comment

"Doctors are not vocal enough in support of non-medical colleagues" **DAVID OLIVER**
" This new contract feels like being kicked when we're already down" **HELEN SALISBURY**
PLUS Refugee policy has to change; consent, students, and phone consultations

TAKING STOCK Rammya Mathew

Emotional toll of being a junior doctor

Watching the TV adaption of Adam Kay's book *This is Going to Hurt* took me back to my junior doctor days. The show characterises the vulnerability of junior doctors in their training years, and, for me, it triggered memories of experiences I personally endured—some comical and some more painful.

I was reminded of the young patient with metastatic ovarian cancer whom we all got to know very well during her long stay on the ward. She wasn't shy about wanting to set me up with my foundation year 1 colleague, and our consultants took great pleasure in joking about how they couldn't allow us to both go on leave at the same time but still wanted an invite to our wedding. I still remember the overwhelming sadness we felt when we found out that she had gone home to die but had sadly died en route.

There was also the over-zealous registrar who would request electrocardiography, chest radiography, arterial blood gas, and medical review if any of our patients had even the slightest of sniffles. I remember calling the medical on-call each time, bracing myself for a barrage of abuse and having to take the rap yet again for wasting their time. One day I decided to rant about this in a colourful text message to a friend, but my tired eyes made the error of sending it to the registrar in question. Coming into work the next day was painful to say the least.

Perhaps most vivid is the terror that accompanied the start of any new job and what it felt like to be perpetually thrown out of my comfort zone. I have memories of frantically looking up how to drain a peritonsillar abscess during my first on-call shift in the ear, nose, and throat department, just before having to greet the patient and give them the impression that I had it all under control and of course hadn't just learnt how to do the procedure by watching a YouTube video.

I realise that, when I started life as a junior doctor, I was wholly unprepared for the mental, physical, and emotional toll that the ensuing years would have on me. The intensity of the work and the lack of control I had over my life—both inside and outside of work—undoubtedly came at great personal cost.

It's worth noting that the prevalence of post-traumatic stress disorder among doctors is in the region of 14%, much higher than the 3-4% prevalence rate found in the general population. In that context, it's no wonder that the TV adaptation of *This is Going to Hurt* has been triggering for so many doctors. I just hope that some of this debate also leads to better support for future doctors while they navigate these wild and wonderful years.

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I was wholly unprepared for the mental, physical, and emotional toll the ensuing years would have on me

OPINION Matteo Besana

The UK's bespoke approach to refugees has to be rejected

The government's response to fleeing Ukrainians highlights the major flaws in the Nationality and Borders Bill

As I was writing this article, I watched the government announce yet another change of policy towards Ukrainians fleeing their country.

The Médecins du Monde network, of which Doctors of the World is a member, has operated in eastern Ukraine since 2015, just after the 2014 conflict started. When the current hostility broke out, we had to ensure the safety of our doctors, support staff, and vital medical supplies, as well as reassess how we can continue to support the country as it descends further into war. This will include supporting refugees fleeing to neighbouring nations.

This latest change in the UK's policy came after the government had previously suggested, among other things, that people fleeing for their lives should apply for seasonal work visas, or meet a very restrictive definition of joining family members. While the latest changes, announced on 1 March, are welcome, they do not match either the rhetoric or the effort put in place by Ukraine's EU neighbours. The UK government is asking people who have fled their homes in fear of their lives to go through a lengthy bureaucratic process to apply for a visa to join family members, when what is needed is to prepare the machinery of government to welcome every Ukrainian refugee who wants to come here.

These latest decisions come with the backdrop of the Nationality and Borders Bill, which is going through parliament. As Lord Kerr said in a House of Lords debate, which saw the government repeatedly defeated, the bill, if already in place now, would disqualify the large majority if not all of the Ukrainians seeking sanctuary. It would do so by using a very twisted view of the "first safe country" and "regular or irregular" means of entry. Both of which are not part of the Refugee Convention, signed shortly after the second world war.

Worse health outcomes

As my colleagues and I have previously argued in *The BMJ*, the bill would massively increase the government's use of institutional accommodation and temporary refugee status. Both of which lead to worse health and wellbeing outcomes for people seeking sanctuary in the country.

More broadly, and even more importantly, the government's approach to Ukrainian refugees

The Refugee Convention was built on the key principle of universality

represents a dangerous view of the refugee system. One that Priti Patel, the home secretary, states will be "bespoke" to the situation at hand.

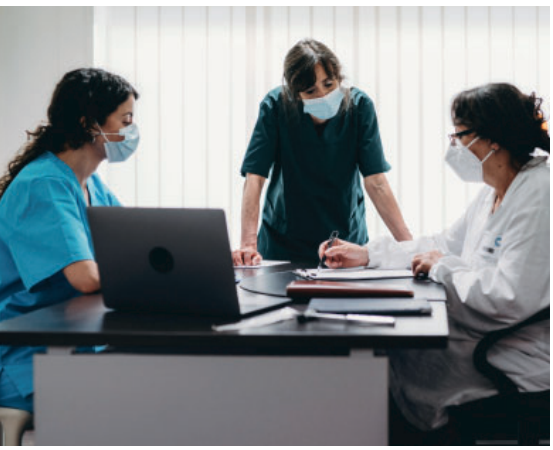
As colleagues from Refugee Action have said, the refugee system that was built after the second world war and the Holocaust wasn't built with the ability for nations to decide which group of refugees a nation should welcome, and which ones it was allowed to reject. The Refugee Convention was built on the key principle of universality, of being available to everyone fleeing violence or persecution.

The latest conflict in Ukraine proves a bespoke system will never be able to adapt to a world in which conflicts, violence, or oppression are still too diverse to be predictable. Such a system would undermine one significant step of progress that emerged following the shame and horror of the Holocaust and would represent a step backwards.

