comment

“We need immediate, radical action to stop services from collapsing this year” **DAVID OLIVER**
“Doctor induction needs reform: the waste of human time is staggering” **ADRIAN BOYLE**
PLUS Five point plan for a workforce strategy

PRIMARY COLOUR Helen Salisbury

A feeling of safety

Recently, I consulted with a satisfied patient. An unexpected abnormality had shown up on a blood test, and further tests at the GP surgery led to an urgent referral to a hospital clinic. The patient was seen within a few days, more tests organised, and explanations given, with a promise of telephone follow-up and a treatment plan in 10 days. At a time of great uncertainty my patient reported feeling safe and looked after, knowing that the doctor she saw was fully engaged with her case and care.

As individuals, we aspire to be that clinician—the one who earns the trust of their patients and makes them feel confident that all of the right things are being done. We can’t always cure, and our ability to relieve suffering also has its limits, but we should be able to reassure patients that we’ll do all we can, that the very best of 21st century western medicine is at their disposal. This does still happen in today’s NHS, but the fact that this consultation stood out in my mind shows how my expectations have fallen. That my patient received good care didn’t surprise me, as I know that the doctors in our local hospitals are expert and attentive; it was more that the system had operated as it should, springing into action like a well oiled machine.

In other parts of the service, the combined effects of underfunding and understaffing—the latter exacerbated by covid absences and the Brexit exodus—have led to long delays for both social and health care. Some of our outpatient clinics are barely functioning: another of my patients, who is in considerable pain, has had a follow-up appointment postponed twice, the date shifting into 2023.

Seeing the latest ambulance waiting times, I understand why people may no longer feel safe: against a target time of 18 minutes, patients wait an average of 51 minutes for help to arrive after a stroke or heart attack. Some areas have reports of nine hour waits after a fall, and 13 hours before being seen on arrival at the emergency department. The reasons for these delays have been well rehearsed, one of the root causes being a lack of capacity in the social care system. There are logjams tailing back from medically fit patients who can’t be discharged, through to the patients waiting on trolleys in the emergency department, out to the queuing ambulances that can’t unload.

We have fallen. The question is, can we get up again? Can we reach a place where patients feel confident that our NHS will treat them quickly, safely, and effectively and that it will do the same for their relatives and neighbours?

In response to those who regard cracks in the health service as evidence that the NHS model is fundamentally broken, I’d suggest that we apply some of the rules of the market to fix it. In this time of labour shortage, we could start by significantly increasing the pay of social care workers and see how quickly that unblocks the system.

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Cite this as: *BMJ* 2022;378:o1914

We have fallen. The question is, can we get up again?

OPINION Billy Palmer

What should be in a health and social care workforce strategy?

A five point plan to deal with the huge staffing shortfall in the sector

Last week's cross party parliamentary report on the NHS and social care workforce paints a bleak picture. Highlighting Nuffield Trust estimates, the committee points out that the NHS has struggled with 12 000 hospital doctor vacancies and more than 50 000 nurse and midwife vacancies. Although the majority of these may be filled from day to day with temporary staff, many thousands are not.

To make matters worse, staff absences across healthcare providers caused by sickness or self-isolation have topped 100 000 a day at various points during the pandemic. The situation, in most respects, is worse in social care.

In the words of the committee, "it is time to stop photographing the problem and deal with it." To do so, the report is clear that credible NHS and social care workforce strategies—things that have been repeatedly kicked into the long grass—are necessary. But what should such strategies cover?

Five essential components

First, a credible strategy will have to include practical, effective measures to improve staff retention. The committee's report laudably recommends, at a minimum, that all NHS staff have access to hot food and drinks 24 hours of the day, as well as places to rest, shower, and take breaks.

More radical perhaps are the recommendations on: reviewing working conditions to reduce the intensity of work; improving childcare; and taking further steps to allow flexible and less-than-full-time working. What seems to be missing though—and what must inform any strategy—is a detailed understanding of why staff are leaving; an area where data fall short.

What seems to be missing is a detailed understanding of why staff are leaving

Second, a proper plan would set out how to deliver an increased, sustainable supply of new staff. In the short term, international recruitment—done in an ethical way—is a key part of the solution. On this, the committee recommends removing administrative barriers. For this vital source of overseas recruitment to work in all services, settings, and parts of the country, there will need to be collaboration between providers, and a strategy should incentivise and support this.

On longer term solutions to the supply of NHS staff, there must be clear plans for more home grown professionals to fill the workforce shortages. This may well include increasing clinical student intakes,

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ACUTE PERSPECTIVE David Oliver

Politicians' abject failure to tackle the existential crisis in the NHS

After the ousting of Boris Johnson as prime minister and the loss or replacement of many government ministers—including those at the Department of Health—we're faced with the ongoing instability of a Conservative party leadership contest, the further ministerial churn that will follow, and a potential general election within 18 months or so.

In the meantime, NHS and social care systems in England are facing a fight for viability right here, right now. But I see no sense of urgency, clarity, or purpose—or even acknowledgment of the scale of the problem—among the leadership contenders or the wider party. Nor do any of their soundbites or policies grasp the need for radical, immediate action. The lack of focus on the NHS and the absence of meaningful discussion on social care have been notable in the leadership race.

Maybe this is no surprise, when government policy over the past 12 years has contributed so much to the current problems and when sections of the Conservative Party are ideologically opposed to the very NHS model, though they may be reluctant to say so in public. Even opposition leaders are avoiding strong, urgent policy suggestions this far out from an election manifesto. But in early July every NHS ambulance trust in England was forced to declare a major emergency, on what was described as their "worst night ever."

