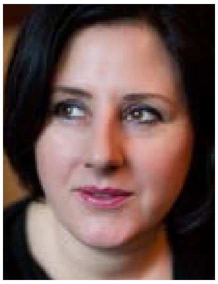
# comment

> Health think tanks approved of more competition in the NHS. There's a lack of evidence that this has done anything other than waste money and lower morale

**NO HOLDS BARRED** Margaret McCartney

## The pull between money and power



Discourse about healthcare is broadly dominated by politicians, unions, medical royal colleges, and think tanks.

Think tanks often have highly visible publication streams calling for change, assessing or proposing policy, or scrutinising data, and their reports can drive the news agenda for days. Many of these reports have the academic rigour or carry the credentials of a scholarly essay—but some do not.

The think tanks are a curious assemblage. They have the freedom to publish research or views that a university may not fund—and certainly, universities shouldn't be the only source of intellectual challenge to policy making.

But is the level of influence from think tanks appropriate? Many emphasise their claims to independence, and several are set up as charities. Invitation-only dinners and "events" may be used as private meetings to influence politicians. Some of the think tanks are paid for from wealthy endowment funds, raising additional money by running courses and conferences. The Institute of Economic Affairs—which has criticised plain cigarette packaging, minimum alcohol pricing, and the NHS in general—has come in for particular criticism for a lack of transparency over funding. Think tanks do not tend to be membership organisations.

Free speech and open debate are essential. But so too is transparency: think tanks shouldn't be used as a conduit to lobbying when the same message delivered directly by their funders would not garner such serious media attention.

Such lobbying prompts two broader concerns. The first is about representation. Think tanks are successful at achieving visibility and influence. But do they do a good enough job of representing evidence or uncertainty, and do they seek out challenge to their views? Consider that mainstream health think tanks approved of more competition in the NHS after the Health and Social Care Act 2012. There's a subsequent lack of evidence that this has done anything other than waste money and lower morale.

The second concern is that think tanks are funded at all. All healthcare professionals face similar challenges: a combination of work and domestic commitments doesn't easily fit with the request to give up a day, far from home, to take part in the debates that think tanks organise to decide policy suggestions.

Who is included and who is excluded matters. This is why we pay representatives, for example, from the BMA or the medical royal colleges, to go to these meetings and ask difficult questions on our behalf. In his 2017 book *On Tyranny*, Timothy Snyder writes, "It is institutions that help us to preserve decency…Choose an institution you care about—a court, a newspaper, a law, a labor union—and take its side."

Holding power to account is hard work. Influencing policy is often painstakingly time consuming. But doctors need to be involved, even in a small way, in and by organisations that will have us as members and whose side we can say we're on, and vice versa. Because, if we don't, the usual gravitational field of money will continue to attract power, with little left to question it.

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**PERSONAL VIEW**

Rebecca O'Connell, Julia Brannen, and Abigail Knight

# Child food poverty requires radical long term solutions

Being back in school will be a respite for children suffering holiday hunger, but food poverty is a year round problem

At the start of this year's summer holidays, the government announced £2m of funding for free holiday activities and meals for disadvantaged families. Children and families minister Nadhim Zahawi noted: "For most pupils, the end of the school summer term signals the start of holidays, days out, and a chance to make memories with friends and family. Other families, who might rely on support provided by schools, are not so lucky."

Luck has nothing to do with it. Children are going hungry in "breadline Britain"—not only during the holidays but all year round—because they are structurally disadvantaged by a shrinking welfare state and a government that refuses to take responsibility for the health and wellbeing of its children. Food "solutions" meet an immediate need but cannot solve food poverty; rather, they risk further stigmatising and excluding families from "ordinary living patterns."

Having enough to eat of an adequate quality has long been a minimal expectation of living in a Western country. But our study, *Families and Food in Hard Times*, found some UK families on low incomes who were unable to feed themselves properly and others who were barely able to do so. Reflecting the findings of previous studies, some parents often went without food so their children did not go hungry, while in other families both parent and child suffered.

The harmful consequences of insufficient food or food of poor nutritional value, particularly for children, are well established and have immediate and long term implications. These include poor growth; overweight and obesity; and the growing incidence of coronary heart disease, type 2 diabetes, and cancer. Suboptimal diets and food habits such as skipping meals are also associated with poor cognition and lower academic achievement.

**The plight of families who are struggling to feed themselves is unlikely to improve**

### Psychological dimensions

Food poverty also has social and psychological dimensions that are especially important for children. Parents' sacrifices can protect their children from food shortages, but the indirect effects of food poverty penetrate deeply into the "emotional heartland" of children's personal and family lives.

Additional funds to help disadvantaged children with "food and

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**ACUTE PERSPECTIVE** David Oliver

# What's behind the reported rise in sepsis deaths?

Recently, Brian Jarman, emeritus professor at Imperial College London and former director of its Doctor Foster Unit—which sends real time mortality rate alerts to hospitals—shared data with the BBC. They were from an analysis of deaths from sepsis in the NHS. "Hospital sepsis deaths 'jump by a third,'" was the headline.

The reported finding was that absolute numbers of deaths clinically coded as being from sepsis as the primary cause, either in hospital or within 30 days of leaving, rose to 15 722 in the year to April 2017, up 38% since 2015.

