

comment

“What’s the issue with hospital doctors working more in the community?” **DAVID OLIVER**
“The conditions mean GPs can’t do the job they were trained to do” **HELEN SALISBURY**
PLUS Messenger review and primary care; decision making with mental health patients

TAKING STOCK Rammya Mathew

Celebrating the quality and calibre of GPs

GPs in the UK are so accustomed to sustained attacks in the media that it’s only ever a matter of time before we’re hit with the next tirade of abuse. It’s often about access, waiting times, or even the fact that many of us are women and work only “part time.”

The latest round of bad press ensued, however, after a documentary series on the menopause by the popular TV presenter Davina McCall. The programme reported that “caseloads” of women had suffered at the hands of their GP after being told that they didn’t need hormone replacement therapy (HRT) or that they weren’t menopausal.

This can easily feed into a narrative that the country’s GPs are underskilled and underqualified and that, as a result of our incompetence, women are being badly let down. However, the more nuanced truth is that many U turns have been made regarding the safety of HRT, which have had a lasting impact on practitioners’ confidence in the available evidence. Women’s symptoms can’t always be attributed to the menopause, and although the benefits of HRT outweigh the risks in most women, this is not always the case.

I don’t deny that individual women have been let down, and I applaud McCall for raising awareness of what’s often still considered a taboo subject in society. But the point about GPs’ competence needs to be challenged. GPs in the UK are among the most skilled generalists in the world: we undergo rigorous postgraduate training and assessment, and we see and treat many conditions that would instead be managed by specialists in other healthcare systems.

It’s also worth noting that the most recent GP Patient Survey showed that 89% of patients felt listened to, and 93% of patients said that they felt as involved as they wanted to be in decisions about

their care. It would seem that the consultation model suggested a few years ago by David Haslam—“Shut up, listen, care, know something”—is underpinning how we practise and how we care for our patients.

Many things are undeniably wrong with UK general practice at the moment, but the calibre of our GPs, and indeed of the wider general practice team, is one of the few things we can still celebrate. Many of my female patients claim that I’ve given them back their sense of wellbeing after we’ve discussed the menopause and reached a joint decision about HRT. I don’t believe that this is the case only for me, as I’m sure that GPs all over the country are doing exactly the same and receiving similar positive feedback. Sadly, however, good news stories rarely make the press.

Rammya Mathew, GP, London
rammya.mathew@nhs.net
Twitter @RammyaMathew
Cite this as: *BMJ* 2022;377:o1389

GPs in the UK are among the most skilled generalists in the world



OPINION Becks Fisher and Judith Smith

The Messenger review: a missed opportunity for primary care

The sector needs bespoke leadership and management support

The government has published its review of health and social care leadership and management by Gordon Messenger and Linda Pollard.

Healthcare management is a broad, highly complex, and politically exposed discipline, typically undervalued by the public, media, and politicians alike. Managers are often characterised as bureaucrats who take up resources that would be better spent on frontline clinical care. But there is extensive UK and international evidence that healthcare management matters. Good management is critical to effective delivery of high quality services and improves health outcomes and staff wellbeing.

In the UK, discussion of healthcare management and leadership typically assumes an NHS trust context or (even more likely) a hospital one. This is where most resource and development programmes are usually targeted. But there is a vital need for good leadership and management

within our struggling primary care sector. Workload is rising quickly, and GP numbers continue to fall. Health policy continues to emphasise primary care's role in transforming future healthcare services, along with an intention to continue to expand the range and complexity of care and services delivered through general practice, in partnership with other professions and sectors.

Cultural change

Such intentions are easier to declare than to put into practice. They represent major organisational, professional, and cultural change, which requires sophisticated and experienced management capacity such as HR, finance, IT, estates management, and service improvement skills, in addition to the "leadership and transformation" that are often exhorted. These are in scarce supply in primary care.

General practice has been moving away from its "corner shop" management



Significant investment is needed to strengthen this area of general practice

approach for many years, gradually becoming more managed and organised. But it's still in stark contrast to the more corporate organisational form of NHS trusts which have the management, professional support, and governance capacity to match.

General practice, with its central role in integrated health and social care, needs and deserves excellent leadership and management if it is to fulfil the expectations placed on it. And better leadership and management may improve GP retention. Significant investment is needed to strengthen this aspect of general practice, crafted with, by, and for primary care teams. Simply adapting training and development programmes designed for NHS trust management will not suffice.

It is disappointing that Messenger's review largely overlooks general practice,

OPINION Martin Brunet

The tyranny of the MDT meeting in mental healthcare

It's been 12 years since the UK government set out its vision for patients having greater involvement in their care with the strapline: "No decision about me, without me." No one said it would be easy, but few doubted the value of such an aspiration.

Despite the good intentions, and the passing of more than a decade, I've seen how the experiences of patients I refer on to community mental health teams is one of increasing marginalisation from the decision making process. This is chiefly because the dominant vehicle for making care decisions is the multidisciplinary team (MDT) meeting, from which patients are expressly excluded.

New referrals to community mental healthcare are given an assessment appointment, conducted by any member

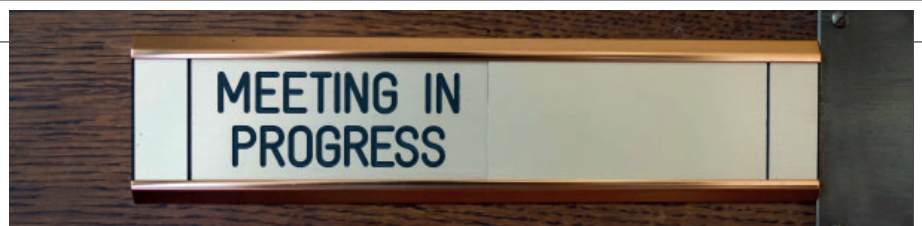
of the mental health team, and usually involve taking a full psychiatric history. This is not a two way conversation between the patient and a health professional but a data gathering exercise on behalf of the MDT, which will convene at a later date to devise a treatment plan. The patient can express their views and preferences, but there is no meaningful dialogue about outcomes, as all decision making power is deferred to the MDT.