At least the cross party Health and Social Care Select Committee has uncompromisingly set out the scale of the challenges in its most recent report. These include the huge number of unfilled clinical vacancies in the NHS (which already has fewer doctors and nurses per 1000 than most high income countries), the workforce crisis in social care, and the impact of covid, burnout, and overwork on staff morale and retention.

We also have a record number of people—over six million and counting—on waiting lists for elective appointments, tests, and procedures; a crisis of overcrowding, long waits, hospital exit blocks, and ambulance response and handover times in acute care; worsening problems with workload and access in primary care; a funding and workforce crisis in social care; and a major shortfall in capital expenditure on maintenance, equipment, and IT.

Good starting point

Acknowledging the scale of the problem openly and honestly, and illustrating it with data, would be a very good starting point. At a recent round table hosted by the *Health Service Journal*, a whole range of current NHS chief executives (and not just those so senior or close to retirement that they were fireproof) spoke out in a way I'd never witnessed. They said in no uncertain terms that they were "presiding over a failing NHS." The British Social Attitudes Survey 2021 showed that, despite high notional support for the NHS and trust in doctors and nurses, public satisfaction with the NHS was at a 25 year low, with respondents clearly citing short staffing and poor access as the biggest

but it is not clear that the committee's recommendation to add 5000 medical school places would represent value for money on the considerable investment it would require given the known leakiness in the pipeline for converting students into (clinical) boots on the (NHS) ground. The report recommendation to review how providers are funded for training staff could be part of a more responsible first step to improving the domestic training pipeline.

Third, to be credible, a workforce strategy will need to set out how to tackle current levels of discrimination. The moral and legal cases to ensure diverse and inclusive health and social care workforces are indisputable. But the evidence also points to this contributing to improved quality of care, a more sustainable workforce supply, and increased efficiency of services. Although there is some good practice that can already be adopted elsewhere—the report highlights some promising examples—the committee also recognises the need for a more evidence based strategy, endorsing our suggestion for a government commissioned "What Works Centre"—an organisation to collect knowledge on effective solutions—which could also benefit the wider public sector.

Unique challenges

Fourth, a strategy should not overlook the unique challenges in the social care workforce. Recognising the need for "meaningful professional development structures, and better contracts with improved pay and training," the committee recommends: restoring free access for social care staff to the same NHS training as community health colleagues; proactive enforcement of minimum wage or living wage, as we had recommended; and a substantial and sustained hike in funding to social care.

However, the concern with social care is even more fundamental. While the government has made some commitments on training and wellbeing covering the next three years, we are left unclear whether a long term strategy to deal with the systemic issues is even in the pipeline.

Finally, to be credible, workforce strategies for health and social care need to learn lessons from previous failures. This is perhaps implied in the committee's report without fully reflecting on past experience. Certainly, shaky projections and flawed clinical workforce plans are as old as the NHS itself. There are many reasons for this, including failing to align roles, responsibilities, and funding while also failing to balance the relative risks of under- and oversupply of staff.

Not sufficiently reflecting the needs of different regions, settings, and providers has been another problem. Future workforce strategies cannot be a refresh, but must learn from previous mistakes and provide a bold and distinct approach.

Workforce planning is not easy, with the considerations above not an exhaustive list of what a credible plan should cover. However, we should not accept a failure to deliver an effective workforce strategy. The report is right not to shy away from the potential impact of continued mishandling of the workforce: persistent staff shortages pose a serious risk to staff wellbeing and to patient care.

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Cite this as: *BMJ* 2022;378:o1906

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problems. More people than ever are resorting to using their own money to access private elective care.

Of course, we need a broader policy discussion about how to redesign and improve services in the long term, but the first thing is to take immediate and radical action to stop services from collapsing this year. We need far better terms for frontline workers—not just pay, but pension rules and conditions of employment—to improve retention and morale before we haemorrhage even more staff. July's proposals by pay review bodies won't begin to cut it.

We need to act now to ensure that immigration rules allow and encourage more overseas staff to come to the UK or stay here, and we must make them feel welcome. This includes lower paid staff groups and social care workers, whose workforce gaps dwarf even those in the NHS. And we must pump money into social care, by any means—the kinds of sums needed to restore coverage and access to the levels of a decade ago.

The desultory £1.8bn a year from national insurance rises, promised in the government's "social care plan" and "levy" last year, won't even touch the sides, as the Health Foundation's economic modelling has clearly shown. And Liz Truss, the likely winner of the Tory leadership contest, wants to reverse even that.

Perhaps most importantly, politicians and NHS national leaders need to level with the public about what we can realistically expect in the current climate and how bad things will continue to be for the foreseeable future, while engaging voters in facing up to the need for hard choices and trade-offs. I can't see it happening, partly because the party of government for the past 12 years has presided over the decline of health and social care services through its own poor decisions. But at some point the conversation must happen—instead of soundbites, over-promising, vague "jam tomorrow" ambitions, and half baked or discredited policy ideas.