To encompass sepsis, Jarman's team looked at coded care episodes with diagnoses including pneumonia, septicaemia, shock, aspiration pneumonitis, bacterial infection, hepatitis, viral infection, other infections (including parasitic), and sexually transmitted infections.

**In the past 3-4 years I've seen a far greater focus on documenting sepsis in notes and initiating early intensive treatment**

From 2013-14 to 2016-17 aggregated patient admissions with these codes rose from 44 321 to 77 996, rising in all of these code groups. Related deaths rose from 9143 to 15 851, while crude death rates were static at just over 20%. The age, acuity, and complexity of the case mix is rising, but surely not enough to explain this increase. Jarman also clarified to me that his team's regression analyses on potential explanatory variables behind all cause hospital mortality ratios had consistently identified doctor-patient ratios and bed occupancy, although not specific to sepsis.

Meanwhile, Bryan Williams, of University College London, a leading developer of National Early Warning Scores to recognise deteriorating patients and trigger earlier intervention, told the *Guardian*, "In reality [there] is an increased awareness and detection of sepsis and an actual reduction in mortality [rates] in hospital and in the first 30 days after discharge from sepsis." He confirmed to me that NHS England data, based on hospital episode statistics, support this.

In the same article Ron Daniels, an intensive care consultant and the Sepsis Trust chief executive, said we can't be certain how much

fun" over school holidays are welcome. But given the scale of the problem, this solution goes nowhere near far enough and cannot tackle the underlying factors that lead to the food poverty of families.

A week after the government announced funding for additional school holiday provision, it was reported that it is commissioning research into the relation between its own policies and the rise in food aid. Yet there is plenty of evidence already that this growth is the predictable result of policies that have taken away from those who had least to begin with. Food aid, including school holiday provision, is an inadequate response that is "susceptible to four particular challenges: it can be inaccessible, unreliable, unaccountable, and socially unacceptable."

To tackle food poverty, the government should make use of research on budget standards to ensure that wages and benefits, in combination, are adequate for a socially acceptable standard of living and eating, which recognises the fundamental role of food in health and social inclusion.

### Grave concern

In the UK, we are living in a period of deep political and economic uncertainty. Given the UK's exit from the European Union, the implementation of further cuts to welfare benefits, and rising inflation (including food prices), the plight of families who are struggling to feed themselves is unlikely to improve. Food poverty and its effects on children's and young people's physical and emotional wellbeing is a matter of grave concern. Yet in the face of piecemeal solutions and government neglect, the outlook is set to remain bleak.

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of the apparent rise is due to coding differences, as coding is inconsistent and there's no national register.

Other columns remain to be written on the empirical evidence behind NICE guidelines; tools for early recognition and early intervention promoted by the Surviving Sepsis Campaign and Sepsis Alliance; variations in delivery of recommended best practice between hospitals; or potential consequences for antibiotic stewardship when serious infection is over-identified.

The drive to identify patients at risk of sepsis, or those who may have it, has some downsides. For instance, data on antibiotic stewardship indicate we often diagnose infection inaccurately, not least in older patients labelled with urinary tract infections.

On balance, I applaud the drive to recognise patients at risk as early as possible and to increase public awareness of sepsis. In the past 3-4 years I've seen a far greater focus on documenting sepsis in notes and initiating early intensive treatment, using National Early Warning Scores.

Coding changes surely play a part in the story behind the headlines. And remember: sepsis is defined as "a life-threatening organ dysfunction caused by a dysregulated host response to infection." I'm not sure that we reliably ascertain this from a range of codes for infections, even in patients who have died. However, it would be great if NHS England could publish the more encouraging data on sepsis, which Williams alluded to in the *Guardian*.

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**BMJ OPINION** Ian Morris

## Stop saying "part time" GPs

Following the recent King's Fund report on the future GP workforce, and subsequent press pieces discussing the increasing number of "part time GPs," the time has come to look at how we define our working patterns, while also considering how they are viewed by the public.

A "full time" worker in the UK currently works an average of 37 hours a week. Anything less than 37 hours is defined as "part time."

GPs in the UK use the same terminology, but the number of hours considered average is quite different. Assumptions around the terms "full time" and "part time" have led to an outcry in the press—and some erroneous conclusions have been reached that need to be corrected.

**What is not taken into account is the work that is done in addition to clinical work**

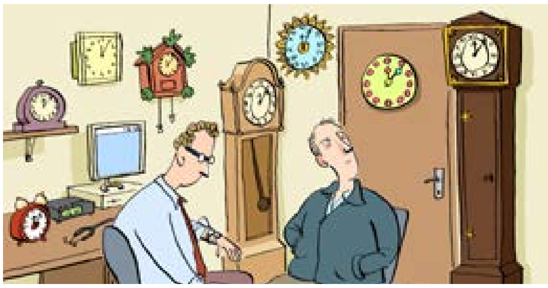
GPs talk about sessions worked, and based on that they are either full time or part time. Full timers traditionally work for 10 sessions a week, with morning and afternoon sessions of clinical patient contact and home visits slotted in between. Most of these sessions are now packed with intense clinical and emotional workloads. On top of this, we have optional extended hour sessions, out-of-hours sessions, and other commitments such as further clinical, managerial, or academic work.