After the assessment, the patient is left to wait for the MDT decision knowing that intimate details of their life will be discussed by a faceless panel, only one of whom they have met. They will not know if their opinions will be voiced, or who holds the power in the meeting—only that they have no power there

Patients are left feeling distressed, dismissed, angry, rejected, or hurt

at all. The MDT's decisions are frequently conveyed to the patient only by letter, especially for those who are deemed to have "not met threshold." In this instance, any relationship that there might have been with the mental health team is over and a range of other suggestions are made, such as self-care or support at a primary care level.

It is often said that people may not remember what you said or what you did, but they will never forget how you made them feel. In my experience as a GP, many of my patients are left feeling distressed, dismissed, angry, rejected, or hurt after a mental health assessment. When patients





apparently regarding clinical leadership by GPs as the main area for attention, rather than the whole gamut of primary care management expertise. Strong primary care strengthens the NHS and is critical to pandemic recovery. But the sector is precarious and requires bespoke, co-designed leadership and management support, alongside a bevy of measures to recruit and retain clinical staff.

Messenger has missed an opportunity with general practice. Eyes now turn to the government's response to the Fuller stocktake (which set out a vision) to provide answers about *how* desired widescale change in primary care can be resourced, led, and managed.

Becks Fisher, GP, senior policy fellow, Health Foundation

Judith Smith, professor of health policy and management, University of Birmingham

Cite this as: *BMJ* 2022;377:o1427

NEWS, p 384

experience a process that has so thoroughly excluded them and are left with such strong emotions as a result, it often no longer matters how "right" the decision made by the MDT was or how helpful their other recommendations might be. The system for making this decision and its delivery has crushed any value out of the MDT's feedback and input as the patient is no longer listening.

The MDT may have merits not apparent from a primary care perspective, and may not be the all powerful, unaccountable behemoth I have described, but that it even seems like that from the outside shows it is not working as it should. Mental health professionals need to be given back much of the autonomy they once had, so they can make decisions in partnership with the patient and truly live up to the aspiration that there should be "no decision about me without me."

Martin Brunet, GP, Godalming

Cite this as: *BMJ* 2022;377:o1405

ACUTE PERSPECTIVE David Oliver

Should more of us work outside hospitals?

NHS England's *Next Steps for Integrating Primary Care*, also known as the Fuller stocktake report, was published last month. It sets out ambitions for "streamlining access to care and advice" (including quicker same day access in primary care), "providing more proactive personalised care with support from a multidisciplinary team of professionals," and "helping people stay well for longer."

The report emphasises the importance of joined-up care systems, integration, and helping more patients access care in the community, but it brings no immediate prospect of tackling the growing crisis of workforce, morale, and workload in "core general practice." One idea to emerge in the subsequent commentary—though not the report itself—is that a cavalry of "medical consultants will be redeployed to save the GP system." This is insulting to everyone in primary care, while the notion of "hospital specialists" sets up false dichotomies.

GPs are "specialists" in primary care, just as secondary and tertiary care consultants are specialists in their disciplines. Those we routinely call "hospital doctors" are only traditionally based in hospitals. By their nature, some acute and interventional disciplines and services can be provided only on a hospital site. But for others being based largely elsewhere is more viable.

Many approaches already see consultants spending time in community and primary care, such as community geriatricians working with community teams, community hospitals, or care homes. Palliative medicine is strongly community

based, as are mental health services. Community paediatrics is another long established specialty.

More broadly, there's a growing emphasis—accelerated by the elective care backlog—on redesigning the way we run outpatient care. There's a move towards using specialist expertise in more innovative ways, such as online advice and consulting or patient initiated follow-up. And we've seen changes to how secondary care specialists can ensure they meet obligations for follow-up, prescribing, referral, and investigations, in a way that doesn't further overburden GPs.

So, what's the issue with hospital doctors working more in the community? Well, secondary care specialties face a workforce crisis of their own. Hospital doctors, like GPs, are struggling with workload and rota gaps. They also often have to contribute substantially to acute and specialty on-call rotas on site, as well as hospital ward based medicine and procedure lists that can only happen on site, not to mention educational and management roles. Who would cover that work if hospital doctors were moved to community care?

Finally, if we want to shift more specialty time into the community because it's good for patient care and team working, fine. But we must heed the evidence, repeatedly set out over the past two decades, that this won't lead to big falls in demand for acute care in a system with the fewest beds per 1000 in the developed world.

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

Cite this as: *BMJ* 2022;377:o1442

Who would cover hospital work if doctors were moved to community care?



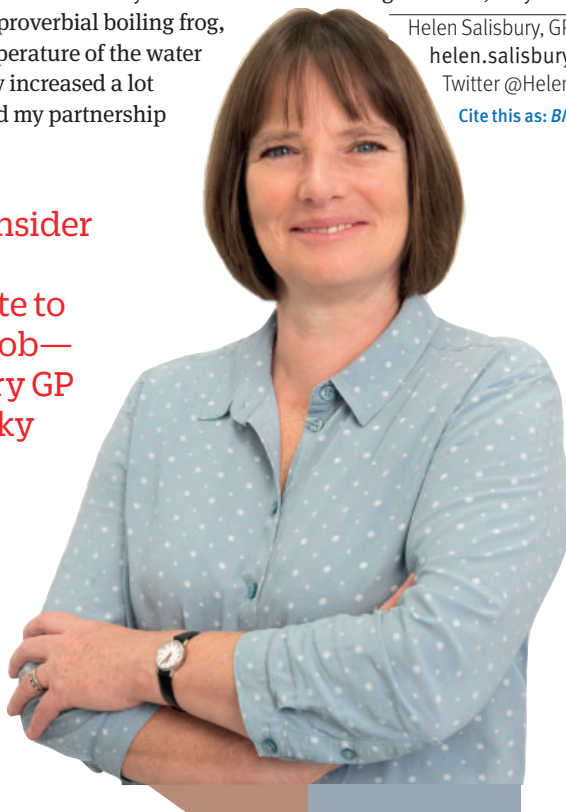
Brickbats and bouquets

My appraisal this week led me to reflect on the highs and lows of general practice. We try hard to provide a good service, but not everyone is satisfied. We have our fair share of unreasonable complaints and rude behaviour—and, recently, a sit-down protest outside the surgery. Happier patients thank us with cake, cards, and even song.