This proposed approach is a direct result of allowing the "hostile environment" to penetrate and influence asylum policies and principles over the past decade. This has had a

OPINION Poppy Welsh

Ensuring patient confidentiality in the virtual world



Telemedicine has become a regular occurrence in both primary and secondary care settings as a result of the pandemic and is a tool that is likely to remain in use. However, with the reintroduction of medical students into placements, concerns about explicit consent and patient confidentiality are emerging, and clear guidance is needed.

In face-to-face consultations where students are present, their inclusion is an immediate visual cue, which naturally leads to consent being gained from the patient. However, with the increasing use of telephone consultations, this visual cue has been removed. When I shadow telephone consultations as a student, most clinicians place the call on speakerphone to allow me to hear both sides of the interaction for educational purposes. Unfortunately, I know from my experience, and that of my

The failure to obtain explicit consent risks reducing the patient's trust

peers, that sometimes gaining explicit verbal consent from the patient is overlooked.

Medical School Council (MSC) guidance says, "Patients must consent to a student being present during a remote consultation." The failure to obtain explicit consent risks reducing the patient's trust, potentially undermining the therapeutic relationship. As a student, I feel uncomfortable if consent has not been gained, and yet often don't feel able to raise it. It has been reported that up to 56% of medical students don't feel able to speak up about concerns over patient safety, and as little as 28.5% feel able to report incidences. A hierarchical structure persists in medicine, and it can be intimidating for students to feel they're disrupting the status quo.

DANIEL LEAL/AFP/GETTY IMAGES

deleterious impact on the efficacy and speed with which asylum applications are processed. The "hostile environment" broke, or at least makes significantly worse, the asylum system and the latest statistics published recently prove this key point once again.

Compounding all of this has been a continuous narrative around "genuine" versus "non genuine" refugees or "refugees" versus "economic migrants." This narrative seeks to sow divisions and implies doubt regarding the person living next door or the patient entering our surgeries and our hospitals. It is a narrative that, as we see every day at Doctors of the World, undermines people's health and wellbeing and pushes them to society's margins. A narrative that, as the pandemic has shown, does not represent good public health or basic humanity.

We need to continue lobbying our MPs to stop this bill in its tracks, but also continue to evidence how with this bill the government is further undermining the health and wellbeing of people seeking sanctuary in the UK.

Matteo Besana, covid-19 advocacy project lead, Doctors of the World UK

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This poses the question of when the most appropriate time is to gain consent and for the medical student to speak up if it's not obtained. The MSC suggests this should be done by the leading clinician at the start of the call. However, if this is not done, the onus falls on the student who could approach this in a few ways: they could proactively mention it at the start of the session, or if the consultations have started, politely remind the clinician in between calls. If they do not feel able to mention it directly, they could discuss it with a clinical supervisor.

It's important to facilitate the participation of students in telephone consultations, while continuing to prioritise the duty to ensure patient safety and respect their autonomy.

Poppy Welsh, fifth year medical student, University of Central Lancashire

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ACUTE PERSPECTIVE David Oliver

Medicine should be a better ally

Modern medicine relies more on multidisciplinary clinical teams and on the wider systems of care than on heroic, decisive individualism in one professional group.

Medically trained doctors and researchers have played a leading role in developing and evaluating techniques, service models, and treatments. And across hundreds of specialty areas there would be no care without a heavy reliance on doctors. Yet, what we as doctors do would prove largely impossible without nurses, allied health professionals, pharmacists, and social care colleagues, or without other workers such as care assistants, administrative staff, and porters.

Recently royal colleges, specialty societies, and the BMA have advocated strongly for more investment in social care and its workforces. There has been some advocacy for a larger nursing, pharmacy, and allied profession workforce to support primary care networks. Others bang the drum for universal services that help tackle wider determinants of health, inequalities, addiction, or crime.

In general, however, I don't think we are vocal enough in support of non-doctor colleagues. We work with them every day, often in tight knit teams. Some of the evidence we rely on for clinical service models explicitly refers to the value of the multidisciplinary team. But do we advocate on their behalf?

We have campaigned too often only for our own profession. This is understandable, given our own workforce gaps, workload, and conditions. Yet, as medicine is the best paid and most influential clinical profession we have the clout to be powerful allies.

Nurses are the biggest professional bloc in the NHS. But we have among the fewest per capita among developed nations, and around one in 10 vacancies is unfilled (the proportion is higher in some regions and clinical areas). General practice relies heavily on nurses managing long term conditions, preventive work, and, of course, vaccination. Yet, in all the recent campaigning by GP organisations and the lauding of the covid vaccine delivery, for example, I have heard too little recognition given to nurses.

In acute hospital care, gaps in the nursing workforce risk worsening care for patients and making our own jobs much harder.

Solidarity with our closest non-medical colleagues isn't just altruism. When nursing care and communication go wrong, it is often senior doctors who have to deal with the fallout. We have a real stake in this.

Allied professionals are also key to many services. Any team involved in rehabilitation, hospital discharge, or admission prevention knows this. Radiology with overstretched radiographers, or an ambulance service with too few paramedics, will become unsafe and beget staff departures or crises. Both professions face serious workforce gaps.

Doctors in key leadership roles need to speak out in solidarity with non-medical colleagues at every turn. Modern healthcare is a team venture.

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Solidarity with our closest non-medical colleagues isn't just altruism

PRIMARY COLOUR Helen Salisbury

The wrong prescription for GPs

When medical consultations go wrong it's sometimes because the doctor didn't listen, and instead of patients feeling ownership of a shared plan they leave with a prescription for pills they won't take or an exercise regimen they have no intention of following. An insightful doctor may be aware of the unspoken dissent, and although they ostensibly have the power in the relationship, the patient holds most of the cards.

This week NHS England has announced changes to the primary care network (PCN) contract, which provides a growing part of funding for GP services. These changes weren't agreed with the BMA and have been met with a chorus of dismay. One key point of contention is that a PCN must provide a full range of primary care services over the "enhanced access period" of 6 30 pm to 8 pm each weekday evening and 9 am to 5 pm on Saturdays. The whole primary care team must be available, including face-to-face appointments with a doctor.