What is not taken into account is this hidden work—the work that is done in addition to clinical work—such as the management of the practice, clinical administration, CCG work, audits, patient participation group work, teaching junior trainees and students, mentoring staff, continuing professional development, emails, reading guidance, and covering illness.

A couple of years ago I dropped my clinical commitment by one session a week to keep my sanity. I wanted to protect my patients and to stop myself from burning out. Despite reducing my hours, I still work substantially more than 37 hours a week—but the result is that I have kept working. Many others have left the profession or left their practices to become sessional GPs.

Part time GPs aren't the problem, but we need to consider the public's perspective. Perhaps we should adopt a sporting analogy and start calling our part timers what they really are—full timers. We could extend the analogy and start calling our full timers what they really are—"extra timers." Hopefully we can then avoid the shootouts.

Ian Morris is a partner at Leatside Surgery, Totnes



## ANALYSIS

# Ageing populations and patient frailty: can primary care adapt?

Focusing on frailty brings considerable challenges but could reduce the burden on GPs, explain **David Reeves and colleagues**

Frailty categories and prevalence rates in 964 486 people aged 65 to 95 on 1 January 2015, from analysis of the Clinical Practice Research Datalink

| Frailty category | eFI score range | Prevalence n | % |
|---|---|---|---|
| Fit | 0-0.12 | 591 527 | 61.3 |
| Mild | >0.12-0.24 | 248 986 | 25.8 |
| Moderate | >0.24-0.36 | 98 096 | 10.2 |
| Severe | >0.36 | 25 877 | 2.7 |

### KEY MESSAGES

- Increasing numbers of frail older people are a major concern to health services worldwide
- In the UK, primary care is at the frontline of policy attempts to meet this challenge, but making frailty an integral part of primary care practice is challenging
- GPs need convincing that this will help to reduce, rather than increase, the professional burden in dealing with complexity, while also benefiting their older patients living with frailty
- Future developments should focus on improving the identification of frail patients and the planning and delivery of frailty appropriate care, taking into account individual patient capacities and circumstances as well as frailty status

Healthcare systems worldwide are challenged to meet the needs of increasingly ageing populations, characterised more by multimorbidity and declining physical and mental function than by the individual acute diseases for which these systems were originally designed.[1]

Especially problematic is the rising number of frail elderly people. Frailty is a condition characterised by age related decline across multiple physiological systems,[2] resulting in high vulnerability to adverse health outcomes, including dependency, need for long term care, and mortality.[3]

Responding to these challenges, healthcare policy in the UK and many other countries[4] has increased its focus on the complex interplay between the multiple health problems frequently encountered in older people and the need to develop integrated and multidisciplinary health and social services. In the NHS, primary care is mainly delivered by general practitioners, medical generalists who also act as gatekeepers to specialist service providers. Primary care is typically the first point of contact for NHS patients (the majority of the population) so is considered the natural hub for integrated activity.

**A frailty label carries substantial stigma for many people**

The UK primary care model, with its emphasis on holistic care and centralised policy, would seem well suited to meet the changing healthcare needs of an ageing population. In this context, the 2017 general medical services (GMS) contract for England introduced a new requirement for general practices to identify and appropriately manage all patients aged 65 or over with moderate or severe frailty.[5]

Under the contract changes, all patients identified with severe frailty should receive annual reviews of medications and falls and should receive appropriate interventions (box 1, see bmj.com).[11] Practices are also encouraged to "go further" by organising comprehensive geriatric assessments and personalised care planning where appropriate.[12] The long term goal is to establish frailty assessment as an integral part of routine primary care practice and to improve the ability of GPs to organise high quality care for their

more complex older patients, both in primary care and in collaboration with other services. The BMA has tried to reassure GPs that the work around frailty will not increase overall bureaucratic burden and will not undermine professional autonomy.[11] Furthermore, the National Institute for Health and Care Excellence has proposed that increased costs from longer appointments, training, and treatment optimisation will be offset by factors such as fewer unnecessary appointments, prescriptions, and unplanned admissions.[13]

Making frailty integral to primary care, however, has important challenges, including the acceptability to primary care professionals and patients of frailty as a relevant concept; robust and efficient assessment of patient frailty; effective use of that information to improve care planning and patient outcomes; and convincing already overstretched[14] primary care professionals that this approach will ultimately reduce, or at least not increase, their workloads.

## Prevalence of frailty in the UK

Estimated prevalence rates of frailty in the population vary widely depending upon the measure used.[15] For the GMS contract, NHS England uses estimates based on the electronic frailty index (eFI)[16] and the ResearchOne database, which indicate that 3% of 207 720 people aged 65 and older are severely frail, and another 12% are moderately frail.[16] Replicating this in the Clinical Practice Research Datalink (CPRD) primary care database, we found similar rates: 2.7% and 10.2% of 964 486 patients, respectively (table). Based on this, the average GP practice of 7000 patients will have around 30 severely and 100 moderately frail patients.

## Challenges to adopting the frailty agenda in primary care

### Acceptance of frailty as a relevant concept for primary care

Frailty is not the only approach to identifying elderly patients with complex management needs. A focus on frailty replaced a previous initiative in the GMS contract that focused on patients at risk of an unplanned hospital admission, which was highly unpopular with GPs for various reasons, including excessive bureaucracy.[11] Another advocated approach is to focus on multimorbidity—people with two or more chronic conditions—and NHS England has published guidelines for multimorbidity management in primary care.[17] Implementing different schemes and guidelines for each group is unduly complex and inefficient, especially as they share several core management elements (medicines review, personalised assessment, care planning). In addition, more than 25% of adults have two or more chronic conditions,[18] hence the multimorbidity guidelines require additional factors to be present such as frailty, risk for unplanned care, or management complexity,[17] further blurring distinctions between the groups.