When we tot up the good and the bad, along with the mundane, the fascinating, the frustrating, and the satisfying, how can we ensure that they add up to a job we still want to do? I need to answer this for myself and for my own practice if we're to keep the show on the road, but it also needs addressing more widely if general practice is to survive, let alone flourish.

It's the team that makes the bad bits bearable. Sharing a grumble about the latest unreasonable request from the hospital, or a late night sympathetic screen message ("You still here too?"), dulls the pain. Mostly, I'm kept afloat by the knowledge that we're doing a good job. Our wait for routine appointments has just crept above two weeks, partly because of bank holidays, but we still manage to see everyone with an urgent problem on the day. We know most of our patients and offer responsive care with reasonable continuity. I sometimes feel like the proverbial boiling frog, and the temperature of the water has certainly increased a lot since I joined my partnership

I still consider myself fortunate to do this job—not every GP is so lucky



20 years ago, but I still consider myself fortunate to do this job.

I know not every GP is so lucky, and there's evidence of unacceptable variation in the standards of care available across the country. We hear of appointments booked out by nine in the morning, with the only option offered to patients being "ring back tomorrow." Some surgeries are left with a single doctor covering an unmanageable list. And some practices are staffed largely by allied health professionals, fully funded by the Additional Roles Reimbursement Scheme and supervised by a small number of harried GPs. I can see this last group of practices must be profitable for whoever holds the contract, but I worry about the doctors who work in them and the patients registered there.

GP training in the UK prepares our new doctors for evidence based medicine with an emphasis on patient centred, holistic care and good communication. The most common reason I hear for GPs deciding to leave their practice is that the conditions mean that they can't do the job they were trained to do. When the level of demand, the time constraints, and the lack of continuity lead to an awareness that what you're offering is a long way below your best, the discomfort must be intense. And if you don't feel supported by your team or organisation, why would you stay?

Helen Salisbury, GP, Oxford
helen.salisbury@phc.ox.ac.uk
Twitter @HelenRSalisbury

Cite this as: *BMJ* 2022;377:o1443

LATEST PODCAST



Milk allergies in infants

Consultations about suspected cow's milk protein allergies are common in primary care, but these allergies can be challenging to diagnose, particularly as symptoms can manifest in different ways and testing can be complicated. In this episode of the Deep Breath In podcast, Nicola Brathwaite, a paediatric allergy consultant, shares tips for diagnosing and managing cow's milk protein allergies in infants, including triaging the initial presentation:

"For allergies, multi-system involvement is common, so a baby with reflux symptoms who also has a bit of mild eczema does point towards an allergic aetiology. The difficulty is the other way around. We all know how common gastro-oesophageal reflux is in infants and the vast majority will not be due to milk allergy. Similarly, eczema is common in babies; for most of them it's not food allergy related. If it's an unclear diagnosis and the baby's otherwise thriving and well in themselves, you've got time. Do a trial of the standard treatment for gastro-oesophageal reflux and see if they respond. If they don't respond and there's a suspicion of milk allergy, certainly you can go on to the next step. Similarly, with eczema, manage the eczema first."

Brathwaite also considers how to navigate discussions with parents who may be distressed or anxious about their child's symptoms and the reintroduction of milk to the diet:

"I have a conversation about the fact that milk allergy is likely to be outgrown. I also have a conversation with parents about how we've moved from thinking prolonged exclusion is a good idea to thinking that allergy is, in extent, either a failure to develop tolerance or a loss of tolerance of a food. So for the body to learn to tolerate that food again, it's important to start to include small amounts as long as that's safe."



Listen and subscribe to *The BMJ* podcast on Apple Podcasts, Spotify, and other major podcast apps

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

ANALYSIS

Normalising menopause

Martha Hickey and colleagues argue that social and cultural attitudes contribute to the varied experience of a natural event and that medicalisation fuels negative perceptions

Menopause is a natural event for half of humankind. The term “menopause” denotes the final menstrual period but is often used to describe the menopause transition, starting with changes in the menstrual cycle and finishing one year after the final menstrual period. While media attention in the UK may give the impression that growing numbers of women are struggling to cope with menopausal symptoms and are seeking hormonal treatment,¹ there is no universal experience and most women prefer not to take medication unless their symptoms are severe.² In fact, socioeconomic status, education level, and social and cultural attitudes to menopause act with biological factors such as hormonal changes, smoking, diet, and body mass index to determine the experience of menopause, including the nature and severity of symptoms.

We argue that medicalisation of menopause risks collapsing the wide range of experiences at the average age associated with this natural process into a narrowly defined disease requiring treatment. Medicalisation tends to emphasise the negative aspects of menopause and, while effective treatments are important for those with troublesome symptoms, medicalisation may increase women’s anxiety and apprehension about this natural life stage. Changing the narrative by normalising menopause and emphasising positive or neutral aspects such as freedom from menstruation, pregnancy, and contraception, together with information about managing troublesome symptoms might empower women to manage menopause with greater confidence. People with functioning ovaries who do not identify as female will also experience menopause if they do not take cross-gender hormones. We use the terms women and women’s health to encompass all these individuals.

KEY MESSAGES

- Menopause is a natural event for half the population, but there is no universal experience
- Experience of menopause is shaped by social, cultural, and biological factors
- The medicalisation of menopause reinforces negative views about reproductive ageing
- Although some women with troublesome menopausal symptoms benefit from menopausal hormone therapy, other effective treatments are available and a narrow focus on symptoms fuels negative expectations
- Challenging gender based ageism, reducing stigma, and providing balanced information about menopause may better equip women to navigate this life stage



Cross cultural studies show substantial geographical and ethnic variation in the experience of menopause

No universal menopause experience

In high income countries, menopause usually occurs at around age 51 years, although the range is wide (45-55 years). Menopause is often earlier in middle and lower income countries, at 46-48 years on average.^{3,4} During the menopause transition women may experience body changes such as vasomotor symptoms (hot flushes and night sweats), sleep difficulties, changes in mood, and aching muscles or joints. These are usually time limited, and their nature and severity vary substantially between women and within the same woman over time. The prevalence of moderate to severe vasomotor symptoms is uncertain but was estimated at 16-40% in a global survey of 11 771 women in 2021, depending on geographical location.⁵

