> The relationships that general practice allows us to form with patients can last decades

NO HOLDS BARRED Margaret McCartney PPA COLUMNIST OF THE YEAR

General practice is a long game

At the end of another long and difficult day, it's easy to lose all sense of the joy of working as a GP. It's still there, under a pile of paperwork maybe, but it's still there.

I'm thinking about the baby born after many years of trying, when you exchange smiles with the parents, who know too well the years of tears and infertility.

I'm thinking about the bereaved husband, and the wife who came to talk to you about her fears about how he'd manage after her death. His wife understood that you'd still be around after she died and that you'd still be offering care to her husband.

I'm thinking about the person you haven't seen for a few years, but who returned to the practice to see you because you helped with her depression before.

General practice is joy in small things, and small things are big things. It's there when you say hello to someone who's at the practice to see not you but the nurse. But you know these patients, their mothers, their sisters. You know that they're at the practice to have blood tests to monitor the cancer you diagnosed last year. You both know this.

The relationships that general practice allows us to form with patients can last decades. They weave between families and overlap across illnesses, presentations, treatment choices, and even death. They make it easier to handle uncertainty, to talk about dying, to think about mortality, to grieve, to make rational choices, and to feel joy.

If you rip the longitudinal care out of general practice, it's just a set of interactions to be monitored by tick box targets or analysed as data on "activity in primary care." Take the relationships with people out of general practice and you have an unsustainable future.

General practice is a risk sink: we are the depository of much uncertainty, which allows an affordable NHS to exist. But it can work only when it's supported by trust between patients and doctors. We make judgments about who we trust, and those judgments are stronger and better when they're formed over time.

If we ensure that long term relationships are the default priority, we'll be closer to getting back to the joy we all need in our working lives.

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com
Follow Margaret on Twitter, @mgtmccartney

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PERSONAL VIEW Katherine McKenzie

Backing human rights, one patient at a time

Medical exams can significantly increase the likelihood that asylum will be granted

I saw my first asylum seeker around 10 years ago in my clinic. He came from a country with an autocratic president against whom he had peacefully protested. The government would not accept dissent from its citizens and they arrested, detained, and tortured him. He was released, but he was told that he would be killed for any future—real or perceived—opposition. He fled to the US for safety, and eventually came to my office for a forensic medical exam to document the scars of his torture.

In the intervening years I have come across many people who have experienced human rights abuses in different forms. A woman who wanted to attend church in a non-Christian country and was attacked each time she tried. A man who lived with his male lover; they were beaten nearly to death when they went to a bar together. A woman whose husband began to abuse her regularly soon after they married; the police refused to intervene when she sought protection as they said it was a "family matter." A woman who was forced, as a young girl, to undergo genital cutting. These individuals are seeking for themselves the rights I am fortunate to enjoy every day. They want to live in a country where they can protest against a government, worship as they desire, live safely in intimate relationships, love the person they want to.

Doctors have unique skills to help asylum seekers: they can use their medical training to document the physical and psychological scars of torture and ill treatment. Although emotionally challenging, the work offers the rewards that attract doctors to the practice of medicine in the first place. We hear stories, we lay on hands, we use our expertise to help. And medical exams can significantly increase the likelihood that asylum will be granted.

Doctors have unique skills to help asylum seekers

Providing refuge to those fleeing danger or injustice has historical precedent, and societies have been offering asylum for millennia. In the 20th century the Universal Declaration of Human Rights was adopted by the United Nations and member states. Many countries have laws protecting these universal human rights and provide a process for those in danger to seek asylum.

Much of the discussion surrounding refugees and asylum seekers involves the vetting process—and this issue is not a small one.

ACUTE PERSPECTIVE David Oliver

Is the ward round dead?

Has the ward round had its day? I recently enjoyed an animated conversation on Twitter with some junior doctors who had posed this question. My intuitive response? Absolutely not.