A focus on frailty aligns well with the generalist perspective of primary care and can motivate constructive dialogue between the primary care team, the patient, and key carers around frailty appropriate care and support needs. GPs might be of the opinion, however, that they are already aware of their relevant patients and are meeting their needs without labelling them frail. They may even view frailty as unnecessary medicalisation or oversimplification of a patient's medical complexity.[20] A frailty label also carries substantial stigma for many people through association with loss of independence and end of life and can deter people from seeking support or make them fear being denied sought after care.[21] This can close discussion down, instead of opening it up. Changing such perceptions of frailty will need a longer term focus, but there are precedents in the evolution of public understanding and acceptance of diagnoses such as cancer or dementia.

Frailty focuses solely on health deficits, an approach that has been criticised for undervaluing the effects of cognitive, material, and social capacities on a person's ability to manage their health and on clinical decisions about their care[22]—equally frail individuals may have very different access to social network support or abilities to manage their treatment burdens. Rather than making frailty identification irrelevant, however, this re-emphasises the importance of using a frailty diagnosis less as a label but more as an opportunity for a holistic discussion around care needs and the support and services required, in the broadest possible sense—not only health but also personal, public, private, voluntary, and community resources.[23] The argument for placing frailty in this broader context has strong theoretical underpinnings in the literature of cumulative complexity and minimally disruptive medicine.[22 24] Although this goes well beyond what most GPs have traditionally seen as their role and what practices are currently set up to do, it seems essential to the goal of providing the best possible personalised care.

### Identification of frail patients

Frailty is a complex medical condition and correctly identifying those affected can be problematic. NHS England recommends a two stage process: an initial screen followed by direct clinical verification. The eFI is proposed by NHS England as an "appropriate tool" for screening[12] and generates a frailty rating (fit, mild, moderate, or severe; table) from a patient's primary care

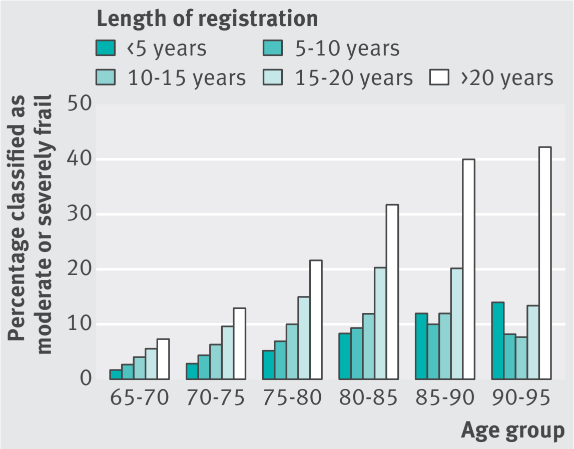
### Box 2 | Deficits on the electronic frailty index (eFI)

- Activity limitation
- Anaemia and haematinic deficiency
- Arthritis
- Atrial fibrillation
- Cerebrovascular disease
- Chronic kidney disease
- Diabetes
- Dizziness
- Dyspnoea
- Falls
- Foot problems
- Fragility fracture
- Hearing impairment
- Heart failure
- Heart valve disease
- Housebound
- Hypertension
- Hypotension or syncope
- Ischaemic heart disease
- Memory and cognitive issues
- Mobility problems
- Osteoporosis
- Parkinsonism and tremor
- Peptic ulcer
- Peripheral vascular disease
- Polypharmacy
- Requirement for care
- Respiratory disease
- Skin ulcer
- Sleep disturbance
- Social vulnerability
- Thyroid disease
- Urinary incontinence
- Urinary system disease
- Visual impairment
- Weight loss and anorexia

electronic health record, based on the accumulation of up to 36 health "deficits" (box 2). Now available in all general practices in England, the eFI can rapidly screen all registered patients using their healthcare records alone. The tool has shown moderate to good discrimination for the outcomes of mortality, unplanned hospitalisation, and nursing home admission.[16]

The accuracy of the initial screen is a major factor in the overall efficiency of the identification process. Screening tools other than the eFI can be used and may identify different sets of people,[25] but no consensus exists on which performs best.