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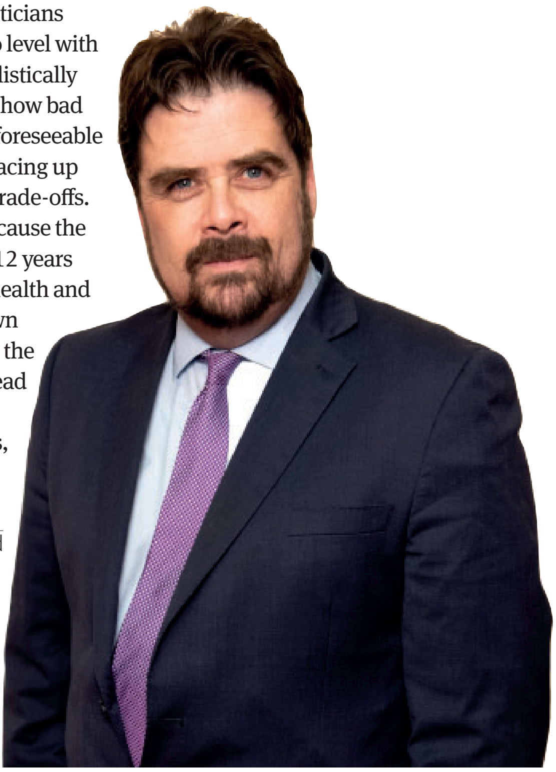
Cite this as: *BMJ* 2022;378:o1904

The desultory £1.8bn a year from national insurance rises won't even touch the sides



OPINION Adrian Boyle

Welcome to your new hospital

August is a month of mass medical migration. Postgraduate doctors are scattered across UK hospitals, and for some, this is their first experience of a workplace as a professional or even their first experience of working in a new country. For others, they leave one hospital after a night shift and find themselves expected to magically teleport themselves to another hospital's compulsory induction that same day.

It seems perverse to change a large proportion of the workforce all on the same day, and human resource departments are frequently overwhelmed in a predictable "capacity demand incident." Permanent staff, who know how to get things done, become even more valuable in August.

First impressions matter, and hospitals aren't always good at this. Hotels know that quick and friendly check-in and check-out times are disproportionately related to guest satisfaction and are often very slick. In a hospital, knowing how to park, get a badge, find your rota, and sort out passwords shouldn't be difficult—even at scale. The mandatory nature of induction programmes, either online or face to face in a lecture theatre of strangers, often feels more designed to tick some governance box rather than establish good working relationships.

We're getting better at some of this, but the waste of human time on induction is staggering. Reforming induction should start by considering what the end outcome should be. There will always need to be some corporate governance so that staff know how the hospital is organised, but surely the aim should be to make new staff capable and effective as efficiently as possible? Any information that is generic to the NHS should not need repeating at every new hospital, especially for people who are returning.

> **The final aim should be to create an environment where doctors can safely learn how to do their job**

There is quite a large management literature about what is effective in introducing new staff to large organisations. Unsurprisingly, culture and leadership really matter. The final aim of this should be to create a learning environment where young doctors can safely and efficiently learn how to do their job.

Consultants who explicitly explain their reasoning by "thinking out loud" and take a pastoral interest develop juniors more quickly. Peer support seems obvious, but it has become harder with online teaching and infection prevention and control measures. Being able to share intelligence about how systems work with the person sitting alongside you quickly creates "herd knowledge."

Social acceptance is an important indicator of how a newcomer is inducted and is important for enjoying work. Individual departments should actively consider planned social events early to build a team, and photo boards of staff explicitly signal that new staff are valued and seen as part of the team.

Starting work in a new hospital can be daunting, so let's make it better.

Adrian Boyle, consultant in emergency medicine, Cambridge University Hospitals NHS Trust

Cite this as: *BMJ* 2022;378:o1907

VICTORIA JONES/PA/ALAMY

LATEST PODCAST

Talk Evidence: shoulder, knees, and woes

In this episode, Juan Franco, editor in chief of *BMJ Evidence-Based Medicine*, and Helen Macdonald, *The BMJ*'s research integrity editor, sit down to discuss what's new in the world of evidence. They talk through recent research on covid-19, a paper looking at viscosupplementation for knee osteoarthritis, and another on serious adverse events after arthroscopic shoulder surgery, with Franco describing what this last paper found:

"This paper tries to assess the incidence of adverse events and reoperation and they got massive data from 288 000 shoulder procedures with 90 days and one year follow-up. They captured the adverse events from different types of surgeries: subacromial decompression, rotator cuff repair, acromioclavicular joint excision, frozen shoulder release, glenohumeral stabilisation. And the main findings are that in 90 days the incidence of complications is between 1.2% and 1.3%, and the rate of reoperation at one year is 3.8%. And it's interesting how they framed the results as one in 26, which I think a lot of people will find more easy to understand. That's very informative, especially in the context of these procedures that are mostly elective, and you need to discuss with patients the benefits and harms."

Macdonald considers how this study equips doctors for conversations with patients about the balance of risks and benefits:

"The nice thing about this study was the pooling of results from across the spectrum of surgery so that you've got enough people to get a clearer picture of how likely those harms are. As Juan says, there may be discussions to be had about how beneficial this surgery might be. It's good to see some more reliable information coming out about the low risk of harm, which is reassuring. But then that low risk of harm also has to be seen in the context of how much benefit there is."

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

ANALYSIS

Long covid and disability: a brave new world

Nicholas Evans and colleagues argue that the condition needs to be better recognised, understood, and supported, and should stimulate a rethink of our approach to disability


NEIL WEBB

One billion people worldwide live with a disability,[1] but they are often overlooked in discussions of pandemic preparedness and response.[2 3] People with physical and cognitive disabilities—including those with "invisible" disabilities that are not obvious from the outside—were at disproportionate risk of harm from covid-19 because of their pre-existing medical conditions or their social circumstances.[4-6] People in the UK whose disabilities affected their day-to-day function were up to three times more likely to have died from covid-19.[7] They also experienced disproportionate loss of access to medical services, education, employment, and care.[8]

The number of people experiencing disability is being swelled by people with "long covid," in which symptoms persist after the acute viral infection subsides. The term "long covid" was coined by patients, initially being used on social media to describe symptoms that were impairing quality of life.[9] We argue that this experience generates an obligation to recognise long covid as a potentially disabling condition defined by clinical diagnostic criteria and supported by ongoing clinical research. Such recognition would also re-enforce the obligation of the state to extend and expand supportive infrastructure and policy for people with other disabilities.