Women with severe vasomotor symptoms often benefit from menopausal hormone therapy, which may also improve sleep.⁶ For those who are symptomatic, a cross-sectional study of 354 US women reported that their main priorities for treatment were vasomotor symptoms, sleep, concentration, and fatigue.⁷

While the majority of women experience body changes over the menopause transition, most consider this a natural process that is manageable without medical intervention. For example, a US longitudinal survey of 2565 midlife women in the 1980s found that almost half were relieved to be going through menopause (42%) or felt neutral about the experience (35%).⁸ An Australian cross-sectional survey of midlife women (n=776) in 2001 found that 90% were not troubled by the physical or psychological changes of the menopause transition.⁹

Furthermore, a systematic review of qualitative studies found that menopause is experienced in different ways globally. Specifically, women’s expectations and experiences of menopause are strongly influenced by personal, family, and sociocultural factors.¹⁰ Even within countries, social factors modify the experience of menopause. A 2021 international scoping review found that social factors including systemic discrimination, racism, and sexism together with personal factors such as socioeconomic status and beliefs about menopause shaped the experience of menopause in migrant women.¹¹ In the US, menopause is earlier, and vasomotor symptoms more common and long lasting, in African American than in white American women.¹² The reasons for these disparities are not known but structural racism, inequalities, and ongoing life stressors may contribute.

Cross-cultural studies show substantial geographical and ethnic variation in the experience of menopause.¹³ Whereas women in high income countries tend to report more vasomotor symptoms, a review of

menopausal women in 11 Asian countries found that body and joint pains were the most problematic symptoms, affecting 76% of Korean women and 96% of Vietnamese women.¹³ Only 5% of Indonesian women reported hot flushes.

Women's experience of menopause is also strongly influenced by social values around reproduction and ageing, with positive or negative ramifications. For example, women tend to have worse experiences of menopause in countries where their value is predicated on youth and reproductive capacity and ageing is associated with decline.¹⁰ In contrast, in a critical review of midlife embodied change, women identified freedom from menstruation, premenstrual symptoms, and contraception as positive consequences of menopause.¹⁴ Where menopause marks the end of restrictions such as purdah during menstruation, menopause may bring freedom, elevated social status, and a "second youth."¹⁵ Together, these findings argue against a universal menopause syndrome because women's experiences are strongly influenced by social context and cultural beliefs and expectations.

Medicalisation fuels negative expectations

Negative views about reproductive ageing in women have pervaded the medical literature for centuries. In the 19th century menopause was thought to cause a nervous disorder with multiple physical and psychological manifestations. The ovaries regulated women's identity (femininity) and their physical and mental health were contingent on the balance between ovarian excess or deficiency. This model was clearly articulated in *Feminine Forever* by the gynaecologist Robert Wilson, who recommended oestrogen for all menopausal women to treat their "serious, painful and often crippling disease" and avoid the "untold misery of alcoholism, drug addiction, divorce and broken homes caused by these unstable, oestrogen-starved women."¹⁶

The message that menopause signals decay and decline, which can potentially be delayed or reversed by hormonal treatments, persists and is reinforced by the media, medical literature, and information for women, often driven by marketing interests. Marketing menopause as a disease is a lucrative business: the industry manufacturing unlicensed "compounded" bioidentical hormones accounts for around 28-68% of all menopausal hormone therapy prescriptions in the US with an estimated worth of around \$2bn.¹⁷ Other unregulated treatments are also marketed using the medical model that depicts menopause as a deficiency needing treatment. Women who see this marketing might understandably believe that menopausal hormone therapy is important for maintaining long term health.

Marketing menopause as a disease is a lucrative business

Women's experience of menopause is also strongly influenced by social values around reproduction and ageing, with positive or negative ramifications

This narrative of loss and decline may amplify women's health concerns as they age.¹⁸ Although long term use of menopausal hormone therapy confers some benefits such as reduction in fractures, it also carries risk. In 2017 the US Public Services Task Force recommended against prescribing menopausal hormone therapy for the prevention of chronic disease.¹⁹

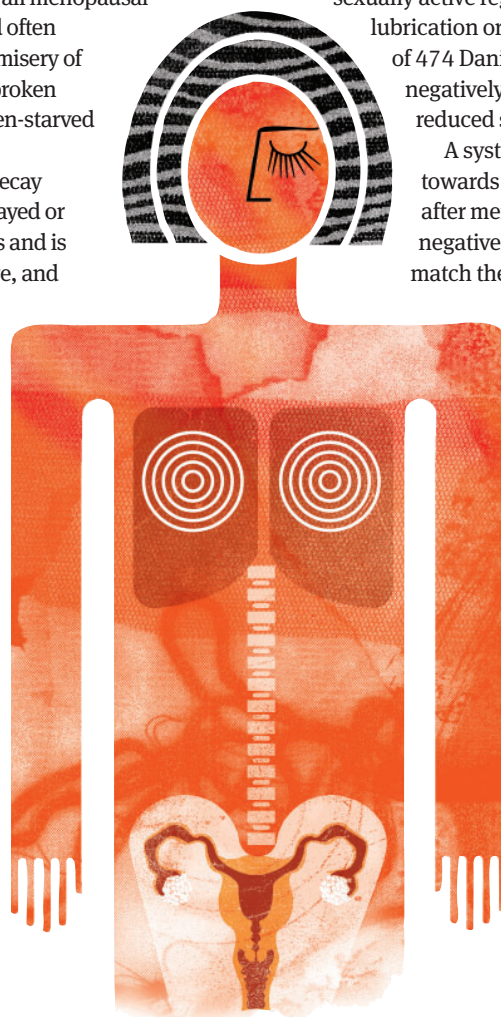
Furthermore, medicalisation and its narrow focus on symptoms may fuel women's negative expectations of menopause and influence what physical and emotional experiences they attribute to menopause.²⁰ Negative expectations of menopause make for a worse experience. For example, a systematic review found that negative attitudes and expectations before menopause predict the likelihood of distressing menopausal symptoms.²¹ In a UK study of 140 women with vasomotor symptoms, those with negative beliefs about menopause were more likely to rate their vasomotor symptoms as "troublesome" and report embarrassment and shame.²²