There are many problems with this plan—most obviously, who will do the work? We don't have enough GPs, and spreading them more thinly across the week won't increase the number. In fact, for many, this imposed change is likely to be the straw that breaks the camel's back: it will push GPs who were struggling with their duty to patients and colleagues, along with their need for self-preservation, to finally take early retirement.

Part of the issue with the new contract is its content. Many GPs stop seeing patients at 6 pm and leave the surgery at 8 30 pm, when the paperwork is done. We have nothing left to give. An equal problem is the manner of its introduction: it's being imposed unilaterally after talks between NHS England and the BMA stalled last month. GPs made many suggestions about what shape a recovery plan for general practice should take and the resources needed to make it work. Instead, this contract feels very much like being kicked when we're already down. It won't help our patients if it results in fewer, more isolated GPs with a further loss of continuity.

Do we have any choices, short of resigning en masse? Some of us warned of this direction of travel from the PCNs' inception; that our funding would be increasingly routed through networks to remove the autonomy of individual practices. One option, particularly for those PCNs that are still only loose associations of practices, is just to walk away. Some of the staff we've taken on with money from the additional roles reimbursement scheme are invaluable, and we'll have to find the resources to keep them, but this is preferable to losing irreplaceable GPs.

NHS England may technically have the power to impose this contract, but I for one have no wish to swallow this bitter pill.

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Do we have any choices, short of resigning en masse?

LATEST PODCAST

The blame game

Blame in healthcare can be corrosive, and in this latest episode of Doctor Informed we hear about how teams and organisations can move away from a culture that is held back by it. Graham Martin, director of research at the Healthcare Improvement Studies Institute, describes why blame can be so harmful to healthcare:

"If people are fearful that the moment they raise a concern about something, either they or a colleague are going to get blamed for it, then they're much less likely to speak up and, therefore, the team and the rest of the organisation is much less likely to learn about it. Blame can have that chilling effect.

"If it's just about pinning responsibility for something that's gone wrong on the most obvious person, then not only is that very bad for the individual, it's not good for the organisation either because it's very rare that something is that simple, particularly in healthcare. These are complex organisations and usually there are systems that could be made better or which could have helped that person not to make the mistake in the first place. So blame is unhelpful if it's all you're looking for because it means you're not looking below the surface beyond those superficial, immediate problems."

Joselle Wright, deputy director of midwifery, gynaecology, and sexual health at Walsall Healthcare NHS Trust, discusses how a blame culture can make healthcare staff defensive in how they practise:

"We overtreat because we're concerned that if we don't and something happens we're going to get the blame. We undertreat because we're frightened of doing something that might cause a problem. We might speak to the patient in a very paternalistic, very authoritarian way because you want them to do what you want, and then, therefore, you diminish their choice."

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Edited by Kelly Brendel, deputy digital content editor, *The BMJ*

ANALYSIS

Protecting younger generations from the ongoing effects of covid-19

Mandeep Dhaliwal and colleagues call for urgent correction of governments' and health services' response to SARS-CoV-2 to safeguard the development of children and young people

As we enter the third year of the covid-19 pandemic, the negative effects have cut across all of the sustainable development goals (SDGs) and led to severe health and developmental challenges.[1] Children and young people in particular continue to face numerous socioeconomic problems as a result of covid-19, including those related to health, poverty, nutrition, education, employment, orphanhood, violence, abuse, and exploitation.

Evidence indicates that integrated solutions to mitigate the many different negative effects of the pandemic on children and young people can be delivered quickly and on a sufficient scale. To deliver solutions that help safeguard younger generations, we need to move beyond a narrow framing of covid-19 and use a multilevel, intersectoral response that takes into account the magnitude, complexity, and intergenerational dimensions of the pandemic.

Covid-19 as a multiwave, intergenerational event

After HIV was conceptualised as a long wave event in 1990, it was shown to have three main curves over time: HIV infection, AIDS related deaths, and societal effects such as children being orphaned and food insecurity. Breaking down the HIV/AIDS epidemic into these curves showed the magnitude, complexity, and intergenerational dimensions of the problem. It highlighted the need for longer term projections of the effects of the HIV/AIDS epidemic and mitigation efforts, including tackling the links between HIV, health, and development.[2]

As with the HIV/AIDS epidemic, the full extent of the covid-19 challenge must be recognised. Infections, illness, and death related to covid-19 have many indirect health and socioeconomic effects in the immediate, medium, and longer term. These effects, which range from disrupted health service delivery and education to increased violence and malnutrition (box), disproportionately affect poor and vulnerable people, including children and young people.[15] They are fuelled by and reinforce inequalities between and within countries, such as in the burden of covid-19, capacity to respond, and social determinants of health—for example, working conditions, housing, and access to healthcare including vaccines.[16] The multiple curves of infection, illness, death, and societal effects from covid-19 are likely to reoccur, creating a multiwave of overlapping health and socioeconomic effects over time.

We need to use a multilevel, intersectoral response that takes into account the magnitude, complexity, and intergenerational dimensions of the pandemic

The duration and multiwave nature of the covid-19 pandemic is mediated by several factors: (a) vaccine inequity, expected to last until 2023 in many low income countries; (b) highly transmissible variants of concern such as the delta and omicron variants; (c) potential for new variants to partly or fully evade current covid-19 vaccines; (d) unpredictable waning of population immunity; and (e) nature and implications of long covid. These and other factors, including inequitable access to covid-19 diagnostics and therapies, varying societal support for public health and social measures, and animal reservoirs of SARS-CoV-2, make it nearly impossible to eradicate the virus.

Effects on children, and young people

Children and young people presently account for a relatively small portion of direct illness and death from covid-19, although they are not immune and face risks of long covid.[17] A narrow focus on the direct and immediate health effects of covid-19 obscures the extent to which the pandemic is affecting children and young people.