Improvements in screening accuracy could produce substantial efficiency gains. The eFI analyses a patient's entire electronic health record, but the Clinical Practice Research Datalink shows a strong association with length of registration, implying underestimation for short records (<10 years), overestimation for long records, or both (figure). All deficits are treated as non-resolvable, so conditions recorded many years ago but not since, including some acute events such as urinary tract infections, count towards the current frailty score. Hence introducing criteria for the frequency of codes and how recently they were recorded might improve alignment with clinical diagnosis. Efficiencies might also be gained by introducing differential weighting of the included deficits and by basing the thresholds for frailty on clinical, rather than the current statistical, criteria. To these ends, we are currently carrying out a study using a panel of GPs to evaluate modifications to the tool to improve its efficiency as a screening instrument.[27]



**Association between length of registration with GP practice, age group, and frailty classification from Clinical Practice Research Datalink data**

**Accurate identification of frailty is important but has little point unless it makes a difference to patients**

### Frailty and care management

Accurate identification of frailty is important but has little point unless it makes a difference to patients. The minimum contract requirement that all severely frail patients receive annual reviews of medications and falls is arguably already expected under NHS quality standards.[28 29] To have a transformative effect on patient care, practices will need to commit to doing more. The main NHS England recommendation, depending on individual need, is a brief comprehensive geriatric assessment (CGA) and personalised care plan,[12] with multidisciplinary CGA or less intensive GP led "holistic medical review" where appropriate. The supporting evidence base, however, is not strong. A well conducted review of CGA in community based people with multimorbidity found clinically important benefits for mortality and care home admissions, but limited effect on quality of life and no benefit for unscheduled care or functional outcomes.[17] An earlier meta-analysis of 24 trials of geriatric assessment of people selected as frail reported a small effect on hospital admissions only.[30] Three later randomised trials of CGA in the Netherland's frailty care programme found almost no clinical benefits.[31] Available evidence for cost effectiveness is inconsistent and inconclusive.[17-32]

Most of this evidence is weak, however, and NHS England recommends further research based on the potential benefits for some critical outcomes.[17] Benefits may also be more certain for more resource intensive interventions[17] and for some patient subgroups.[30] Developing greater understanding of approaches that work and for whom will nevertheless take considerable time. More immediately, finding ways to streamline frailty related work would help. Examples include replacing condition specific annual reviews with a single holistic review for those with severe frailty and introducing a primary care nursing role for frail people, as exists in some other countries and with which some UK services are experimenting.[33] The expansion of clinical pharmacists in general practice teams and nursing homes can facilitate greater use of medication review, and more efficient means of delivering CGA and care planning could also help, such as geriatrician "outreach" clinics in primary care and involvement of carers and the voluntary sector in care planning.[34 35] Using frailty information more directly in management decisions might also bring efficiencies.[19] Adequate discussion of this is beyond the current article, but one example would be having specific guidelines for subgroups of frail older people, such as people with type 2 diabetes.[36] Such initiatives may already be happening locally, but frailty could offer opportunities on a national scale.

### Conclusion

The goal of making frailty an integral part of primary care practice provides opportunities for beneficial change but is not without considerable challenges. Further developments could help overcome the many current limitations and obstacles, but in the overstretched UK primary care system, the acid test is likely to be whether GPs find that a focus on frailty helps to reduce, rather than increase, the professional burden in dealing with their most complex patients, while also benefiting their older patients with frailty.

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VALPROATE AND PREGNANCY

## Valproate, women, and exceptional circumstances

The Medicines and Healthcare Products Regulatory Agency (MHRA) now requires women of childbearing potential who take valproate to provide annual signed confirmation of adherence to the pregnancy prevention programme. The MHRA acknowledges that discontinuing valproate may not be possible for some women with epilepsy, so they may continue to take it (with appropriate specialist care) in pregnancy.

In an open letter to the MHRA, we outlined the exceptional circumstances when, despite childbearing potential, a pregnancy prevention programme is inappropriate. These include emergency situations (such as status epilepticus); fully informed women deciding to take valproate who may become pregnant but may not (Analysis, 21 April); and those lacking capacity (such as those with intellectual disabilities), where a best interest process supports continuation of valproate. This guidance is endorsed by the Royal College of Psychiatrists' intellectual disability section, the United Kingdom Learning Disability Professional Senate, and 62 individual epilepsy clinicians.

**Heather Angus-Leppan, consultant neurologist, London**
**Rohit Shankar, consultant in adult developmental neuropsychiatry, Bodmin**
**Hannah Cock, professor of epilepsy and medical education, London**

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LETTER OF THE WEEK

## Call for a national assessment body

**Health secretary Matt Hancock should create national assessment body**

Performance assessment of hospital doctors and GPs is initiated by NHS England. Doctors are referred to the General Medical Council for further assessment and sanctioning, a process that can span years with a heavy toll. It can destroy the doctor's career, health, and family (Bawa-Garba case, 3 February). To the country, the cost of suspension is colossal.

The medical profession has lost confidence in its regulator, owing to its harsh sanctioning process. The previous health secretary said that no doctor would be prosecuted for genuine mistakes and that all death would be reviewed by highly trained medical advisers. He stripped the GMC of the right to appeal against its own fitness to practise tribunal.

As head of performance, the health secretary [Matt Hancock] should take responsibility for performance assessment by creating a national body. This would be staffed by consultants and GPs, accredited by the royal colleges, and should be transparent. The main principles should be to support, protect, and save doctors. GMC supervision is archaic and seems more punitive than educative. It is funded entirely by the supervised doctor. It should be replaced by mentorship financed by the government, remembering that no doctor is infallible.

The future of the medical profession belongs to every doctor. Please write to your MP and campaign for this new national body.

**A R Sooltan, retired GP, Leeds**

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HEALTH OF SEX WORKERS

## Better political protection for sex workers

Howard discusses sexual and reproductive rights for UK sex workers (Feature, 23 June). Policies that actively target sex workers for arrest and criminal charges foster an attitude of fear and distrust of all authorities including the health sector, which limits access to appropriate care.