Social influences on the experience of menopause are further illustrated by the effects of migration. Women who migrated from India to the UK (n=52) reported similar vasomotor and psychological symptoms to white British women (n=51), while those who remained in India (n=50) reported few or no vasomotor symptoms.²³ Attitudes to ageing also predict sexual activity in postmenopausal women. In a longitudinal study of 602 US women, those who believed sex was important continued to be sexually active regardless of menopause or changes in vaginal lubrication or elasticity.²⁴ Conversely, in a longitudinal study of 474 Danish women, those who expected menopause to negatively affect sexuality were more likely to experience reduced sexual desire.²⁵

A systematic review of factors affecting attitudes towards menopause reported more positive attitudes after menopause compared with before, suggesting that negative socially mediated expectations do not always match the reality of women's experiences.²⁶ However, the positive aspects of menopause are rarely discussed in the medical literature. A systematic review of standardised menopause questionnaires found only questions asking about negative symptoms and experiences. Hence, there was no opportunity for women to report positive experiences of menopause.²⁷

Poor support exacerbates negativity

Population based surveys in the US and Ireland found that most women (65-77%) feel unprepared for menopause and report that they lack important knowledge about what to expect and how to optimise their health.^{28,29} Together with limited public discussion and education and shame attached to ageing in women, this may contribute to embarrassment and negative expectations about menopause. Women in



the US seeking medical advice at menopause also report wishing to be heard and better supported by their healthcare providers.³⁰ They prefer to hear that their symptoms are normal and not to take prescribed treatments unless necessary. Unfortunately, some women report feeling dismissed and receiving inaccurate information and ineffective treatments. In a survey of almost 1000 US women approaching menopause who consulted clinicians, patient dissatisfaction was associated with feeling dismissed, being told that their symptoms were not due to perimenopause, receiving inaccurate information, and not receiving helpful advice.³⁰

Limited evidence from non-binary and transgender people shows gaps in clinicians' knowledge about menopause, compounded by a lack of culturally safe and appropriate services for these people.³¹ Migrant women are another vulnerable group, with a qualitative study in 85 migrant women from 10 low and middle income countries reporting a lack of information about normal changes at menopause exacerbated by cultural taboos around discussion of symptoms.¹⁴

Creating more positive experiences of menopause

Understanding the influence of social and cultural factors is critical to reducing negative experiences of menopause. For individual women, it is not possible to reliably predict who will experience troublesome symptoms and for how long. Balanced, evidence based information about the spectrum of normal changes to expect over the menopause transition—in both clinical and community settings—may help women prepare, empower them to manage menopause and instil confidence in navigating this life stage.

For example, perimenopausal and postmenopausal women randomised to a psychoeducational and health promotion programme showed greater knowledge about menopause, more positive attitudes, less discomfort, and greater engagement in healthy habits compared with those who did not participate.³² Understanding the normal changes may also help women differentiate menopausal symptoms from other conditions such as depression, which require different management. Other helpful strategies may include taking time to process midlife changes, roles, and responsibilities; challenging overly negative attitudes expressed by others; and using exercise and mindfulness to reduce stress and promote wellbeing.³³ The box (right) provides some evidence based information resources on menopause.

Medical education should normalise the physical changes of menopause. Clinicians should provide reassurance about symptoms and their likely time course. Clinicians are also well placed to challenge their own and others' negative views that menopause is a deficiency disease that leads to decline. Women who adopt a medicalised view of reproductive events, including menopause, are more likely to report distress and attribute physical and mental changes to menopause rather than other causes.² For women requesting treatment for troublesome symptoms, clinicians should offer effective strategies using a shared decision making approach.

A range of pharmaceutical and non-pharmaceutical approaches are effective for vasomotor symptoms. For example, cognitive behaviour therapy can help by reducing stress, challenging overly negative beliefs about menopause, and improving reactions to

Efforts to raise public awareness and reduce stigma around menopause may improve women's experience

vasomotor symptoms, which facilitates coping.³³ Menopause is also an opportunity for clinicians to encourage positive health related behaviours, such as dietary change and physical exercise, which may improve wellbeing, reduce the risk of chronic diseases, and support long term mental and physical health.³⁴

Efforts to raise public awareness and reduce stigma around menopause may improve women's experience. In 2021 international guidance brought much needed attention to menopause in the workplace. In an unsupportive workplace, hot flushes and efforts to manage them may cause embarrassment, shame, and potential stigmatisation. These guidelines suggest educating managers and providing practical support such as access to cold drinking water, temperature regulation, and flexible working hours.³⁵ A more inclusive workplace culture might enable employees to disclose health issues, thereby reducing sources of work related stress.³⁵

Medicalisation of menopause as a disease requiring treatment prepares women to expect the worst. As social meanings and expectations commonly shape women's actual experiences, there is an urgent need to disseminate a more realistic and balanced narrative that challenges stigma around ageing in women, prepares women for expected changes, and recognises menopause as a natural process with both positive and negative aspects.

Normalising ageing in women and celebrating the strength, beauty, and achievements of older women can change the narrative and provide positive role models.³⁶ In the UK, women who have been through the menopause have raised the profile of menopause through media campaigns and within the workplace.³⁷ Menopause is now included in the UK high school curriculum, and organisations have developed menopause policies and online resources for employers to better support their employees managing menopausal symptoms.³⁸ Though outcomes of these policies will need to be carefully tracked, continuing to raise awareness through public health and education campaigns can support women to expect—and enjoy—more positive experiences of menopause.