Each wave of covid infection, illness, and death makes children and young people vulnerable to many negative socioeconomic outcomes (box). These negatively reinforce each other and could combine given the long and multiwave nature of the pandemic. Consideration of the multiple effects of the pandemic has prompted the Human Rights Council to request a study on how to mitigate the effect of covid-19 on the human rights of young people.[18]

KEY MESSAGES

- The covid-19 pandemic is a long and multiwave event
- Children and young people are at disproportionately higher risk of the effects of covid-19
- A multilevel, intersectoral response is needed to mitigate the negative effects of the pandemic on children and young people, with a focus on long term planning, layering of effective interventions, and scaled investments
- Evidence from other epidemics suggests investment in social protection, evidence based parenting support, education re-enrolment, and child health promotion can mitigate the effects of covid-19

Stronger and more resilient systems for health must be at the centre of intersectoral efforts

Covid-19 related problems affecting children and young people

Physical and mental health

- By May 2020, disruption of routine immunisation services for young children in 68 countries had already put about 80 million children under the age of 1 at risk of contracting vaccine preventable infections
- Six months of disrupted prevention services for perinatal HIV transmission could lead to an additional 124 000 children contracting HIV[3]
- Contraceptive interruptions for around 12 million women (because of disruptions to supplies and services) led to an estimated 1.4 million unplanned pregnancies in 2020[4]
- Younger people are among the most affected by the effect of the pandemic on major depressive disorder (more than 50 million additional cases) and anxiety disorders (more than 75 million additional cases).[5] Service disruptions for children and young people with mental health conditions or disabilities have been substantial since the pandemic began[6]

Learning

- 1.6 billion children, or 94% of students globally, were out of school in April 2020[7]
- In April 2021, an estimated 50% of the world's children (enrolled in pre-primary, primary, lower secondary, and upper secondary education) were still affected by partial or full school closures[8]
- About one third of schoolchildren worldwide (463 million children) did not have access to remote learning technologies or policies in 2020. Three quarters of these children were living in rural areas or the poorest households[9]

Employment

- One in six young people (17%) employed before the pandemic stopped working
- Disruption of work or education makes young people twice as likely to report as "probably affected by anxiety or depression"[10]

Poverty

- 140 million more children in developing countries are projected to be living in poverty because of the pandemic
- An estimated 150 million more children have been pushed into multidimensional poverty; a 9% increase compared with levels before covid-19[3]

Nutrition

- 6-7 million more children under 5 had wasting or acute malnutrition in 2020
- 62 million fewer children received two-dose vitamin A supplementation in 2020 compared with 2019
- 44 million children may have gone hungry in 2020 and 370 million may have missed nutritious school meals[3]

Protection

From March 2020 to October 2021, five million children lost a primary caregiver because of deaths associated with covid-19.[7 12] By 2030, up to 10 million more girls could be pushed into early marriage because of the pandemic.[13] The pandemic has also led to increases in violence against children and women, sexual violence and exploitation of children, intimate partner violence, and domestic violence.[14]

The covid-19 related crises affecting children and young people intersect and exacerbate each other. Being orphaned can trigger mental ill health, greater vulnerability to infectious diseases, physical abuse and sexual violence, and poverty.[11] Disrupted schooling interferes with access to and delivery of essential health and other services, such as nutritious foods. It increases girls' vulnerability to child marriage, early pregnancy, and gender based violence, making return to school less likely and HIV infection more likely.[19 20] Disrupted schooling also causes parents, especially mothers, to leave work to provide care, reducing income which could support children and young people.[21] In undermining the development of children and young people, such effects have profound consequences for societies. In December 2021, the World Bank, Unesco, and Unicef warned that the learning crisis alone could result in $17tn (£12.5tn) in lost lifetime earnings at present value globally.[22]

Children and young people in lower income countries will be most adversely affected by covid-19 because of inequities in covid-19 vaccination, fiscal capacity to respond, and social protection coverage. As of 12 January 2022, just 11.4% of people in low income countries had received at least one covid-19 vaccine dose compared with 67.6% in high income countries.[23] At a time when over 60% of low and middle income countries are highly vulnerable to debt,[24] poorer countries would need to add hundreds of millions of dollars to their existing public debt to cover the cost of vaccinating 70% of their population.[23] Even if they were able to do this, it could compromise investment in other measures to protect children and young people, such as healthcare and nutrition. Furthermore, income support programmes appear to have mitigated overall increases in poverty in upper middle income countries, at least temporarily, but have been insufficient to do so in low income countries.[25] More than four billion people, including three in four children, still lack any social protection such as support grants or bursary schemes.[26]

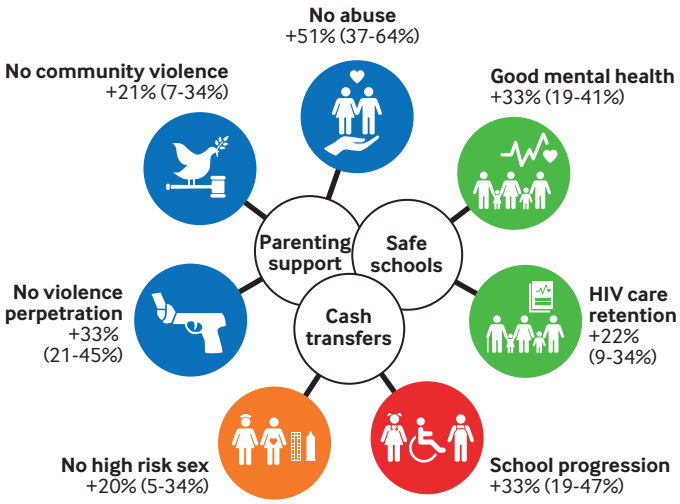
Planning and investing to safeguard generations

Understanding covid-19 as a long and multiwave event can inform multilevel, intersectoral responses to mitigate its negative effects on children and young people, thus protecting their health and wellbeing in the short and longer term. Stronger and more resilient systems for health must be at the centre of intersectoral efforts. Such systems are crucial to reduce the spread of the virus, deliver vaccines and other essential health services, and strengthen pandemic preparedness and response. Empowerment and inclusion of young people can help ensure effective, equitable, and rights based approaches. The multilevel, intersectoral responses should focus on longer term planning, layering of effective interventions, and scaled investments.