Legalisation would allow sex workers to work together and have alarm and support systems to help each other avoid danger. The current legal framework classifies this as "brothel keeping," which is prohibited.

Sex workers need access to reproductive health services beyond condom provision, including access to effective contraception and maternity and gynaecology services.

The health "problem" here cannot be fixed by health services—the right policies and politics are needed before the health sector can be more effective. Robust economic policy, stable employment, and social security would be the most important interventions in the health of sex workers and the population in general.

**John Reynolds-Wright, associate editor**
**Sandy Goldbeck-Wood, editor in chief, *BMJ Sexual and Reproductive Health***

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## Sweden shows benefits of Nordic model

Howard doesn't fully explore the overall aims of and evidence for the two opposing models of legislating sex work (Feature, 23 June).

The Nordic model is a socially progressive movement, which sees prostitution as harmful to the public good and requires men to stop buying sex. Legislation to reduce demand and social programmes to support exit protect the most vulnerable. Conversely, full decriminalisation normalises prostitution as "work."

Sweden provides a case study of the Nordic model, reporting reductions in street prostitution and no overall rise compared with comparators; reductions in demand from men; and support of the police. By contrast, claims of health benefits of the New Zealand decriminalisation model are not based on measured outcomes. In 2017 the BMA's annual representative meeting voted decisively against it.

We support the Nordic model based on the evidence available; research is needed to understand how best to make and monitor progress elsewhere.

**Harriet Evans, survivor and activist, Nordic Model Now!**
**Richard Byng, GP and professor in primary care research, Plymouth**
**Lynne Callaghan, senior research fellow, Plymouth**
**Anna Fisher, chair, Nordic Model Now!**

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## Decriminalisation ensures human rights

Although some sex workers are forced to work because of personal circumstances, most of the sex workers I have interviewed over the past 20 years are adamant that that they chose sex work because it suited their needs. They just want their human rights to be respected.

Research that supports the Nordic model presents stories from only those sex workers who have traumatic accounts of their experiences. Claims are then made that all sex workers' experiences are harrowing and damaging.

No evidence shows that sex worker numbers have fallen in Sweden as a result of prostitution laws, but it does show the harms that have been caused by the criminalisation of clients.

Both the UN and WHO support the decriminalisation of sex work to ensure sex workers' human rights.

**Gillian Abel, head of Department of Population Health, University of Otago**

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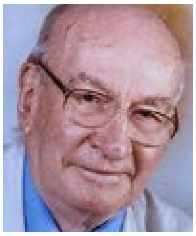
## Michael Courtenay



**General practitioner Battersea, London (b 1923; q Cambridge/St Thomas' Hospital 1952), died from old age on 25 June 2018**

Under the pressure of practice in the early years of the NHS, Michael Courtenay ("Mike") turned to the approach of Michael Balint to make sense of medicine. He became the second president of the Balint Society and was later president of the Society for Psychosomatic Research. At St Thomas' he became involved in training doctors for general practice and became course organiser for the hospital scheme. Later, as senior research fellow, he was in charge of the fellowship course, and, later still, he was a lecturer in evidence based medicine on a new MSc course for GPs. In 1985 he retired to north Oxfordshire, from where he travelled the world, but he also continued to do research and write books. He leaves seven children, 12 grandchildren, and seven great grandchildren.

**Michael Courtenay**

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## John Godfrey Fairer

**Consultant anaesthetist (b 1926; q Charing Cross Hospital 1949; TD, FRCA), died from heart failure and old age on 27 June 2018**

John Godfrey Fairer—universally known as "Dickie"—was appointed consultant anaesthetist to Charing Cross Hospital in London in 1956-57. He resigned in 1966 to travel and work all over the world. In his retirement he moved to France. Dickie kept the archival records for the Royal College of Anaesthetists and was awarded the Pask certificate of honour for services to anaesthesia in 2004. A qualified barrister of the Inner Temple, he had degrees from the Open University in history of art and English literature. He served as a major in the Territorial Army and held high office in Masonic lodges. Married three times, Dickie leaves his wife, Margaret; six children; seven grandchildren; four great grandchildren; and Joan, his loving companion and partner of the last 18 years of his life.

**Joan Robinson**

Cite this as: *BMJ* 2018;362:k3352

## John Michael Holden

**General practitioner Rothwell Health Centre, Kettering, Northamptonshire (b 1947; q Royal Free Hospital School of Medicine 1971), died from complications of supranuclear palsy on 28 March 2018**

Born in Nigeria, where his father was chief justice, John Michael Holden was educated at various schools in the UK. Problems with eyesight scuppered his plans to join the Royal Air Force air crew, and he switched to studying medicine. As a student he met and married Rosemary, a technician in the anatomy department. After house posts at Northampton General Hospital, John entered a short service commission in the RAF, initially in the UK and then in Sardinia and Germany. Before he left the RAF, he was offered a choice of "rehabilitation" courses and qualified in centre lathe turning. In 1978 he joined a busy practice in Northamptonshire and reached parity in three years. He leaves Rosemary, two sons, and two grandchildren.