Martha Hickey, obstetrician-gynaecologist, Royal Women's Hospital, Victoria, Australia hickeym@unimelb.edu.au

Myra S Hunter, clinical health psychologist, King's College London

Nanette Santoro, obstetrician-gynaecologist, University of Colorado School of Medicine

Jane Ussher, critical health psychologist, Western Sydney University

Cite this as: *BMJ* 2022;377:e069369

Examples of evidence based resources on menopause

- My Meno Plan (mymenoplan.org/)
- "What really happens to your body during menopause" (www.ted.com/talks/jen_gunter_what_really_happens_to_your_body_during_menopause#t-71391)
- Menopause Whilst Black (www.reddskin.co.uk/menopause/whilstblack), recognises the diversity of women's experiences
- Menopause Inclusion Collective (www.menopausecollective.org)
- Queer Menopause (www.queermenopause.com) considers how race, neurodivergence, sexual orientation, gender identity, and trauma inform the experience of menopause

Data sharing measures exclude children

This failure of the Health and Care Bill perpetuates poor outcomes, and must be remedied

The new Health and Care Bill received royal assent in April 2022.¹ One key aspect of the bill is more effective data sharing between health and adult social care sectors, to enable better decision making and deliver better treatment and outcomes for patients. The bill sets out specific measures for improving data sharing agreements, including requiring health and adult social care organisations to share anonymised information; addressing cultural and legislative barriers; requiring arm's length bodies to provide clarity on information sharing; and introducing new powers for the secretary of state to mandate data standards.¹

However, all these measures apply only to adults. Children and young people are specifically excluded from common identifiers across health and social sectors, even though their use might have averted some of the high profile child deaths in recent years through better data sharing.^{2,3} The bill's failure to push for better systems for children, while prioritising the needs of adults, is discriminatory, and represents another example the UK government's failure to protect children's rights.

Poor health outcomes

The UK's children and young adults have poor health outcomes compared with those in other high income countries.^{4,5} In addition, socioeconomic inequalities in several aspects of child physical and mental health are well documented, and some are widening.⁶ In Scotland, Australia, and Norway linkage of children's social care data to healthcare systems



Children and young people are specifically excluded from common identifiers across health and social care

has been successful in informing health policy.⁷⁻⁹

After much lobbying by members of the Children and Young People's Health Policy Influencing Group—which includes more than 70 voluntary organisations representing the voices of children and young people¹⁰—the government has acknowledged the specific challenges associated with sharing children's health and social care data. These include ethical considerations such as consent, data access, storage, and management.

The government will present plans to improve data sharing to parliament within the next year.¹¹ Professionals working with children and young people must use this time to strengthen and amplify the case for key amendments to the Health and Care Bill to ensure that data for children and young people are shared effectively and safely, to deliver much needed improvement in health outcomes.

What needs to change?

Developing a single common identifier for children and young people across multiple agencies including health, education, and social care is essential to improved data sharing.

Executives for children's services on the government's new integrated care boards¹¹ will need strong strategic leadership skills and clear lines of accountability to ensure that data sharing for children and young people is prioritised. Performance indicators

on statutory duties and outcome data on vulnerable children and young people for each integrated care board can be used to evaluate data sharing in terms of outcomes, referrals, safeguarding, and efficiency savings.

A legislative duty is required within the bill to ensure that agencies such as local authorities share relevant data with children and young people's health teams through appropriate data linkage. Concerns surrounding confidentiality and misunderstanding about what information can be shared have been shown to be a barrier to effective data sharing.¹² National guidance from government is required to ensure that staff in integrated care systems have adequate training on the legal, technical, and regulatory aspects of linking children's health and social care data. The new duties that empower the secretary of state to maintain data standards should also extend to data for children and young people.

Children and young people have a right to be involved in matters about them,¹³ and guidance is required for integrated care boards to listen to the voices of children and young people, and, where appropriate, their parents and carers, on data sharing between health and social care.

Children and young people have often been neglected during policy making. The Health and Care Bill risks repeating history by excluding children and young people from the section on information sharing, missing a crucial opportunity to promote child health. This failure, if allowed to stand, will widen inequalities further, by disproportionately affecting the most vulnerable. Action must be taken to ensure that the health of our children and young people is given equal priority to that of adults.

Cite this as: *BMJ* 2022;377:e071227

Find the full version with references at doi: 10.1136/bmj-2022-071227

Rakhee Shah, clinical research fellow, Imperial College London, UK
Rakhee.shah@imperial.ac.uk

Gabrielle Mathews, children and young persons' advocate, Imperial College School of Medicine, London

Dougal Hargreaves, Houston reader in paediatrics and population health, Imperial College London

LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Preventing lead exposure in children



Roberts and colleagues provide an impressive summary of lead exposure and poisoning in the UK (Clinical Updates, 30 April). But I question whether it is relevant to say that exposure in the UK is “likely to be similar” to that in the United States and France. The US is celebrating 30 years of lead poisoning prevention programmes and France started to limit lead in paint in 1909. The UK could have a worse lead exposure problem than those countries.

A recent Unicef report, quoting data from the Institute for Health Metrics and Evaluation, estimated that around 214 000 (range 186 117 to 281 542) children in the UK have blood lead concentrations above 5 µg/dL (the UK public health intervention level). This broadly matches the numbers reported in the US.

Roberts and colleagues describe interventions and communications that can be implemented after elevated lead exposure has been identified in children. There are also cheap and simple initiatives that could be put in place to prevent lead exposure in a population. These include checking all homes for sale or rent for lead paint and, if found, providing information on how to manage the risk; placing leaflets in professional and DIY stores that stock paint and abrasives used in decorating, explaining how to deal with lead paint safely; and reminding GPs and carers to consider lead exposure as a potential cause for many non-specific presentations including miscarriage, preterm birth, low birth weight, problem behaviours, attention deficit/hyperactivity disorder, developmental intellectual disability, delayed puberty, coronary heart disease, and kidney disease.

These measures, together with simple changes in behaviour and screening for elevated blood lead concentrations, would be a good start at improving the lives of many UK children that are diminished in length and quality through lead exposure.

Tim Pye, patient and public representative, UK Health Security Agency

Cite this as: *BMJ* 2022;377:o1348

PRESCRIBED EXERCISE FOR OSTEOARTHRITIS

Let patients self-refer to lifestyle services

I agree that the aims of the new draft NICE guidance on the management of osteoarthritis in primary care are good, but the problem will be providing patients with access to suitable lifestyle and exercise programmes. In many parts of England these services are not currently in place. We also need to ensure that there is equitable access to these services, based on clinical need. We know from experience that it is the more affluent and better educated patients who are likely to take up these kinds of lifestyle and exercise interventions.