Long term planning

Current global and national plans for responding to the effects of covid-19 on health, development, and society are rarely longer than 18 months and are typically shorter. These plans are also severely underfinanced.[27] To better account for the multiwave effects of the pandemic on children and young people, longer term and fully financed covid-19 plans are needed, covering 24 month surge efforts and 36 month plans. The surge efforts should focus on maintaining essential child health services, ensuring age appropriate remedial support through education, comprehensive social protection, and equitable access to vaccines. The 36 month plans should seek to mitigate and reverse losses in human capital by making use of advances necessitated by covid-19, for example increased use of digital technology for healthcare and education as well as greater emphasis on the mental health of children and young people.

Approaches used during the covid-19 pandemic can guide longer term planning. For example, in what could be seen as part of a surge



Effects of layered support for children and young people affected by HIV showing percentage point improvements (with 95% CIs) in percentage probabilities of SDG aligned targets, for adolescents with access to layered safe schools, parenting support, and government cash transfers, compared with no intervention. Each outer circle represents an SDG target within SDGs 3 (health), 4 (education), 5 (gender equality), and 16 (violence prevention). Adapted from Cluver et al[40]

effort, Liberia, Nepal, and Senegal have employed various mitigation strategies to maintain routine immunisation.[28] Countries that have safeguarded nutrition and maternal and child health during other crises, such as Bangladesh, Liberia, Peru, and Rwanda, also provide lessons to guide covid-19 planning and investment.[29]

UN instruments to support planning, financing, and implementation of measures to advance sustainable development at the country level, building from the UN comprehensive response to covid-19, offer opportunities to tackle the multiwave nature of covid-19. Engaging young people in national vaccination plans for covid-19 could reduce demand side barriers and thus enhance equity and effect. Merging national covid-19 response plans into longer term planning to achieve the SDGs is an opportunity to further strengthen protection of the current and future lives of children and young people.

Integrated national financing frameworks, which support countries to finance and implement their sustainable development priorities, can promote effective and innovative strategies targeted to children and young people. For example, health taxes on sugary beverages can reduce consumption of an unhealthy product while raising resources to invest in the development of children and young people.[35]

Layering of effective interventions

Interventions to safeguard children and young people need to mitigate as many important effects of covid-19 as possible.[36] They also need to be cost effective given reduced resources and increased need.[37] Evidence from other epidemics indicates the potential of accelerator approaches (eg, government cash transfers, violence prevention and sexual and reproductive health services) to simultaneously tackle several of the overlapping effects of covid-19 on children and young people.[38] Studies in sub-Saharan Africa have identified services that together can improve health, education and sexual health for children and young people in the context of HIV and Ebola virus disease.[39] These studies have found consistent evidence of the beneficial effects on many SDGs of social protection combined with evidence based parenting support, sexual and reproductive health and rights education and/or safe school access, and essential child health and nutrition services (figure).[40 41] The findings suggest the value of layering additional child-focused services, such as parenting programmes and adolescent-friendly health services, into covid-19 social protection responses.

Interventions also need to be delivered on an adequate scale within current systems and with minimal disruption to families experiencing covid-19 illness and death.[42] Digital methods can help deliver packages of support—for example, cash transfers and evidence-based violence prevention programmes—and have inbuilt monitoring systems that can provide evidence of use and effect even when more formal evaluations are limited.

Scaled investments

Bold investments are needed to mitigate the socioeconomic effects of the pandemic on children and young people while accelerating longer term progress. This investment includes immediately ending covid-19 vaccine inequity, which persists despite an estimated cost of just $50bn (£37bn) to vaccinate the world.[43] Covid-19 vaccination not only protects health, including the health of parents and caregivers of children and young people, but also helps to recover human capital loss by reducing the need for lockdowns and enabling health systems, schools, economies, and early childhood development services to function.[44] Investments can reach beyond mitigating the effects of covid-19, in line with commitments of countries and the international community, to build better systems going forward. Ambitious but feasible investments across the SDGs can help the world exceed the development trajectory it was on before the pandemic. For example, an SDG push for education, which includes targeted investments in governance, social protection, and digital innovation, could result in an additional 25 million children obtaining upper secondary education every year by 2030, compared with the pre-pandemic development path.[45] A monthly investment of just 0.07% of the gross domestic product of low and middle income countries could provide financial security to 613 million women of working age living in poverty.[46] Going beyond a temporary basic income to a universal basic income would further protect children and young people, particularly if combined with universal health coverage.

Conclusion

Understanding covid-19 as a long and multiwave event helps us to understand the pandemic's profound effect on children and young people, both now and in the future. This understanding also points to the need for proportional, evidence based strategies for longer term planning, layering of effective interventions, and scaled investments in order to mitigate the effects of covid-19 on children and young people, which will benefit entire societies. This will require greater investment in multilevel, intersectoral responses and stronger and more resilient systems for health.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

GP numbers and the future of primary care

Appleby has picked up something of a poisoned chalice in predicting GP workforce requirements (Data Briefing, 5 February). His article appears in the same online publication period as two others that countenance the extinction of the profession.

Calculating the numbers needed based on what we currently do and know may generate unachievable recruitment targets: expanding the workforce quickly enough is going to be very difficult. Instead, shouldn't we be looking at redeploying and reconfiguring primary care staff and primary care working practices to try to maximise efficiency and effectiveness? It will be interesting to know, for example, if well organised GP federations and "super practices" have been more successful in weathering the current storms than more isolated, smaller practices, and whether we can learn from their experiences.