Seeing and talking with each of our patients, reviewing their progress, treatment, and investigations, and planning their ongoing care or discharge, is what inpatient hospital doctors do. It's often accompanied by a multidisciplinary team discussion of all patients—perhaps a better use of non-medical staff time than traipsing after a medical entourage. This all sounded like a ward round to me, so what was the problem? Besides, earlier in my career we consultants were often content to do the round twice a week, delegating most daily work to a team who worked more independently and unsupervised. Was that better for patients or for us?

Nowadays, frequent senior review is the norm, even at weekends. Consultants on acute assessment and intake are expected to see all newly admitted patients within hours rather than only on epic, morning-only, "post-take" ward rounds. We focus relentlessly on patient flow and discharge, sometimes at the expense of other priorities including teaching and training.

Were those modern juniors justified in their regret for a lost golden age? Maybe.

Each week now brings a different permutation of junior doctors on the ward. They've often been doing shift work on take or doing out-of-hours ward cover and can't possibly know the patients. The senior doctors must sometimes provide the continuity, effectively presenting patients to the juniors to get them up to speed.

In the Royal College of Physicians' recent report *Being a Junior Doctor*, trainees described the downsides of their working lives, including a lack of continuity; a gradual erosion of the traditional "firm" structure

ROBERT A LISAK

But physicians are not required to determine whether a person is a security risk. In fact, rigorous background checks are performed on all asylum seekers. The doctor's role is to approach each person individually and assess whether their exam findings corroborate the story they tell.

The US recently elected a president who has stated his strong opposition to giving people asylum. Irrespective of the election results, a record number of people remain globally displaced. Now more than ever, over 65 million women, men, and children need protection; this fact has not changed despite the new political landscape.

As a physician dedicated to supporting refugees and asylum seekers, I will continue to vote for candidates who advocate for them. But political change may be a long way off, so this week I will again have the privilege of entering the exam room with someone who came to this country to be free from persecution and, if their story is credible, my exam will help that person live a safer life.

Katherine McKenzie is director, Yale Center for Asylum Medicine, Yale University, Connecticut
katherine.mckenzie@yale.edu

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Senior doctors must sometimes provide the continuity, effectively presenting patients to juniors to get them up to speed

with its team ethos; a lack of opportunity for teaching, learning, and reflection; and less opportunity to take autonomous responsibility without "senior decision makers" diving in so early.

I reckon my friends on Twitter were mourning the chance to assess and initially manage patients, to present them to seniors, to learn and grow from the feedback, and to be patients' fulcrum of continuity.

But acute admissions are rising, as are patient turnover, frequency, and the pace of decisions.

We have 3-4 hours to get around 25 or more patients—several new and unknown. Perhaps the biggest skills to learn are how to see all patients quickly and often, spot and stabilise the sickest, discharge the least unstable early, accept calibrated risk, cut corners, and prioritise. Peeling off mid-round to do pressing administrative jobs is inevitable. Delays deny beds to other patients.

If the ward round really is dead, then long live the ward round. Maybe it's simply had a reincarnation.

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

References are in the version on bmj.com.

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BMJ OPINION Daniel Gibney

Simplistic measures hide reality of patient care

Since 2004 NHS emergency departments in the UK have been set the "four hour target"—the time from arrival to discharge and transfer out of the department should take no longer than four hours for all patients.

Initially the target was for 98% of patients to be seen in this time, that was lowered to 95% in 2010, and in January 2017 the health secretary, Jeremy Hunt, suggested that the target was likely to change again in response to the 2016-17 winter crisis.

But is the four hour target really the most accurate marker of quality and performance? The target has led to fears that patients are being moved inappropriately—in pain, too early, or without complete treatment—leading to a detrimental effect on their care. And in 2017 the failure to meet the target is because demand has outstripped capacity rather than any failings in the departments themselves.

The target has led to fears that patients are being moved inappropriately

There are several other statistics that trusts use to assess emergency departments, which are arguably more telling than the four hour target.