We also need to simplify clinical pathways and allow patients to refer themselves directly to services without requiring a referral from a GP. This will improve the speed of access and reduce demand on already overstretched GP services.

Azeem Majeed, professor of primary care and public health, London

Cite this as: *BMJ* 2022;377:o1359

STEROID AND ANAESTHETIC INJECTION IN HIP OSTEOARTHRITIS

Anaesthetic alone might be effective

Paskins and colleagues report favourable effects of ultrasound guided intra-articular lidocaine with or without triamcinolone in patients with moderate to severe pain from primary hip osteoarthritis. A strong placebo response cannot be excluded, but the attenuated efficacy of lidocaine alone in patients with synovitis and effusion suggests a therapeutic benefit of at least four months' duration with dual injection therapy. The safety of repeated intra-articular steroid administration needs scrutiny.

Paskins and colleagues' data also indicate that, in patients without significant secondary inflammation, lidocaine alone might confer equal benefit, with respect to the main outcome measure at least. If so, then ultrasound guided intra-articular delivery of local anaesthesia (without steroids) might be safer and non-inferior to triamcinolone in these patients; a placebo controlled trial of such a strategy would be worthwhile. For patients with inflammation, a comparative trial of intra-muscular steroids versus intra-articular delivery might show similar efficacy at substantially lower cost.

Mark J Garton, consultant physician, Wrexham

Cite this as: *BMJ* 2022;377:o1360

PAXLOVID IN COVID-19

Three more points about Paxlovid for covid-19

I have three points to add to Extance's overview of the oral antiviral combination of nirmatrelvir plus ritonavir (Paxlovid) (Briefing, 7 May).

Firstly, Paxlovid is not currently authorised for use in children in the UK. Secondly, the evidence for Paxlovid is based on its effects in people who were not vaccinated against SARS-CoV-2. The EPIC-HR study recruited unvaccinated, symptomatic adults with a confirmed diagnosis of SARS-CoV-2 infection within 5 days who were not admitted to hospital and were at increased risk of progressing to severe illness. Anyone who had received or was expected to receive any dose of a SARS-CoV-2 vaccine was excluded. We don't know how effective the drug will be in a highly vaccinated population.

Thirdly, ritonavir has many drug-drug interactions, and Paxlovid's product information contains details of contraindications and warnings. Careful assessment of a patient's concomitant medicines (including over-the-counter, herbal, and recreational drugs) is needed before prescribing Paxlovid.

David Phizackerley, deputy editor, *Drug and Therapeutics Bulletin*

Cite this as: *BMJ* 2022;377:o1397



OBITUARIES

Michael Stuart Musgrave

GP (b 1950; q Trinity College Dublin, 1974; DCH, DRCOG, MRCP), died peacefully at home on 17 April 2022 after two years with motor neurone disease



Michael Stuart Musgrave was born in Edgware

General Hospital on 9 July 1950 and received his medical qualification from Trinity College Dublin in 1974. He worked as a GP for over 40 years; his last position was at Bupa. He retired in 2017. His parents were John Brendan Musgrave and Evelyn Musgrave—between them they served St George's Medical Centre in Hendon for 55 years. During this time father and son also worked as medical officers at Hendon police college. He is deeply missed and lovingly remembered by his three siblings and their spouses, his five grandchildren, his son-in-law, and two daughters-in-law. He leaves his wife, Annick; three children, and a stepson.

Benjamin Musgrave

Cite this as: *BMJ* 2022;377:o1236

Ann Isabel Fawcett

Consultant genitourinary medicine Peterborough District Hospital (b 1935; q Birmingham 1958; FRCP), died from pancreatic cancer on 29 December 2021



Ann Isabel Fawcett married fellow graduate

John in 1960 and moved to Singapore for his three year commission in the Royal Army Medical Corps. Unusually for an "army wife" in that era, she worked as a part time medical officer for the army and for the Singapore Family Planning Association. In 1969 she was appointed clinical assistant in dermatology at Peterborough District Hospital as well as continuing to work part time in general practice and family planning. She was appointed as full time consultant in genitourinary medicine for Peterborough and King's Lynn in 1978. Ann developed and modernised the clinics, recruited GPs as clinical assistants, and trained nurses, midwives, and health advisers. Predeceased by her husband in 1986, she leaves two children and three grandchildren.

Charles Fawcett

Cite this as: *BMJ* 2022;377:o1137

Sanjeev Datt Sharma

Consultant in obstetrics and gynaecology Southport and Ormskirk NHS Trust (b 1955; q University of Delhi, New Delhi, India, 1978; MD, FRCOG), died from complications of covid-19 on 7 February 2022



Sanjeev Datt Sharma married Deepali Das in 1984 and they came to the UK in 1985. He trained in obstetrics and gynaecology in Scotland and later in the north west of England while Deepali pursued a career in community medicine. Sanjeev worked as a consultant in obstetrics and gynaecology at the Southport and Ormskirk NHS Trust from 1992 until 2020, when he contracted covid-19. He developed serious and limiting complications that led him to retire in 2021. He led an active social life and made many friends. Several parents even named the children he delivered after him. He died while visiting family in Delhi. He leaves Deepali and a daughter, Iona.

Nikhil Kaushik

Cite this as: *BMJ* 2022;377:o1140

Robert Kenneth Jackson

Consultant orthopaedic surgeon Southampton General Hospital (b 1933; q Cambridge/St Thomas' Hospital 1958; MA, FRCS), died from a cardiac arrest on 29 April 2022



After national service in the Royal Air Force Robert Kenneth Jackson trained in orthopaedics in Edinburgh. This was followed by a fellowship at the Albert Einstein College of Medicine in New York and subsequently two years as chief assistant to orthopaedic surgeon Ronnie Furlong at London's St Thomas' Hospital. In 1971 he was appointed consultant in Southampton and at the Lord Mayor Treloar Hospital in Alton. His specialist interest was children's orthopaedics and scoliosis surgery. He set up a scoliosis service on the south coast and was a founder member and later president of the British Scoliosis Society. In retirement he chaired the British Scoliosis Research Foundation and the Lymington Hospital League of Friends. Predeceased by his wife, Maggie, he leaves two children and five grandchildren.