The need for just social policies grounded in contemporary theories of disability, designed by disabled people for disabled people, can also form the basis for advocacy and policy change beyond the pandemic.

KEY MESSAGES

- The rise of long covid has created millions of new people with disabilities who will have to navigate the post-pandemic world
- The need for change to support people with disabilities predated the pandemic
- Long covid needs to be legally recognised as disabling through clinical research and practice
- The state must support people with long covid through expanded or reformed infrastructure and policy and by changing social norms
- Such changes will benefit all disabled people and wider society

> At least 16.5 million of the 562 million people infected with covid worldwide as of 20 July may have long covid

What is long covid?

Although long covid is widely acknowledged to exist, diagnostic criteria vary, with different authorities acknowledging a diversity of symptoms and severity levels. Symptoms include fatigue, cognitive symptoms such as difficulty concentrating and impaired memory, and sensory changes like permanent loss of smell or taste.[10] Physiologically, long covid may cause damage to extremities, in some cases requiring amputation[11 12]; multiorgan injury such as chronic kidney disease requiring dialysis or transplant[13 14]; or respiratory complications and persistent post-exertional symptoms. These symptoms may exist in isolation or in clusters, and though they range in severity, many greatly affect people's wellbeing and life plans.

The exact prevalence of long covid is unknown because the wide range of presentations overlap numerous other conditions, there is no definitive diagnostic test, some people with long covid may struggle to access care (and thereby not counted), and covid-19 testing was difficult to access in many settings at the beginning of the pandemic.

In the UK, the Coronavirus Infection Survey conducted from April 2020 to August 2021 estimated between 3% and 11% of 15 061 participants with covid-19 infection experienced symptoms for more than 12 weeks.[15] The US Centers for Disease Control and Prevention found up to 20% of 353 000 patients aged 18-64 years had one symptom attributable to covid-19 more than four weeks after infection.[16] At its lower bound, at least 16.5 million of the 562 million people infected with covid-19 worldwide as of 20 July 2022[17] may have long covid, but at its higher estimates the number could extend to over 100 million people.

Symptoms of long covid can persist for over a year and potentially be permanent. One international online survey in 2020 of 3762 people in 56 countries with confirmed or suspected covid-19 who had illness lasting over 28 days found 45% of respondents had required a reduced work schedule, and another 23% had left the workforce because of suspected long covid.[18] Long covid in children and young people could similarly jeopardise educational attainment.

HANNAH MCKAY/PA/ALAMY

Long covid and disability

Long covid itself may not be a disability but, given its potentially debilitating effects on people's lives, it can be disabling. Long covid symptoms may also constitute disabilities because of loss of human function or because of a persistent impairment that undermines a person's quality of life.[19]

Another way in which long covid symptoms may be disabling is if a person experiences social discrimination or social subordination, wherein they lose status in society as a result of perceived "defective bodily functioning."[19 20] Some evidence suggests that people with long covid already experience discrimination. For example, in a cross sectional survey of 127 patients with long covid symptoms conducted between August 2020 and March 2021 in Japan, 55 people had experienced at least one form of discrimination and stigma, including being treated as if still contagious or being the subject of harmful rumours or verbal harassment.[21] Subsequent research does not suggest attitudes have changed.[22] People with long covid can also experience social isolation, stigma, and loss of social identity because of their inability to perform at work, maintain their relationships, care for their families, exercise, and so on.[23]

Clear diagnostic criteria facilitate care and legal recognition

Long covid would be better understood as a potentially disabling condition if there were clinical diagnostic criteria to create meaningful pathways to care. This would benefit people with disabling symptoms in at least three ways. Firstly, those affected may need ongoing medical and allied care to retain or restore functions or to fulfil their life plans. Applications for state funded disability related health assistance usually require a clinical examination and sometimes a diagnostic code, such as an ICD-10 code. Diagnostic criteria for long covid may facilitate access to interventions and services that support social engagement and physical function (eg, hand rails, modified work environments, or access to rehabilitative therapy or psychiatric care).

Clear diagnostic criteria—supported by ongoing research into the underlying mechanisms of persistent symptoms[24] —might also reduce uncertainty and validate the experience of patients with long covid, including those who did not have access to testing at the time of presumed infection. A 2020 qualitative study in 24 patients with long covid identified uncertainty and being taken seriously as important concerns.[25]

The third and potentially more profound implication of establishing diagnostic criteria for long covid is in legal recognition of disability through instruments such as the Americans with Disabilities Act in the US and the Equality Act 2010 in the UK. Because people with long covid may experience long term, substantial impairment of their ability or autonomy to participate in society, in principle these instruments may already cover long covid. For example, the Equality Act covers discrimination on the grounds of "protected characteristics," one of which is disability, and can require employers and others to make "reasonable adjustments" for people with disabilities. However, the widely variable presentations of long covid and absence of definitive diagnostic criteria or biomarkers may make it harder for patients to prove that they qualify as disabled. The Americans with Disabilities Act Amendments Act also requires people to prove qualification before they can claim a right to accommodations.[26] This means the disability must be recognised by a court rather than relying on self-reported limitations in a person's ability to undertake major life activities.