The time from arrival to treatment is rarely recognised as a marker of quality of care. However, in advanced quality frameworks or commissioning for quality and innovation payment frameworks the "time to treatment" is emphasised. The time taken to receive antibiotics in sepsis cases, for example, is surely the most crucial part of emergency treatment; the overall time spent waiting for a bed in the department is not. Equally, time to intravenous fluids for an acute kidney injury, or analgesia for acute pain are probably more important than a patient being in and out in four hours.

The 12 hour trolley waits, and delayed ambulance handovers that take longer than 60 minutes—at a £1000 fine a time—show that the system is running to capacity. The time from arrival to nurse triage, which ought to be within 15 minutes, is also an important statistic that we do not pay enough attention to.

Many emergency departments have minor injury units attached to them. These often have shorter waiting times, as do specialist emergency departments such as gynaecology, obstetrics, or eye hospitals. When these patients are grouped in with the figures, it may look like a hospital is doing well on the four hour target, but actually the average wait to see a doctor and for treatment may be several hours at times—this is surely where the patient safety issues lie.

Daniel Gibney, locum in emergency medicine, Liverpool

ANALYSIS

Making mindset matter

Alia Crum and colleagues argue that acting on the growing evidence about the influence of patient mindset and social context on response to healthcare can improve outcomes

The current standard for evaluating medications and treatments, the randomised controlled trial, involves identifying the effects of active ingredients by subtracting out effects produced by placebo. This model effectively isolates medical treatment by comparing it against "medically superfluous," forces of healing, including social context (eg, medical ritual, patient-provider relationship, institutional reputation, branding), mindset of the patient (eg, the patient's conscious or embodied expectation to heal), and the body's natural ability to heal itself with time.

The randomised trial is a good and rigorous standard for testing the efficacy of new medications. But what this model obscures is that, in the practice of medicine, the psychological and social elements underlying placebo effects remain an influence in active treatment (figure). Indeed, medical diagnoses and treatments are never isolated from patient mindsets and social context.

SUMMARY POINTS

- Mindsets and the social context affect every medical encounter, for better or for worse
- The effects of mindsets and the social context are not magical or mysterious
- Sophisticated psychological measures and advanced neurobiological technologies enable them to be measured, categorised, and quantified
- Understanding and harnessing psychological and social forces in medicine can help optimise the effects of advancing medical treatments and knowledge

Diagnoses and treatments are never isolated from mindsets and social context

When interacting with patients, physicians communicate scientific evidence within the framework of subjective judgments, expectations of treatment outcomes, and perceived patient preferences. Patients are influenced by their trust in physicians and how their physicians listen to, engage, and inform them. Context or environment, such as the branding, price, and advertising of drugs, or the hospital or doctor's credentials, also have an influence. Rather than being incidental to treatment, these psychological and social elements play crucial roles in determining clinical outcomes.[1-3]

From this perspective, the whole meaning of placebo effect changes. It's no longer a mysterious response to a sugar pill but the scaffolding of psychological and social forces—the support system—on which the total effect of treatment rests. Knowing this, we can move beyond merely asking how a treatment compares with a placebo and begin to ask more useful questions such as what are the components driving placebo responses and what can we, as patients and providers, do to more effectively leverage these components to improve healthcare?

Neurobiology

The placebo response, evoked by people's mindset (conscious or embodied expectation) that they will heal, can account for clinically significant benefit in an estimated 60-90% of conditions, including pain, anxiety, depression, Parkinson's disease, asthma, allergies, hypertension, immune deficiencies, and Alzheimer's disease and even recovery from surgery.[1 2]

Neurobiological research over the past 30 years has shown that the expectation to heal triggers distinct brain areas associated with anxiety, pain, and reward circuitry, as well as peripheral physiology involved in many biological systems, including the cardiovascular, endocrine, respiratory, nervous, and immune systems.[1 2]

