later received a message from the transplant coordinator passing on thanks and “good cheer” from the recipient, who was fit and living a transformed life.

He leaves his wife, Pat; their three children; and seven grandchildren.

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