Conversely, formally conceiving of long covid as a disability in law or policy is not the same as an individual determining whether their identity has changed to include "disabled." This creates a tension between self-identification as disabled and the law,

Widely variable presentations of long covid and an absence of definitive diagnostic criteria may make it harder for patients to prove they qualify as disabled

where it is often necessary to have clear definitions and boundaries. Excessive focus on biomarkers or black and white diagnostic criteria for long covid could inadvertently exclude people who experience debilitating symptoms that do not fit accepted definitions of disease.[27] Disability is not merely a medical phenomenon but a social one, and a loss of social function should be included as part of an assessment of disability.

Given the strong grassroots and patient led movement to recognise long covid, patients and advocacy groups should be included in developing disease criteria as a basis for self-identification.[28] The successes of disability rights movements and other movements such as HIV/AIDS activism, in which self-advocacy formed the basis for change are instructive: nothing about us, without us.[29] Establishing well defined criteria can empower people with long covid by providing a long term basis for coalitions and building communities. These can be leveraged into activism to bring about social change, including motivating state responses.

State obligations

Diagnostic criteria can provide the basis for care and accommodations, but it is the state that is required to meet the needs of people with disabilities through medical care or other political, infrastructural, or welfare systems.

In the case of long covid, these needs may be diverse. People with organ injury will require continued and robust access to affordable and accessible healthcare. Those whose symptoms impair mobility may require aids or modifications to their physical environments, like many other people with physical disabilities. People with cognitive deficits, profound fatigue, or psychiatric symptoms may require specific support—for example, access to unemployment or other benefits, modifications to their work duties or schedule, or allowances for remote working when symptoms preclude commuting.[30] Flexible attendance and modified activities for students with brain fog and other stress mediated effects of long covid may be necessary to support educational attainment.[31] Increases in funding for, training, and availability of home care aides for families will arguably be needed when care givers and primary earners are affected by long covid.

Many of these accommodations and improvements will arguably be best financed or accomplished through state intervention and may require policy interventions. For example, private firms may decide against the perceived additional expense of accessibility unless it is considered “reasonable” and enforceable by legal protections such as the Equality Act in the UK. Given the potential scale of long covid, novel workplace legislation mandating the right to remote work and flexible work hours (for long covid as well as other important needs such as other disabilities, family illness, and childrearing) would improve accessibility.

There may even be grounds to invert the status quo on accessibility and make the right to flexible work a presumption, effectively placing the onus on employers to justify on-site work requirements. For people whose symptoms flare or require additional medical leave, legislation introducing formal paid time off legislation in countries that do not have it would be a step towards an equitable society built on the recognition of disability.

There may even be grounds to invert the status quo on accessibility and make the right to flexible work a presumption

In other cases, accommodation may simply be a public good. Historically, mobility aids such as dropped kerbs in pavements allowing access to the road and ramps into or through buildings rather than stairs benefit people with a variety of mobility needs—some, but not all, resulting from disability.[32] These public works are typically achievable at scale only with state support and also benefit the broader population.

These accommodations are social needs that predated the pandemic but are now critical with the rise of long covid. Crucially, support services are currently understaffed and under-resourced. The pandemic has seen the degradation or collapse of welfare services, combined in some countries with decades of defunding and neglect.[33] These services now have millions of new users.

Recognition, respect, access to care, and an adjustment of our social norms and infrastructure have long been demands of disability activists. Covid-19, as in many other areas of life, may have shown the depth of our failures, but it did not create them. The emergence of long covid has made visible an emerging disability community that has the potential to shine a light on disability rights. What is now needed is a concerted political will to act to benefit the millions of individuals who are, or will become, disabled as a result of this global pandemic.

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Cite this as: *BMJ* 2022;378:e069868

LETTERS Selected from rapid responses on bmj.com

MALCOLM WILLETT

LETTER OF THE WEEK

Paediatric "virtual wards" were reducing admissions well before the pandemic

Best's article on using virtual wards to ease hospital pressures (Cover, 9 July) resonated with me because in paediatrics we have been doing this for over 25 years. Much of our paediatric practice could map nicely to adult care; the adage that children are little adults is untrue, but the reverse—adults being big children—holds some truth, medically speaking.

The central tenet of ambulatory paediatrics, a concept described by Meates et al in 1997, is keeping children at home. In many situations, once children on the ward are getting better they can continue to improve at home. Sometimes their clinical condition allows them to be kept out of hospital altogether. A check-in phone call or community nurse visit can support the family.

There is "no place like home." Crucial to this are "ruby slippers" such as daily intravenous antibiotic regimens which enable ongoing treatment at home. High dose inhaled bronchodilator through spacers, as opposed to nebulisers, have also enabled ambulatory practice to be embedded in paediatrics.

Commissioning and formal IT arrangements haven't always been supportive, but it is true to say that often there are more children being managed on an ambulatory basis at home, or coming in for a daily intravenous treatment, than there are in the ward. Obviously, our patient population have able carers to look after them, but those adults who can be managed at home should be.

It is interesting it has taken a pandemic to try to embed a practice that paediatric doctors have been doing for years. What else can teams caring for adults learn from paediatrics and the way they look after children?

Ashley Reece, consultant paediatrician and director of medical education, Watford

Cite this as: *BMJ* 2022;378:o1856

GP SUSPENSION FOR FAILURE TO REFER FAST TRACK

Sword of Damocles

The GP who didn't refer a patient with suspected cancer symptoms early enough undoubtedly made a mistake (This Week, 2 July). He was said to have "had an otherwise unblemished record." Does every error need to be punished by suspension or erasure to "uphold the public interest in marking the seriousness of a doctor's misconduct?"