Moreover, this research shows different mindsets evoke distinct, objective correlates that work through a unique cascade of physiological effect to produce the expected outcome. For example, the mindset that pain will be relieved activates endogenous opioid systems in the brain, whereas the mindset that anxiety will be reduced activates corresponding changes in the anterior cingulated and orbitofrontal cortices as well as in sympathetic nervous system activation, resulting in decreasing blood pressure and heart rate.[2]

Mindsets are also responsible for negative effects or "nocebo" responses, which include heightened pain response after patients are informed that an injection will hurt and increased presence of side effects such as nausea, fatigue, and sexual dysfunction after physician disclosure of possible negative side effects of medication.[4] An estimated 4-26% of participants randomised to placebo in clinical trials drop out because of nocebo effects.[5]

Research also suggests that the benefits of behavioural treatments are influenced by patients' mindsets about those behaviours. For example, the physical benefits of exercise depend on the degree to which someone perceives a specific physical activity to

be "good exercise."[7] Studies have shown that believing stress is debilitating for performance or productivity alters cortisol activity and stunts dehydroepiandrosterone response when compared with believing that stress can be enhancing.[8] And a large cohort study of over 28 000 people found that, after actual levels of stress were controlled for, individuals who believed stress negatively affects health were 43% more likely to die prematurely.[9]

Mindsets do not appear out of nowhere; they are shaped by social context. In medicine these sources include explicit expectations set by the doctor and more subtle social or environmental factors. A review of "open-hidden design" studies found that when medication is administered openly by a physician or healthcare provider who informs a patient they will experience benefit (such as pain relief, reduced blood pressure), it has a significantly greater effect than when it is administered by a hidden machine.[10] These studies show that a doctor's language matters tremendously,[11] but subtle cues like the doctor's coat and the label, colour, price, and advertising of medication can also make a difference.[12 13]

The qualities of the patient-provider relationship, like empathy and understanding, can also produce measurable physiological improvements beyond the effects of actual treatment by boosting patient expectations, lowering anxiety, increasing psychological support, and improving patient mood. For example, physician empathy has been associated with better clinical outcomes for patients with diabetes, including better haemoglobin A_{1c} and LDL cholesterol control[14] and fewer instances of acute metabolic complications.[15]

Moving forward

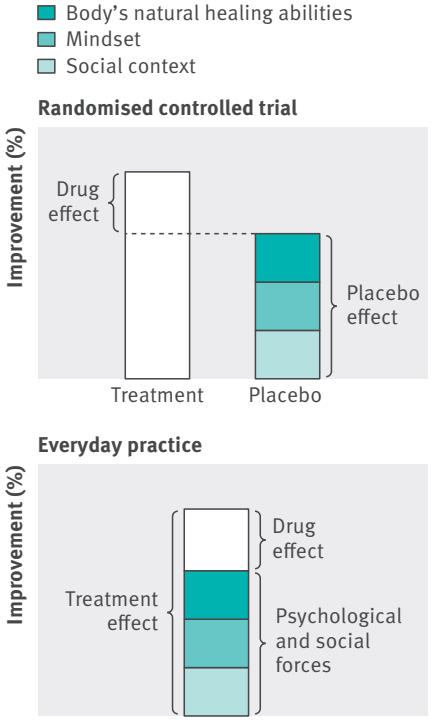
Despite the potential benefits of psychological and social forces in healing, they have received much less attention than drugs and devices. Most physicians are enacting these components on a daily basis, but their awareness of this and effectiveness varies. Physicians receive minimal training in how to harness these forces to their patients' advantage. Beyond accepting these forces as prevalent and critical components of the clinical encounter, other steps are needed to more effectively understand and harness them. We offer the following recommendations for research, education, and health systems.