**Geoff Ridgway**

Cite this as: *BMJ* 2018;362:k3059

## Krishan Mohan Khurana

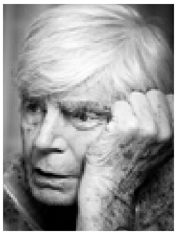
**General practitioner (b 1934; q King George's Medical College, Lucknow, India, 1956; DMRE Bombay, DMRD Eng), died from aspiration pneumonitis on 2 June 2018**

Krishan Mohan Khurana was a consultant radiologist in Zambia and Fiji from 1964 to 1975 and then a general practitioner in Partington, Manchester, from 1975 to 1996. He was president of the Rotary Club of Altrincham in 1982. His life came full circle when he returned to India in his retirement. As a consultant radiologist, he made quite a difference with his pioneering work in the mental health sector in India, as the founding member of the Richmond fellowship branch in Delhi. Inspired by his middle daughter, Leena, he set up a psychosocial residential halfway home for schizophrenia patients in 1999, which continues to house about 20 residents. Krishan died in Delhi and leaves his wife, Kalpna; two daughters; and a son.

**Payal Kumar**

Cite this as: *BMJ* 2018;362:k3351

## Ian Alexander Ruthven-Stuart



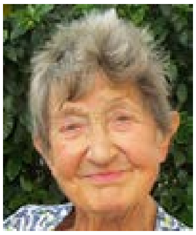
**General practitioner Hambledon, Hampshire (b 1927; q Edinburgh 1949), died from sepsis and multiple organ failure on 19 May 2018**

Conscripted in 1952, as acting temporary surgeon lieutenant, Ian Alexander Ruthven-Stuart was posted to Portsmouth. He then turned his attention to general practice and worked at Raigmore Hospital in Inverness to gain experience in obstetrics and gynaecology. With his young family, he moved to Hambledon, where he remained for 35 years. In addition to becoming a Treasury medical officer, Ian was involved with training final year students from Southampton University. He retired in 1994, after treatment for rectal cancer, but he continued to do locums and medicolegal examinations into his 80s. Ian leaves Christina, his wife of 65 years; five children; and nine grandchildren.

**Nicholas, Sarah, David, Peter, and Sophie Ruthven-Stuart**

Cite this as: *BMJ* 2018;362:k3356

## Stephanie Saville



**Consultant anaesthetist London (b 1927; q Trinity College Dublin, 1949; FFARCS), died from a massive stroke on 30 June 2018**

Stephanie Saville helped set up the intensive therapy unit at St Stephen's Hospital, London, and introduced epidurals as a regular practice in labour. She was among those who hastened the development of anaesthesia into the area of pain relief and started the pain relief clinic. At the time of her retirement in 1987, the hospital—which closed in 1989—had four well equipped operating theatres, a large recovery area, and an immediately adjacent intensive care unit. At a time when women were only beginning to forge careers in the competitive world of medicine, Stephanie Saville was a role model for many. Her determination was equalled only by her compassion for humanity, which inspired all her thoughts and deeds.

**Barbara Wright**

Cite this as: *BMJ* 2018;362:k3354

# Davida Coady

## Humanitarian paediatrician, political activist, and recovering alcoholic

**Davida Coady (b 1938, q Columbia University College of Physicians and Surgeons, New York City, 1965), died from ovarian cancer on 3 May 2018**

Davida Coady for more than two decades risked her life flying in rickety aeroplanes to war zones and disaster areas to provide medical care—and her love—to children in nearly 35 countries in Africa, Asia, and Latin America. She also trained local healthcare workers, led infectious disease control efforts, and worked to improve nutrition. She was affiliated at various times with the Peace Corps, the World Health Organization, the World Bank, the UN Refugee Agency, and many others.

She was often in personal contact with politicians such as the late US senator Ted Kennedy, and famous human rights activists, such as actor Martin Sheen and Bianca Jagger.

Coady was also a political activist. Arrested more than 50 times, she protested against nuclear proliferation, against global food giant Nestlé for promoting infant milk formula over breastfeeding in developing nations, against US support for Central American dictators, and many other causes for concern.

### Medical career

She was born Davida Elizabeth Taylor on 15 April 1938 in Berkeley, California.

For her medical studies she chose Columbia University College of Physicians and Surgeons in New York City because it offered a fourth year elective to train in tropical medicine in Liberia, in Africa.

She eventually graduated from Columbia in 1965. She trained for two years in paediatrics at the University of California in Los Angeles, and was named chief resident in her final year. She studied for a certificate of international nutrition at the Guatemala City based Institute of Nutrition for Central America and Panama, and followed this with a masters in public health in 1969.

At Harvard she fell under the influence of French born Jean Mayer, a leading expert on world hunger. At the time, Mayer and peace activist Norman Cousins were directing emergency aid efforts for Biafra during the Nigerian civil war, during which two million people starved to death. Coady was named field director for the effort and in June 1969 flew with Cousins to Lagos and then on to Biafra.

On her return to the US in early 1970, she testified before the US Congress about the suffering. She also privately briefed Henry Kissinger, at the time national security adviser for president Richard Nixon.

Back in California, she joined the UCLA faculty and also became involved in the Venice Family Clinic, a free clinic for low income families. She later also joined the faculty of the University of California, San Francisco.

In 1971 she took a temporary leave of absence from UCLA to provide medical care in refugee camps in Bangladesh during its war of independence with West Pakistan. She then moved on to India, working as a field epidemiologist for the World Health Organization's smallpox eradication campaign.