A *BMJ* paper estimates that, in the US, "medical error results in 44 000–98 000 unnecessary deaths each year and 1 000 000 excess injuries." If one were to assume similar rates of medical errors in the UK, and if even a tiny proportion were punished by suspension or erasure, many doctors would be practising medicine that is even more defensive with the "sword of Damocles" hanging over them every day.

Doctors who persistently underperform should be punished, but society needs to decide whether honest mistakes by doctors with good insight should be punished harshly every time.

Santhanam Sundar, consultant oncologist, Nottingham

Cite this as: *BMJ* 2022;378:o1828

ENGLAND'S FOOD STRATEGY

A missed opportunity

The government's long awaited food strategy for England was finally published on 13 June 2022 (News online, 14 June; Editorial and Opinion, 2 July).

Crucially, it ducks the sugar and salt reformulation levy, a powerful public health measure that has long been recommended by the wider scientific community. Fiscal policies targeting salt, fats, and sugar have been proved to be particularly effective, decreasing consumption of unhealthful foods and thus saving thousands of lives. A 20% sugary drinks duty in England could gain over 40 000 quality adjusted life years every year.

The unfolding economic and food supply crises are increasing food prices, particularly fruit and vegetables. Additional systemic shocks (such as Brexit food trade barriers) are also having a negative effect on the diets and health of the population. The government must urgently consider powerful, evidence based policies that substantially improve the quality of diets and reduce social inequalities.

Zoé Colombet, postdoctoral research fellow in epidemiology and data modelling; Martin O'Flaherty, professor of epidemiology and interim head; Simon Capewell, emeritus professor, Liverpool

Cite this as: *BMJ* 2022;378:o1835

Local public health directors need power and resources

The delayed national food strategy lacks sufficient time specific targets, ringfenced funding, and a robust evaluation. Key settings are missing, including hospitals and workplaces.

The strategy fails to tackle food poverty and the cost of living crisis. Foodbanks and free school meals are crucial in supporting some families, but we urgently need long term initiatives to make these types of interventions redundant.

The important role of public health directors and their teams was also omitted. Public health directors have had some success when working across settings with local dietitians, GPs, teachers, caterers, and environmental health officers. But government support and funding are needed.

The magnitude of the obesity epidemic should not be underestimated, but real improvements in health are possible. We urge the government to build on this work and increase the resources of public health directors so that they can drive forward local multifaceted strategies for healthy eating.

Michael Craig Watson, trustee; John Lloyd, honorary vice president, Institute of Health Promotion and Education

Cite this as: *BMJ* 2022;378:o1837

POLITICS AND MORTALITY IN THE US

Rural areas could be hazardous to your health

The variance in mortality rates between US counties that vote predominantly Republican and those that vote predominantly Democrat can be explained by the geographic proximity of voters to a properly equipped medical facility. This is a failure of national and state medical policy and initiatives. A more appropriate premise of the research paper by Warraich and colleagues (Research, 25 June) is: "Living in rural areas could be hazardous to your health because politicians are spending more tax dollars on urban areas than on rural communities."

Studies show that mortality rates from 1999 to 2019 declined overall, but less in rural than in urban areas, and that rural area decline in mortality has been essentially stagnant since 2010. An elderly person or someone with emergency medical needs is more likely to survive an event based on their distance from and time to travel to a properly staffed and equipped medical facility.

James Reed, co-founder and director of data analytics, Primidio Holdings

Cite this as: *BMJ* 2022;378:o1847

Authors' reply

Reed suggests that increased mortality in Republican areas is because they are rural with poor healthcare access. The urban-rural gap does not, however, account for our findings.

All Democratic areas experienced greater reductions in mortality from 2001 to 2019. Although Democratic rural areas had higher mortality in 2001, over the ensuing two decades they experienced a 16.5% relative improvement in mortality while Republican rural areas experienced a 6.6% improvement. This difference wasn't restricted to rural areas.

One factor driving rural mortality is healthcare access. Medicaid expansion can increase insurance rates and is associated with fewer rural hospital closures. This measure has been opposed by Republican lawmakers, exemplifying how partisanship has worsened rural health.

Health behaviours can also differ by party affiliation. Smoking rates are higher in Republican counties, for example. Republican states have less stringent tobacco regulations.

While the political gap in mortality is multifactorial, these data provide impetus for bipartisan efforts to close it.

Haider J Warraich, assistant professor; Rishi K Wadhera, assistant professor, Harvard Medical School; Pankaj Kumar, internal medicine intern, Karachi

Cite this as: *BMJ* 2022;378:o1871

UNDERSTANDING HOW OTHERS RELATE TO YOU

Listen to your enemies

People fall into four groups based on how they react to us: those who love you unconditionally (Blinds), those who gravitate towards you over time because they respect you (Rationals), those who want to be close to you for their own reasons but who are not your friends (Shapeshifters), and those who don't like you (Haters) (Partha Kar, 2 July).

When I first started as a clinical leader, my approach to Shapeshifters and Haters was exactly as Kar suggests—just step away. But over time, I realised that the best ideas were coming from detractors, not supporters. Some of the hate included things I would never have thought of and views that made good sense. It's difficult to stay calm through the noise, but that's where the good stuff is. So, make time for blind followers and rational friends, but don't stop listening to your enemies.