Research

We need interdisciplinary investigations that manipulate psychosocial elements in the context of existing medical practices. Studies using physiological measures as outcomes will enable us to tackle questions such as how can we inform patients of risks or side effects without causing unnecessary harm? How can we create social contexts, relationships imbued with warmth and competence, for people of all races, genders, ages, and backgrounds? What individual and institutional mindsets can help physicians connect with patients while also prioritising self care and reducing burnout? And how can psychological and social forces help prevent serious oversights, medical errors, diagnostic delay, and unnecessary tests and treatments?[17 18]

Practice and education

Additional training should be developed to highlight the role of psychological and social forces in healing and provide the skills and knowledge to help medical students and residents harness their personal strengths to connect with diverse patients; shape patient expectations in the midst of uncertain, or threatening, circumstances; and inform patients about the role of psychological and social forces, enabling them to choose optimal mindsets and shape the social context to their advantage.



The psychological and social forces of healing are typically viewed as in competition with drug effects in placebo controlled trials (top) but in everyday practice they underlie all treatment effects (bottom). Relative percentages of placebo response and drug responses vary across drugs and conditions

Healthcare systems

System reform should align with and promote effective use of psychosocial elements in healthcare. A first step is to rethink and reform standards of randomised trials so that they include natural conditions (no placebo treatment) and conditions in which elements of the social context and mindset are present or absent (high or low placebo conditions), allowing researchers to understand how beliefs, labels, and context can help magnify the effect of the drug and treatment. Additionally, it is time to reconsider best practices for informing patients of side effects to avoid making those side effects more likely.

The right systemic incentives and resources must be provided to ensure that lessons instilled in medical training are implemented and measured to prove their efficacy. This should include providing adequate time and incentives for physicians to harness relationships with patients. Coordinated care models, in which patients have a comprehensive healthcare support team, could help leverage patient mindset and the social context by treating the patient holistically. Advances in medical technology should also be harnessed to free doctors' time to focus on the social context and relationship of the clinical encounter.

No stones left unturned

Tackling the future threats to our health and the increasing complexity of non-communicable diseases will require all the tools at our disposal to improve the health and wellbeing of our population. Alongside advances in drug and surgical treatment, improved understanding of the ability of the social context and patients' mindsets to evoke healing properties in the body can be an extraordinary resource for health and healing. We need to open our own minds to that possibility.

Alia J Crum, assistant professor of psychology
crum@stanford.edu
Kari A Leibowitz, doctoral candidate
Abraham Verghese, professor of medicine, Stanford University, Stanford, CA, USA

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OBITUARIES

Lindsey Dow

Stroke consultant Bristol Royal Infirmary (b 1957; q Middlesex Hospital Medical School, London, 1981; MSc, DM, FRCP), died from metastatic breast cancer on 21 November 2016

Lindsey Dow worked as a research fellow in the department of medicine at Southampton Hospital. During this time she met Patrick J Gallagher, a cardiovascular pathologist and an academic at Southampton University, whom she married in 1988. In 1989-92 she was a senior registrar in general medicine and geriatrics in Oxford, and in 1992-2004 a consultant senior lecturer in medicine for the elderly at Frenchay Hospital, Bristol. She took up the post of consultant in geriatrics and stroke medicine at the Royal United Hospital in Bath in 2004. From 2015 to 2016 she worked briefly as a stroke consultant at the Bristol Royal Infirmary, but ceased working in March 2016 on receiving her cancer diagnosis. She leaves her husband and five children.

Judy Towers

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Michael Massam

Paediatrician South Tyneside District Hospital (b 1949; q Manchester 1972; FRCPCH; FRCP), d 14 November 2016

Michael Massam ("Mike") trained as a paediatrician in Manchester and the north east of England before being appointed to a consultant post at South Tyneside District Hospital in South Shields, where he spent 23 years practising general and neonatal paediatrics. He had a daily competition with a long time colleague, Margaret Taylor, over the *Times* crossword. He retired in 2009 from both the hospital and the Territorial Army. He had received the Territorial Decoration and held the rank of lieutenant colonel. He was interested in military history, organised a series of battlefield tours, and saw operational duty, serving in Afghanistan, Bosnia, Iraq, and Northern Ireland. His paediatric experience and general duties expertise were invaluable to the medical services provision of the TA.