During the next 20 years her life alternated between her work in California and her humanitarian missions. Her marriage during this time to Patrick Coady, a former Catholic priest, ended in divorce.

In her memoir, Coady says she experienced post-traumatic stress disorder as a result of her work in Biafra. Over the years she was plagued with depression, for which she occasionally sought psychiatric help. She was also a binge drinker from the early 1960s until 30 October 1989. On that day she participated in a heavy drinking session in El Salvador and found herself shaking with alcohol withdrawal a few days later. She vowed never to drink again, and, as a "recovering" alcoholic, regularly attended meetings of Alcoholics Anonymous.

**Arrested more than 50 times, Coady protested against global food giant Nestlé for promoting infant milk formula over breastfeeding**

In 1996 she founded Options Recovery Services and later started a programme to train inmates in California prisons as substance misuse counsellors.

One day in court in the late 1990s, a judge told Coady about "a guy" in jail beyond help. Tom Gorham, a former truck driver who had been homeless for 11 years. He had been arrested 280 times, mostly for minor crimes, and been in jail 47 times. He was a beggar and a drunk, but funny and seen as harmless. Coady agreed to talk to him.

Gorham eventually sobered up, thanks to Coady's Options Recovery Services and got off the street. He began helping out and eventually qualified as an addiction counsellor. He and Coady also fell in love. They married in 2002 and remained together for the rest of her life.

Coady died in a hospice near her home in Berkeley, California. She leaves her husband, Tom Gorham.

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## BMJ.COM HIGHLIGHTS

# Doctors for the NHS essay competition

The organisation Doctors for the NHS are offering a cash prize for the best essay with the title: "Our profession in today's NHS." They want to hear the views of doctors in training and encourage them to reflect on the core professional values of a doctor; the role that they see for the medical profession in the NHS; whether their training and experiences have equipped them for their professional lives; and other ideas.

Essays will be judged by a panel looking for fresh ideas, originality, and an insight into the place of the profession in today's NHS. There is a first prize of £500, with a second prize of £200. The winning essay will be published in *The BMJ* (subject to editorial approval) and the winners announced at the Doctors for the NHS annual meeting in October.

The word limit is 2000 words, and the closing date for submissions is 16 September 2018. Essays should be submitted by email to: doctors4thenhs@gmail.com, and any questions about the competition can be directed to that address.

## MOST READ ONLINE

Don't use our fees to pay Bawa-Garba's court costs, doctors tell GMC

*BMJ* 2018;362:k3612

The resurgent influence of big formula

*BMJ* 2018;362:k3577

Measles: Europe sees record number of cases and 37 deaths so far this year

*BMJ* 2018;362:k3596

Pressure grows on Lancet to review "flawed" PACE trial

*BMJ* 2018;362:k3621

Hadiza Bawa-Garba wins right to practise again

*BMJ* 2018;362:k3510

# A special collection on global child health

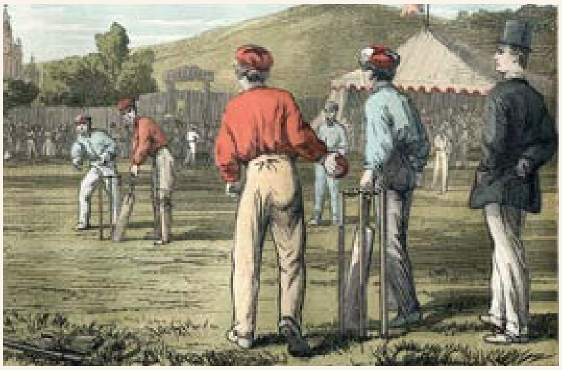
Over the past quarter of a century, child mortality has more than halved. Yet in 2016 an estimated 5.6 million children still died before reaching their 5th birthday, mostly from conditions that are readily preventable or treatable.

*The BMJ*, in partnership with the World Health Organization and Unicef, has launched a special collection of articles to provide direction on how countries, supported by the global child health community, can deliver the best possible strategies to help each child to survive and thrive.

You can read the collection of articles at bmj.com/child-health

## FROM THE ARCHIVE

# The real cost of a medical education



In this week's issue, *The BMJ* reports New York University's announcement that it will offer free tuition to all current and future medical students because of the rising cost of medical education (p 216). Such concerns are not new: in 1896 *The BMJ* published an article that stated, "It is of the greatest importance that the intending student, before embarking on so great an adventure, should form an accurate estimate of the probable cost of obtaining a diploma" (*BMJ* 1896;2:546)

The journal's description of the costs that potential students should consider will be familiar to many readers today, including payments for education; fees for examination; costs of housing, maintenance, and books. Yet the author's parting piece of advice may be less expected:

"It must also not be forgotten that the life of a medical student is a trying one and that, for the maintenance of health, provision must be made for a considerable amount of outdoor exercise.

Boating, cricket, tennis, football—things for which the solitary walk is no substitute—all mean clubs and subscriptions, and, although this is a side of student life which is often overdone, it is absolutely essential that some provision be made for it. Two years spent in laboratories and dissecting rooms form but a poor preliminary from a health point of view to the long study of disease which then has to be undertaken, in wards and out-patient rooms, mixing daily with the sick of every kind. The athletic side of education is really more necessary for the medical than for any other class of student, and for all this allowance must be made in estimating the cost of a medical education."

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