Ruth L Evans, GP, North Tyneside

Cite this as: *BMJ* 2022;378:o1842

LEARNING FROM COMPLAINTS DURING COVID-19

Change the culture of complaints

David Oliver asks what we can learn from complaints during covid-19 (9 July). Excellent clinicians can get complaints; weaker ones can get no complaints. Accessible systems take on more risk than less accessible systems. The latter create a risk filter as patients drift towards more accessible systems.

The resources consumed by complaints are often disproportionate. This damages the services and leads to more complaints.

Clinical decisions are made quickly. Analysis of those decisions is often made over weeks, with the benefit of hindsight. Complaints analyses and conclusions should reflect this.

Complaints are a poor measure of the quality and effectiveness of a service because they don't recognise the pressure the service is under and the risks being taken in efforts to tackle demand.

A change to the culture of complaints should reflect that the system is often broken and that this pits providers against patients.

Graeme Mackenzie, general practitioner, London

Cite this as: *BMJ* 2022;378:o1865

Discuss risks before treatment

For surgeons and anaesthetists, in particular, the concept of discussing risks and benefits in advance of treatment is well understood and well established.

Perhaps we should regard a hospital based episode of care in much the same way. Rather than apologising when things go wrong or are not as expected, we could inform patients of general hazards and unintended adverse consequences before admission to hospital. We could highlight those areas over which we have little control, explain why this is the case, and suggest what steps the patient might take in mitigation of the risk.

This approach could be used to excuse poor standards of care—but it could instead be an opportunity for doctors, patients, and managers to, together, grasp the nettle of healthcare shortfalls that continue to cause dissatisfaction, suffering, and complaint.

Mark W Davies, consultant anaesthetist, Liverpool

Cite this as: *BMJ* 2022;378:o1858

OBITUARIES

Robert Noel Evans

Command consultant anaesthetist (b 1922; q National University of Ireland, Cork, 1947; CB, DTM&H, FFARCS, MFCM), died from sepsis on 22 February 2022

While at University College Cork, Robert Noel Evans ("Bob") met Betty O'Brien, a fellow medical student, who was to be his wife from 1950 until her death in 2007. Since work for doctors was scarce in Ireland he left for England and was commissioned in the army in 1951. In the 1950s and 1960s his career took him to Germany, Hong Kong, and Singapore. He was a major-general in the Royal Army Medical Corps, postgraduate dean and commandant of the Royal Army Medical College, colonel commandant of the corps, honorary physician to the Queen, and Companion of the Bath. Predeceased by Betty and one of their sons, Bob leaves three sons, a daughter, 10 grandchildren, and five great grandchildren.

R A Evans, S J Evans

Cite this as: *BMJ* 2022;378:o1795

Pharic Nelson Gillibrand

Consultant obstetrician and gynaecologist Princess Anne Hospital, Southampton (b 1935; q St Mary's Hospital, Paddington, London, 1958; MD, FRCOG), died from lymphoma on 8 June 2022

Pharic Nelson Gillibrand was appointed as consultant obstetrician and gynaecologist to the Southampton hospitals in 1969, when the medical school was new. He joined what was, essentially, a large district general hospital—by the time of his death it had become a centre of world class clinical medicine and surgery and a highly respected medical school. Pharic was an exemplary exponent and leader of the support of the NHS consultant staff throughout the whole of his tenure. He played a full part in the work of the royal college by sitting on committees, taking part in clinical inquiries, and acting as an examiner in the UK and internationally. His wife, Patricia, predeceased him, and he leaves three children and 10 grandchildren.

Eric Thomas

Cite this as: *BMJ* 2022;378:o1826

Arun Raha

GP Scunthorpe (b 1938; q Kolkata University, India, 1961), died from secondary bone cancer on 24 February 2022

Arun Raha worked in India before coming to the UK in 1967. He started in general practice in 1971. He was based at Oswald Road Medical Centre, Scunthorpe, where he became a senior partner. He later developed and renovated the premises of the surgery, which provided services to communities in the heart of Scunthorpe town. He also did a few sessions for occupational health and for Ashby Family Planning services. Later, he played an important part working as a member of the clinical commissioning group. He finally retired in 2012, having served the local population for over 40 years. Arun was a keen golfer and an Anglophile, and he loved going on cruises with his wife, Mary. He leaves Mary, two daughters, his son in law, and two grandchildren.

Arun Chaudhary

Cite this as: *BMJ* 2022;378:o1807

John David Bruce

GP, medical teacher, coroner, and administrator (b 1929; q St Bartholomew's Hospital, London, 1952; FRCGP), died from aortic stenosis and age related dementia on 2 February 2022

John David Bruce ("David") was a GP in Bodmin, Cornwall, for more than three decades. He set up his own practice with another doctor. He was a trainer and created the GP vocational training scheme in Truro. He served on the area health board and on the local medical committee, including as chair. David was an examiner for the Royal College of GPs and was awarded a fellowship for his service to the college. For several years he was the coroner for north Cornwall. David was a meticulous doctor and a brilliant diagnostician. He cared deeply for his patients and for the welfare of healthcare in Cornwall and beyond. David leaves his wife, Juliet; three children; and eight grandchildren.

Steve Watkins

Cite this as: *BMJ* 2022;378:o1794

Jessel Josephs

GP South Shields (b 1924: q King's College Durham, 1947; MRCGP), died from frailty of old age on 8 May 2022

Jessel Josephs worked in South Moor, Stanley, immediately before the establishment of the NHS. After conscription and serving in the Royal Army Medical Corps, he formed a successful GP practice in South Shields, where he worked until his retirement in 1985. During his career he, together with his partner, handled upwards of 300 "home confinements" per year as well as general medical practice work. They expanded the range of services they were able to offer patients. During his career he served as chairman of the local BMA branch and worked on establishing and running a postgraduate centre. Predeceased by his wife and his daughter, he leaves a son, a daughter in law, two grandchildren, and two great grandchildren.