More radically, it's also time to look at new structures that are likely to promote commitment to primary care, increase collaboration between primary and secondary care, and improve access and promote savings and efficiencies on the basis of scale. I'm thinking, for example, of the Roundhouse model of practice developed in recent years in north London and the acute primary care centres in the Netherlands, where co-location of GPs and acute hospital facilities provides 24 hour access and relatively seamless provision of investigations and acute treatments. These centres contain comprehensive primary care clinical teams, to which patients have direct access.

With political energy and NHS resources focused on dealing with the waiting list backlog, this may be a difficult time to engineer effective and imaginative change in the way that primary care works, but it has never been more important to think creatively and urgently about the future of the service.

Roger H Jones, emeritus professor of general practice, London

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HOW MANY GPS DO WE NEED?

The answer is not a number

Planning the workforce is harder than guessing the number of GPs needed (Data Briefing, 5 February). Patients feel underserved and confused. GPs feel demoralised and are struggling to manage their workloads. There are many causes of this crisis.

Patients might think the problem is access to healthcare, and GPs might think it is a capacity problem. The real problem is quality. Assuring high quality care needs more than the bureaucracy of the Care Quality Commission and NHS appraisals.

The direction of travel is that GPs will have a much reduced role as the patient's trusted personal family doctor who can manage most problems without referral. This change risks GPs failing to meet the needs of their patients and the NHS being overwhelmed and not surviving as an effective service that is free to all at the point of care.

Goals for the future should be to stop tinkering and assure quality.

Terry Kemple GP, Bristol

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Look at average list sizes

Appleby does not supply a number—let me try. It is widely accepted that 1800 patients per fully qualified full time equivalent GP is about right. That seems to be the basis of the government's commitment to an extra 6000 GPs by 2025.

In November 2021 the average list size for fully qualified fulltime equivalent GPs, excluding locums, was 2282 patients. A net increase of about 7000 GPs, without any increase in the number of patients, would be required to achieve an average list of 1800.

Just as important are the huge differences across England: ranging from 1500 patients per GP in some areas to more than 6000 in others. We no longer have a mechanism aimed at producing an equitable distribution of GPs, and the health minister in the House of Lords dismissed an amendment to introduce one at committee stage of the Health and Care Bill in January 2022.

John G Gooderham, school crossing supervisor, Billingshurst

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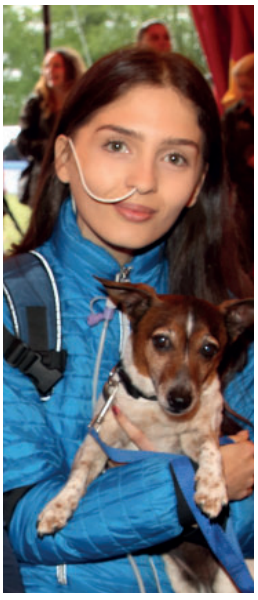
"WRONGFUL CONCEPTION" CASE

From self-responsibility to blaming clinicians



WENN/ALAMY

I was saddened to read about Philip Mitchell being found guilty of negligence regarding periconceptional advice he gave 20 years ago (Editor's Choice and Editorial, 22 January). I struggle to see where the line is drawn between general public health information that the government should be providing and the role of the GP in dispensing specific advice.

Many people I know have become pregnant without prior discussion with their GP. Female patients are often prescribed all sorts of medications that are not ideal or suitable for pregnancy. And I only find out because they are now pregnant—what about pre-conception advice then?

We are moving from a culture of self-responsibility to one of finding fault with clinicians. What if I prescribe an opiate for postoperative pain, and the patient develops confusion, falls down the stairs, and has a large intracranial bleed because they were also on low molecular weight heparin?

Victor Li, general practitioner, Newcastle upon Tyne

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DIFFERENCE BETWEEN A DOCTOR AND A FAMILY DOCTOR

Let's develop multiple layers of primary care

Mathew discusses the difference between a doctor and a family doctor (Rammya Mathew, 5 February). A GP's sole duty must be to the patient. Healthcare, properly provided, is not and never can be a commercial undertaking: the conflicts of interest, the perverse incentives, and the moral hazards are insuperable obstacles.

The rate of change in medical practice is accelerating. Specialists work hard to stay abreast of their fields of interest, so what hope is there for generalists?

The cornerstone of any healthcare system is primary care—including all the disciplines that work in the community. Ideally, they would work in coherent collaborative teams covering defined areas. Patients benefit from having a single system portal near their homes or workplaces.

Medicine is blessed with diversely gifted people; there's a place for everyone. Let's develop multiple layers of primary care—the genuine frontline, street level, "barefoot doctors" at the perimeter, with second and third echelons a step or two back from the front who can specialise at the primary care level.

Steven Ford, retired GP, Haydon Bridge

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Family doctors have a holistic approach

There is an enormous difference between being a doctor and being the family doctor, as Mathew expounds—the most important element is understanding patients in their overall lives and, frequently, over a long time.

Over the past two years we have seen many patients die at an earlier stage of their lives than we would have expected. As our senior receptionist said to me after a particularly harrowing day, "These weren't just our patients, they were our friends."

Many of us continue to be part of our communities, and, despite emphasis on access, continuity and a broader holistic approach are far more important. This is what being a family doctor is.

Jonathan Leach, GP, Bromsgrove

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HEALTH, POVERTY, AND STIGMA

Asking patients about financial hardship

Salisbury asks whether healthcare staff should pay more attention to poverty (Helen Salisbury, 22 January).

Healthcare professionals can fear mentioning poverty, even if they think it is a problem, because they think they have nothing to offer. But many patients would derive psychological comfort from knowing that their healthcare professional was better informed, aware of the challenges they face managing their health due to income poverty, and better able to empathise with them, if not signpost them to practical support.

Potential financial challenges are difficult to discuss, but that shouldn't prevent healthcare professionals from bringing them up. In addition to practical clinical reasons, there are also compelling ethical reasons for doing so.

In the current UK context of the looming cost of living crisis, conversations about financial hardship should no longer be off limits in clinical conversations. Training and organisational support, with signposting to appropriate resources, are needed.