Stephen Cronin, Ann Clouston

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Nicholas Wright

Consultant psychiatrist Park Prewett Hospital, Basingstoke (b 1932; q Cambridge/St Thomas' Hospital 1956; FRCP, FRCPsych), died from prostate cancer on 2 October 2016

Nicholas Wright was born in Newcastle upon Tyne and won a scholarship from Newcastle Royal Grammar School to Cambridge. During national service he joined the Royal Army Medical Corps at Netley, the army's main psychiatric hospital. He returned to St Thomas' as neuropsychiatric registrar. In 1966 he was appointed consultant at Park Prewett Hospital in Basingstoke, a large county asylum, and became the first visiting psychiatrist to Winchester prison. He was an expert witness in several high profile murder trials. In retirement he worked for the Parole Board and pursued his interests in travel, gardening, opera, and bridge. He leaves his wife, Rosemary; children; and grandchildren.

Ian Ellison-Wright

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John Frederick Perren

General practitioner Welwyn Garden City (b 1930; q Charing Cross Hospital Medical School, London, 1953; DRCOG, MRCGP), died from interstitial lung disease on 19 September 2015

After house jobs, John Frederick Perren served as medical officer in the Royal Air Force. On demobilisation he passed the examination for the Diploma of the Royal College of Obstetricians and Gynaecologists (DRCOG) at St Luke's Hospital in Bradford before joining a general practice in Welwyn Garden City, where he was a GP for 32 years. Throughout his professional life, John was an active member of the BMA. A founder member of the junior doctors' forum, he held office in the Hertfordshire division until his death. After retiring he served as clinical tutor at the postgraduate centre at the Queen Elizabeth II Hospital in Welwyn and as medical officer to Herts Constabulary. John leaves his wife, Mary; four children; and 11 of his 12 grandchildren.

Matthew Perren

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Christopher James Stevenson

Consultant dermatologist Newcastle upon Tyne (b 1922; q London 1945; MRCS Eng, FRCP Lond, MD Lond, MFOM RCP), d 30 October 2016

Christopher James Stevenson ("Chris") trained at the London Hospital during the war, funding his studies by fire watching. He was consultant dermatologist in Newcastle upon Tyne from 1961 to 1988, working at the Royal Victoria Infirmary, Newcastle General Hospital, and, latterly, the Freeman Hospital. He taught at the medical school and took particular interest in industrial dermatology and leprosy. He enjoyed weekly clinics at Alnwick, Berwick, and Hexham and meeting patients from different walks of life. After retiring from the NHS he continued working part time, including war pension claims, medicals for the Gas Board, and assessing doctors applying to work in the UK from overseas. He finally retired aged 78. Predeceased by his wife, Lizzie, on 13 September 2016, he leaves two children.

Bernard Stevenson

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Edwin Thomas Melley

General practitioner Redditch (b 1930; q Birmingham 1954), died suddenly from ischaemic heart disease on 21 October 2016

Edwin Thomas Melley ("Eddie") was born in Redditch, Worcestershire, where he was to practise medicine for most of his professional life. During his national service in Germany he married Barbara. After returning to the UK, Eddie entered general practice. In 1961 he moved back to Redditch to join H E Hufton as a practice partner. Within a year he became senior partner. He oversaw the move of the practice to a new, purpose built health centre in 1972, and he led the practice until he retired in 1993. In retirement Eddie developed ischaemic heart disease and needed coronary artery bypass surgery; eventually he was fitted with a defibrillator. Predeceased by one of his daughters, he leaves Barbara, a son, a daughter, seven grandchildren, and one great grandchild.