David Josephs

Cite this as: *BMJ* 2022;378:o1802

Roger John Mitchell

Consultant surgeon Jersey, Channel Islands (b 1932 q St Bartholomew's Medical College, London, 1958; FRCS), died from covid-19 on 11 March 2022

Roger John Mitchell studied medicine at Cambridge and Barts in London, qualifying in 1958. He then returned to Cambridge to demonstrate anatomy to medical students and met his future wife, Angela. He moved to Jersey in 1972 as one of just three surgeons on the island. Roger was a true general surgeon and was instrumental in bringing about modern changes in surgical practice in Jersey. A standard list for Roger could include a bowel cancer resection, complex breast cancer surgery, a ruptured aortic aneurysm, and then a caesarean section. Outside his clinical work, Roger assisted fundraising for the Wessex Medical Trust and became a senior judge for the British Show Jumping Association. He leaves his wife, Angela; three children; seven grandchildren; and one great grandchild.

Andrew Mitchell

Cite this as: *BMJ* 2022;378:o1805

OBITUARIES

Alastair Lack

Physician-inventor with a focus on patient safety in anaesthesia

John Alastair Lack (b 1942; q University College Hospital, London, 1965; FFARCS), died from amyloidosis on 11 March 2022

Anaesthesia is reported to be the first medical specialty to champion patient safety as a specific focus. This reduced mortality, morbidity, and inpatient stays, with vast economic benefits as well as benefits for patients—a vomiting, postoperative patient has to be kept in hospital overnight.

Recipe book

Alastair Lack had a pivotal role in this transformation. His legacy is reflected today in the Royal College of Anaesthetists' 400 page *Raising the Standard: Quality Improvement Compendium*. Launched in 2000 and now in its fourth edition, it was originally unofficially known as the "audit recipe book."

The concept was cooked up in the late 1990s by Lack and a team of "self-confessed pedants" in the kitchen of his river front home in the picturesque village of Coombe Bissett in Wiltshire. They wanted to devise a manual of quality improvement and audit tools for anaesthetists for national use.

Some observers say that the book was the biggest achievement of a clinician-scientist renowned for his boundless energy, towering intellect, passionate drive, and for writing an extraordinary number of controversial letters to the *Times*—he was also forthright on Twitter.

Lack was among the first to recognise the need to integrate computers into anaesthetic systems. Globally, he is best known for inventing the Lack circuit, a means of reducing pollution from anaesthetic gases in the operating theatre.

Paramedic services

But within Wiltshire, where he was a consultant anaesthetist in Salisbury, he was known primarily as the pioneer of paramedic services. Beginning in the late 1970s, initially on his motorbike and later in a Range Rover, "Wiltshire's flying doctor" sped to road traffic crashes to try to fill "the therapeutic vacuum," the first few critical minutes after a crash. In one analysis of 1000 incidents, it was estimated that of 106 near fatal cases, 34 lives had been saved by doctors' prompt responses.

In Wiltshire, Lack was known primarily as the pioneer of paramedic services

Lack persuaded ambulance control to call him if a patient had lost a lot of blood at a crash site. He began training ambulance staff by the roadside and in casualty and the operating theatre—these were some of the early paramedics. It was one of several such initiatives in the country, leading, eventually, to a national training scheme and formation of the British Paramedic Association, now known as the College of Paramedics.

Life and career

Always known by his middle name, John Alastair Lack was born in Tintagel, Cornwall. When studying medicine at University College Hospital, London, he met his future wife, Maggie, a nurse, while they were both looking after a drug addict. He spent his first student elective in the RNOH neurophysiology laboratory building miniature probes for recording spinal cord signals. His boss encouraged his interest in engineering and gave him an introduction to Westminster Hospital, where he trained in anaesthesia.

After only six months at Westminster, he took the primary examination for the anaesthetic fellowship. In 1968, aged 25, he became the college's youngest fellow. In 1969 he started a medical engineering postgraduate degree at Imperial College, studying electronics, computing, signal processing, and materials science. His thesis was on transmitting an electrocardiogram signal by means of light emitting diodes.

As assistant professor of anaesthesia at Stanford University, California, in 1971, he researched remote supervision of anaesthesia (telemedicine) and fast Fourier transforms of the electroencephalogram.

Back home again the Lacks were torn as to whether or not to return to the US, but Maggie argued, "They changed their wives more often than they changed their cars." After a weekend at her sister's in Devon, they opted to live in Salisbury.

Lack circuit

In 1974 Lack became a consultant in Salisbury—and joined the illustrious roll call of physician-inventors with equipment named after them. The usual way to deliver anaesthetic gases was through a rubber tube attached to a reservoir bag and an exhaust valve. The expired gases were simply released into the air of the theatre.

In some poorly ventilated theatres, the exhaust vapours eventually made the atmosphere seriously soporific. Lack later recalled, "It was claimed in the newspapers that the exhaust vapours caused theatre nurses to miscarry. I came up with the idea of ducting gases back through the anaesthetic circuit and thence through pipework to the outside air. The positive pressure ventilation system, present in all operating theatres, drove the waste anaesthetic gases through ducts to the outside."

Lack leaves Maggie and three children.

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Cite this as: *BMJ* 2022;377:o1141