Flora C Douglas, professor of public health, Aberdeen; Alison Avenell, clinical chair in health services research; Sophie Mohamed, trainee health psychologist, Aberdeen

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UK DRUGS STRATEGY

Advocating for evidence based drug policy

Rolles highlights the ongoing lack of evidence based drug policy (Opinion, 21 December online; see also Editorial by Aiton, 22 January). The refusal of policing minister Kit Malthouse to believe the evidence in support of safe drug consumption rooms demonstrates the political orthodoxy.

There are good reasons to suspect that the epidemiology of injecting drug use and its potential harms have changed as a result of covid-19, but detailed analysis is lacking. Failing to understand these changes might compound the political and social neglect that injecting drug users experience.

Perhaps it is not surprising that leaders without a grounding in critical appraisal might ignore the evidence for political expedience, moralistic posturing, or through a misplaced confidence in their own public health instincts.

It is left to clinicians to advocate for their patients, and researchers to react to the recent strains on services and somehow gather evidence that will be difficult for politicians to ignore.

John P Kelly, specialty trainee year 5 infectious diseases and medical microbiology, Edinburgh

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NEUROPSYCHIATRIC SYMPTOMS IN DEMENTIA

Music as an intervention for dementia

Watt and colleagues miss an intervention of high relevance to many people with dementia: music (Clinical Updates, 29 January). Evidence from meta-analyses indicates that music based therapeutic interventions in dementia can reduce depressive symptoms, ameliorate behavioural disturbance, and might also reduce anxiety and improve emotional wellbeing and quality of life.

Benefits might be further enhanced by personalised playlists holding resonance for the patient, potentially in later stages of the illness when opportunities for intervention can be limited. By facilitating communication, music might also reduce the frustration and helplessness that contribute to challenging behaviours.

As an intervention, music is accessible, flexible, and relatively easy to implement. It is a source of pleasure and resilience for many people and may help to maintain social connectedness in ways that are difficult to quantify. Music is a unique source of solace against loneliness and despair: a lesson that the covid-19 pandemic has poignantly affirmed.

Laura M Bolton, music therapist, older people mental health, Edinburgh; Jessica Jiang, research psychologist; Jason D Warren, professor of neurology, London

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OBITUARIES

Jack Cantor

GP (b 1925; q Middlesex Hospital, London, 1949; DRCOG, MRCGP), died from dementia and a heart attack on 29 October 2021

In 1953 Jack Cantor obtained a post in a small practice in Faversham, Kent. His duties included being on call every night and every weekend, apart from one weekend a month. After two years he was offered a partnership. In the late 1950s his senior partner retired, leaving him temporarily as a singlehanded GP. Over the years he expanded the practice's list and when he retired in 1991 there were four partners. Jack was also for a while chairman of the East Kent Division of the BMA and sat on the local medical committee. In retirement he took a job as a part-time assistant GP at the Elham Valley Practice. Predeceased by his wife, Kathleen, in 2020, Jack leaves three children, five grandchildren, and three great grandchildren.

Tim Cantor, Chris Cantor

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Joseph Shoel Conway

Consultant ophthalmologist (b 1921; q 1945; MRCS Eng LRCP Lond, DOMS, FRCS, FRCOphth), died from old age on 16 December 2021

Joseph Shoel Conway was appointed senior registrar at Moorfields Eye Hospital in 1956. He subsequently became consultant ophthalmologist to New End Hospital, Hampstead, and later to the Royal Free. He was past president of the London Jewish Medical Society. In 1966 he was funded by the Medical Research Council to work on freezing the ciliary body in animals, followed by an innovative paper in 1973 in which he described the use of implanted magnets in the upper eyelid to alleviate myasthenic ptosis. Joseph retired from the NHS in 1987 but continued in private practice and did medicolegal work for several years, after which he and his wife, Joy, retired to Israel. Joy predeceased him, and he leaves four children and numerous grandchildren and great grandchildren.

David Goldmeier

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H Gordon Pledger

Director of public health (b 1931; q Durham 1953; MD, FFPH, FRCA), died from pneumonia after a fractured neck of femur on 1 January 2022

In 1965 H Gordon Pledger was appointed consultant anaesthetist in Aberdeen, specialising in paediatrics. In 1969 he moved into the developing specialty of public health, working in Oxford, Northampton, Newcastle, and Northumberland. His early experiences of poor health outcomes in mining communities led to a lifelong passion for population health and the need to tackle the social determinants of health. After retiring in 1992 he became a longstanding medical referee to the City of Newcastle. In his late 50s he renewed his early passion for flying. He died peacefully in a general hospital that he commissioned and on whose board he had served as a non-executive director. He leaves his wife of 67 years, five children, seven grandchildren, and four great grandchildren.

Sarah E Pledger

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Sheila Grace Sykes

GP principal Borrowash and Breaston, Derbyshire (b 1931; q Manchester 1955; DRCOG, DPH, DCH), died from chronic obstructive pulmonary disease on 26 January 2022

After completing house jobs in Manchester, Sheila Grace Quain moved to Scotland, working in obstetrics, gynaecology, and paediatrics. Having moved to Derbyshire she worked in public health. She then worked as both assistant medical officer for Derbyshire County Council and GP assistant. She met her future husband, Richard Sykes ("Dick"), at Chilwell Golf Club in 1961 and married him in 1962. She became a GP principal and partner in 1966, joining Dick at what is now known as the Overdale Medical Practice in Borrowash and Breaston. She retired from medical practice in 1992 but continued to remain active with the Medical Women's Federation. Predeceased by Dick, she leaves three children, six grandchildren, and one great granddaughter.