W J S T Shaw

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Halfdan Mahler

Former director general of the World Health Organization whose aspiration was "Health for All"

Halfdan Theodor Mahler (b 1923; q University of Copenhagen 1948), died from renal failure on 14 December 2016

The run up to the event that Halfdan Mahler, former director general of the World Health Organization, will be best remembered for was a fraught process. In 1978 the International Conference on Primary Health Care took place in Alma Ata (today Almaty), the capital of what was then the Soviet republic of Kazakhstan. At the end of the conference, the historic declaration, Health for All by the Year 2000, was made, with its lofty aim of the "human right to health."

The conference was held at a time of change for WHO, when Mahler, who had become director general in 1973, was reorienting the organisation's focus away from single diseases. By the 1970s countries in Africa and Asia, finally free from their colonial masters, were asking for help to build their health systems: Mahler thought that primary healthcare, rather than expensive technological solutions, was the best solution.

Some thought that Health for All was a woolly and unachievable aim. However, for Mahler the phrase was more about an aspiration or an ideal.

The idea of health equity was important to Mahler, who took pains to ensure that no one was left out

Social revolution in public health

The idea of health equity was important to Mahler, who, in both his personal and his professional dealings, took pains to ensure that no one was left out. When he became director general, Mahler had already spent more than 20 years working for the organisation. He had joined the tuberculosis programme in India in 1951, working his way up to become chief of the programme in 1962, then becoming director of systems analysis before serving as assistant director general from 1970 to 1973.

In 1977 he cut headquarter staff by a quarter and refocused the organisation, devolving power to regional offices which Mahler believed were the drivers of the Health for All agenda. Mahler described this as a "social revolution in public health." Headquarter staff were, unsurprisingly, not happy about the changes.

Mahler's vision of primary care being implemented throughout the world did not come to fruition, for various reasons. However, one of his lasting achievements was the adoption of the Model List of Essential Drugs—later renamed the Model List of Essential Medicines—designed to curb aggressive marketing of pharmaceutical products in developing countries. And in 1980 Mahler had the happy job of declaring the eradication of smallpox, after a worldwide immunisation campaign that began in 1966.

Mahler, one of seven children, two of whom died in childhood, was born in Vivild in Denmark. His father was a priest whose fire and brimstone brand of Christianity both turned his son off religion and gave him the Protestant work ethic which was to drive his career.

Mahler qualified from the University of Copenhagen in 1948 and after six months in a sanatorium in Sweden decided that clinical medicine was not for him. He took a job with the Danish Red Cross, where he met his future wife, Ebba Fischer-Simonsen, a geriatric psychiatrist. He ran a tuberculosis programme in Ecuador for the Red Cross before joining WHO in India.

Diplomacy

Mahler put his attainment of high office down to a series of lucky events. He was a skilled diplomat and managed to divert a minor diplomatic incident when the US registered its displeasure at the prospect of Cuba chairing WHO's general assembly. When he visited Cuba, the country's president, Fidel Castro, told him, "You're a nice guy. It will be okay."

Mahler stepped down from WHO in 1988 after three terms as director general. In his final term the AIDS epidemic exploded, and Mahler said that WHO's response to the disease was too slow. He told the *New York Times* that he "in particular" had underestimated the disease. However, he appointed a US HIV specialist, Jonathan Mann, in 1987 to run the HIV programme and made combating the infection a priority.

Stepping down from WHO was hard, but he continued to be engaged with the health world, becoming director of the International Planned Parenthood Federation until 1995 and visiting WHO headquarters in Geneva for many years.

Halfdan Mahler's wife died in 2015. He leaves two sons.

Anne Gulland, London
annecgulland@yahoo.co.uk

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LETTER OF THE WEEK

Four hour target in A&E isn't clinically sound

The statistics that track its performance might be part of the NHS's problem (This week, 21 January). The idea that 95% of patients attending hospital emergency departments should be seen and admitted or discharged in four hours was wrong from the start.