Robert Jackson

Cite this as: *BMJ* 2022;377:o1238

John Alan Loveless

GP (b 1919; q Middlesex Hospital, London, 1943; MA, MRCS, LRCP, DCH), died age 102 from old age on 28 June 2021



John Alan Loveless

("Alan") grew up in east Kent, where his father was a GP. After graduating he had a short spell as a junior doctor in the Midlands. He worked long hours and enjoyed only brief spells of leisure playing golf. In an era where antibiotics were only just being discovered, he encountered substantial morbidity and mortality, especially on the children's ward (25% death rate). In 1949 Alan joined his father in practice in Ramsgate. He married Mary in 1951 and together they established a lovely home for their children and friends. In retirement Alan took on the post of hospice chaplain to the Pilgrim's Hospice in Margate. Mary died in 2005. Alan leaves six children, 11 grandchildren, and two great grandchildren.

Richard Loveless

Cite this as: *BMJ* 2022;377:o1139

Narindar Nath Sood

Consultant ophthalmic surgeon (b 1935; q Amritsar, Punjab, India, 1958; FRCS, FRCOphth), died from complications of covid-19 on 14 February 2022



Narindar Nath Sood

was appointed as consultant ophthalmic surgeon at East Surrey Hospital, UK, after training at Moorfields Eye Hospital. In 1966 he emigrated back to India to head the ophthalmology department in Jawaharlal Institute of Postgraduate Education and Research, Pondicherry. In 1968 he moved to the Dr Rajendra Prasad Centre for Ophthalmic Sciences, All India Institute of Medical Sciences, New Delhi, India, where he retired as the head of the department for glaucoma services in 1993. He was founder-president of the Glaucoma Society of India. He was a great teacher and a remarkable and unique human being who touched the lives of many people. Predeceased less than a year ago by his wife, Veena Sood, he leaves two children and their families, including four grandchildren.

Devindra Sood, Soupramanien Sandramouli

Cite this as: *BMJ* 2022;377:o1142

Paul Farmer

Public health and social medicine visionary

Paul Edward Farmer (b 1959; q 1989), died unexpectedly in his sleep from an acute cardiac event on 21 February 2022

Paul Farmer's humanitarian passion was summed up in the title of the book by Pulitzer Prize winning author Tracy Kidder: *Mountains Beyond Mountains: The Quest of Paul Farmer, A Man Who Would Cure the World*.

Partners in Health

Student idealism fired his pursuit of "global health equity" and dream to build a clinic in Cange, Haiti, where he lived in a squatter settlement with people who struggled to feed their families.

His one room clinic became the precursor of 16 medical centres and 7000 staff in Haiti and the formation in 1987 of Partners in Health (PIH), now a global network in more than 10 countries.

Farmer died in the grounds of a hospital and university he helped to establish in Butaro, a mountain town in Rwanda bordering Uganda and the Democratic Republic of Congo. He had travelled there to teach and celebrate "the white coat ceremony" of its first cohort of medical students. The night before his death, he was said to have been up late seeing patients, which, Kidder said, "was his equivalent of a night on the town."

He saw PIH as part of a cooperative that fed on support. For example, the Rwandan University of Global Health Equity was a PIH

initiative launched in 2015, in collaboration with the Rwandan government and with support from the Bill and Melinda Gates Foundation and the Cummings Foundation.

In less than the two decades after the 1994 genocide that killed nearly a million Rwandans and displaced another two million, the number of Rwandans treated for AIDS rose to 108 000 from near zero. Speaking to students at Point Loma Nazarene University in San Diego in 2014, Farmer said that between 2002 and 2012, Rwanda recorded the world's steepest decline in AIDS related deaths and mortality among children younger than 5 years fell by 70%. He attributed such success to the creation of strong links between community care and clinical and hospital services. Rwanda built up a corps of 45 000 healthcare workers, elected by their own villages, to provide primary care for malaria, diarrhoea, family planning, prenatal care, and vaccination.

In 2019 PIH opened the Butaro Cancer Support Centre to provide free long term housing on the hospital campus for patients, family members, and caregivers during extended treatment.

Early life and career

Born in Massachusetts and raised in Alabama and Florida, Farmer was one of six children. His father converted an old school bus for holidays, but it became the family home for a few years, mostly in Florida, where they also lived on a houseboat in a

creek. During this time Farmer developed "a very compliant gastrointestinal system," an inability to be shy or embarrassed, and the ability to sleep anywhere.

Encouraged by his parents to study, he shone academically despite the family's itinerant lifestyle and financial ups and downs that led to their taking on menial work, such as fruit picking with Haitian migrants. Farmer's lifelong interest in Haiti began as he heard the migrants chatting to one another. He studied the country's history and learned Creole. After receiving a full scholarship to Duke University and graduating with a degree in medical anthropology in 1982, he worked as a volunteer in Haiti. He left the island disillusioned—but driven.

Farmer went to Harvard in 1984, obtaining a medical degree and a doctorate in medical anthropology despite frequently returning to Haiti to continue his work there. In 1987 he founded PIH with Ophelia Dahl, another Haiti volunteer worker; Todd McCormack, a fellow Duke student; and Jim Young Kim, a fellow Harvard student.

Remarkably, Farmer not only obtained \$1m seed money for PIH from Thomas White, who owned a Boston construction company, but he also insisted that White should visit Haiti to see where and how his money would be spent. This was the first of many millions of dollars he raised for community health projects. His passion empowered his sales pitch.

In 2010 Farmer became the first incumbent to the Kolokotronis university professorship at Harvard Medical School. University professorships, Harvard's highest professorial distinction, were created in 1935 to celebrate "individuals of distinction." Only 23 of some 12 000 faculty members then held university professorships. Farmer was also professor and chair of the Department of Global Health and Social Medicine at Harvard, chief of the Division of Global Health Equity at Brigham and Women's Hospital, and chancellor of the University of Global Health Equity in Rwanda.

In 1996 he married a fellow medical anthropologist, Didi Bertrand, the daughter of a pastor and a school principal. Farmer leaves her, their three children, his mother, and five siblings.

John Illman, London
john@jicmedia.org

Cite this as: *BMJ* 2022;376:o582



Farmer attributed his Rwandan success to the strong links between community care and hospitals