Ian Sykes

Cite this as: *BMJ* 2022;376:o288

Barbara Vaudrey

Locum GP (b 1922; q Barts 1953), died from old age on 17 December 2021

Barbara Vaudrey (née Lewis) left school in 1940 and volunteered, helping refugees. Called up, she enrolled in the Auxiliary Territorial Service. After the war her mother instructed her to "get a degree and the means to support yourself." She chose medicine. Her experiences of men at work, during the war, and her ability to stand up for herself stood her in good stead. At the Rotunda Hospital in Dublin she worked with impoverished mothers who, by their own admission, had too many children. That, and her own unwanted first pregnancy, made her a firm advocate for contraception and its benefits. On qualifying she worked as a locum GP in London. In 1970 the family moved to Suffolk and she worked for several practices. She leaves three children (all wanted), five grandchildren, and two great grandchildren.

Caroline Durk

Cite this as: *BMJ* 2022;376:o290

Nicholas Matthew Wharton

Consultant anaesthetist Bristol Royal Infirmary (b 1971; q St Andrews/ Manchester 1996; FRCA), died from metastatic carcinoma of the thymus gland on 14 August 2021

Nicholas Matthew Wharton ("Nick") was born in Liverpool and brought up in Preston. He did his anaesthetic training mainly in South West England, with a specialist year in New Zealand. As a consultant in Bristol, he undertook upper airway surgery, thoracic anaesthesia, and obstetric anaesthesia. He was a supervisor and college tutor for trainees. His main achievement was to organise and develop a course for difficult airway management. This continues in Bristol and has been introduced in other centres. Having been a keen fell walker as a student, he enjoyed water sports, especially sailing, windsurfing, and scuba diving, with annual trips to the Scilly Isles and northwest Scotland. He was also a keen cyclist. He leaves his wife, Vicki, and two daughters.

Lucy Bushby, Malcolm Wharton

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Fiona Denison

Obstetrician, academic, and innovator

Fiona Charlotte Denison (b 1970; q 1994; MRCOG, MD, DFFP), died by suicide after covid-19 complications on 8 January 2022

Edinburgh obstetrician Fiona Denison was once concerned to hear that it could be difficult to see a baby's head crowning during a waterbirth. The midwife had to crouch down and peer into the pool with a mirror in one hand and a torch in the other. Denison, who has died aged 51, thought there had to be a better way and reached out to engineers at nearby Heriot-Watt University. Together they designed the multi-award winning "EASI birth mirror," or as Denison modestly referred to it, her "mirror on a stick."

Denison enjoyed partnerships with engineers throughout her career, relishing opportunities to share knowledge, solve practical matters, and make childbirth safer. With colleagues at Heriot-Watt and elsewhere she worked on projects to use magnetic resonance imaging scanners to monitor fetal health non-invasively; developed fetal biosensors to detect lactate (a sign of distress); and an epidural needle with ultrasound at the tip ("the needle that can see") to guide anaesthetists giving an epidural to obese women in labour.

In 2018 when she was appointed to a personal chair, Denison chose the title "professor of translational obstetrics," reflecting her interests. In 2019 Heriot-Watt made her an honorary professor in recognition of her interdisciplinary work with engineers and asked her to become clinical lead for its new medical device manufacturing centre.

Early days

Fiona Charlotte Denison was born on 22 July 1970 to Richard, a GP, and Jean (née Cree), a dentist. She grew up in Morningside, Edinburgh, with her younger brother, Alan (now dean of postgraduate medicine at NHS Education for Scotland), and once said it was making Alan's Airfix models that sparked her curiosity about how things worked.

After attending St George's School, Denison went to the Edinburgh Academy to take her A levels, where she also shone at music, passing her flute grade eight exam with distinction. Music continued to be a joy throughout adulthood, and she played regularly in a quintet with friends and in Edinburgh's "The Really Terrible Orchestra."

Denison had an extraordinary rapport with her patients, and a calm efficient demeanour

Denison read medicine at Edinburgh University, graduating in bacteriology in1992 and later winning several prizes, including becoming the top woman graduate in medicine in 1994. In May 1997 she married Gordon Taylor, and the couple went on to have two sons, James and David.

Denison decided early on to make obstetrics her specialty, and after several junior posts in and around Edinburgh, in 2009 she became senior lecturer at the University of Edinburgh and honorary consultant obstetrician at NHS Lothian. Finally, in 2018 she became professor of translational obstetrics.

Obstetric research

As a clinician, Denison had an extraordinary rapport with her patients, and a calm efficient demeanour that those on the labour ward found reassuring. She also was a much respected teacher and mentor. Her clinical work informed her research priorities and she put together a successful bid to set up the Tommy's Edinburgh Research Centre (which opened in 2008) and later became its director.

One of her passions was to improve care for pregnant women with a body mass index over 40. In what was the UK's first clinic of its kind, she joined forces with a diabetologist, anaesthetist, dietitian, and others. The multidisciplinary approach was hugely successful, reducing rates of stillbirth and low birth weight and improving the diagnosis and treatment of diabetes. Denison channelled her knowledge into writing *Care of Women with Obesity in Pregnancy*, the Royal College of Obstetricians and Gynaecologists' national guidelines (2018).

In 2017 Denison got a major grant from the National Institute of Health Research for the Got-It trial, investigating a treatment for a retained placenta. Recruiting women in labour into a trial was going to be problematic, so Denison found ways of seeking consent that took into account labouring women's exhausted state, such as providing them with a succinct summary document, and her methods became a road map for future researchers.

As well as her work in Scotland, Denison had a global reach. She took a great interest in improving outcomes for mothers and babies in low income countries and with an Edinburgh University grant in 2019 set up projects in Uganda.

In March 2020 Denison was at the top of her game. She caught covid-19, however, which left her with severe physical and mental health problems. Ever resourceful, she used her time during treatment to become an accomplished artist, and enjoyed being at home with her family. When well enough, she managed to work intermittently and was pleased to be promoted from vice chair to chair of NICE's medical technologies advisory committee and to be included on the Academy of Medical Sciences' prestigious Future Leaders in Innovation, Enterprise, and Research programme.

Problems with her health inexorably mounted, however, and eventually became too much to bear. On 8 January 2022 she took her own life. She leaves Gordon; her sons; her parents, Richard and Jean; and her brother.

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