As a junior doctor at the turn of the century, I often had to drop more pressing clinical problems to quickly clerk a patient to avoid breaching the target. Sometimes clinical managers would interrupt me to move the patient out of the emergency department, even though I was assessing whether they needed to be admitted at all. The patient would then be admitted by nurses to a medical ward, and a tsunami of paperwork would engulf the case.

What other country or system in the world makes such a promise? It is an open invitation for inappropriate use, and the NHS lacks the resources to deliver. These patients need alternative sources of healthcare advice. For example, rapid response teams could see elderly patients who fall at home.

We need to examine why these options aren't available nationwide and to build up scientific evidence to prove that they work. Entitling everyone to a four hour promise is neither clinically sound nor sustainable by emergency departments. It dissuades us from looking at genuine alternative solutions that might share the burden.

M Justin Zaman (justinzaman@nhs.net)

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BCG AND CHILDHOOD MORTALITY

Non-specific effects of BCG on childhood mortality

BCG can reduce childhood mortality more than would be expected from its specific protection against tuberculosis alone (Research, 13 October 2016); it was associated with lower mortality of infants with low birth weight in Guinea-Bissau.

However, we found no non-specific beneficial effects on early childhood morbidity in a randomised controlled trial in Denmark, where routine BCG vaccination was discontinued from 1979 owing to low prevalence of tuberculosis.

Maybe the effect of BCG is at least partly specific; its strongest benefit was observed in settings where tuberculosis is prevalent and cause of death is based on verbal autopsy. Moreover, low birth weight is a risk factor for tuberculosis. Notably, the beneficial effect of BCG on neonatal mortality in Guinea-Bissau was mainly due to fewer cases of neonatal sepsis, respiratory infections, and fever; that is, potential early mycobacterial infection. Further scrutiny is needed.

Lone G Stensballe (lone.graff.stensballe@regionh.dk)

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WE READ SPAM A LOT

Young researchers receive spam a lot too

Grey et al assess the academic spam received by mid-career academics (Food for thought, 17 December). These emails aim to deliberately mislead academics and to earn money through unethical practice. The concern goes beyond mid-career academics: many researchers early in their career and even postgraduate students receive such spam. Colleagues and students have been shocked to find out that invitations they received were from fake journals aiming to make money.

The rise in journals targeting academics is concerning, particularly given the pressures of publishing among early career academics and sometimes students. These predatory journals that offer quick turnaround of articles are often not indexed, have questionable review processes, have fake websites and publishers, and hide the cost of publishing. Receiving invitations from these outlets has become a daily occurrence. Universities should highlight the dangers of predatory journals to ensure that researchers use companies that are reputable and ethical.

Stuart W Flint (s.w.flint@leedsbeckett.ac.uk)

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FDA DRUG PACKAGES

Search FDA documents easily at fda.opentrials.net

Good progress has been made since Turner wrote about how to find data on the Food and Drug Administration's website (Research Methods and Reporting, October 2013). We have made a public facing tool for accessing and searching FDA documents. It is freely available online at https://fda.opentrials.net/search.

We automatically download a copy of every document on the FDA website. We upload them to an online tool where they are processed, run through optical character recognition, made searchable, and placed in a repository where they can be tagged. We have extracted trial identification codes and linked them, where possible, to the matching OpenTrials entries for those trials.

Ben Goldacre (ben.goldacre@phc.ox.ac.uk)
Erick Turner On behalf of the OpenTrials team

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ANTI-BULLYING PROGRAMME

Holistic view is needed to tackle bullying

Although the British Orthopaedic Trainees Association should be applauded for investigating concerns about bullying and trying to "create a positive workforce culture," their approach seems somewhat shortsighted (This week, 28 January).

Trainees are not the only victims: consultants and specialty doctors may often be on the receiving end of such behaviours from more senior colleagues, managers, or trainees themselves. This issue has been recognised and reported in other surgical specialties. Unless a more holistic view is taken, this programme seems destined to be empty rhetoric rather than a genuine attempt to "get our house in order."

Stephen Dalgleish (sdalgleish@nhs.net)

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