

# comment

“I focus on ‘attentiveness’—it carries nuances of empathy and compassion” **JOHN LAUNER**  
“This looks suspiciously like a fuelling of the war on general practice” **HELEN SALISBURY**  
**PLUS** Thérèse Coffey's threadbare plan; the “mini budget” and inequalities

**TAKING STOCK** Rammya Mathew

## We shouldn't feel guilty for working “part time”

**M**y son started school this September, and I've been reflecting on what it's been like to juggle parenting and my career over the past few years. Life has changed immeasurably since I had children—my ability to ruthlessly pursue my career ambitions came to a halt with the birth of my first child. Since then I've been perpetually searching for the right balance between being a “present” mother and a fulfilled doctor.

I'm not alone in this. Last week a survey by the King's Fund found that two thirds of GP trainees in England were planning to work part time, citing work based pressures as well as the need for some work-life balance and having a sustainable career.

I used to be that person who loved work and probably spent an unhealthy amount of time outside working hours pursuing any of several additional projects. Without any real boundaries, I never even considered that one day I'd work less than full time. But when the time came it wasn't even a question. I knew that work would always be there, but I didn't want to miss precious time with my young children.

Regardless, on many occasions since making that decision I've felt as though I'm just not doing enough professionally and have wanted more challenge and stimulation out of my week. Those feelings haven't been helped by comments such as, “Oh, but you work only three days a week,” from people who I'm sure are well meaning but who have perhaps forgotten the intensity and physicality of looking after small children all day.

In the past year I've increased the amount of work that I do, and I'm now working more or less full time again. I have, however, been very intentional about choosing a portfolio of work that includes elements

that can be done flexibly. I've also asked to start later or finish earlier on one or two of my clinical and managerial days, so that I can do some of the school pick-ups and drop-offs.

Like many other doctors who work flexibly or choose to work less than full time, I'm trying my best to keep all the plates spinning. I try not to feel guilty or invalidated when I read tabloid articles that continually berate GPs for wasting taxpayers' money. The reality is that everyone's lives have more than one dimension: work is a substantial part of that, but all of us are contributing to society in all sorts of wonderful ways—and we shouldn't feel guilty for doing so.

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Everyone's lives  
have more than  
one dimension



**OPINION** Richard Vize

## NHS plans fail to tackle a system in crisis

Coffey offers nothing of substance to improve recruitment, morale, retention, or productivity

**T**he government's plan to get the NHS through this winter offers virtually nothing of substance and shows ministers are in denial about the scale of the crisis. In her first big announcement as England's health and social care secretary, Thérèse Coffey unveiled *Our Plan for Patients*. Having promised in the opening lines of the document that "we will not paper over the problems that we face," she spends much of the following 4000 words doing precisely that.

The overwhelming pressures on services such as ambulances, emergency departments, and primary care are presented as unfortunate side effects of poor performance and bureaucratic barriers such as too few phone lines into GPs' surgeries and too little data sharing between ambulance trusts. At no point does Coffey reference the fundamental problem that

there are too few staff to meet the high and growing demand from an ageing population.

One of the few solid commitments is £500m to restart support for discharging patients into the community through improved social care, including more staff. But this too is far from adequate for the size of the task, with 165 000 vacancies in England's social care workforce. It also repeats the mistake—often made by the NHS itself—of treating social care as a hospital discharge service rather than a community care service. The *Health Service Journal* has reported that the £500m will come from existing budgets, so it is not new money.

### "Patients' champion"

In an attempt to establish some credibility with the public, Coffey is trying to position herself as the patients' champion, standing with them in opposition to the shortcomings of the service that her party has overseen for more than a decade. Her pronouncements

on primary care exemplify this approach, raising unrealistic expectations about getting a GP appointment while failing to provide the resources to make it happen.

The plan was met with derision by the King's Fund ("tinkering around the edges"), the NHS Confederation ("complete and glaring absence of a workforce plan"), and the Royal College of General Practitioners ("minimal impact"). Perhaps the most caustic response came from former health and social care secretary Jeremy Hunt in the Commons, who said of the instruction that GPs should offer patients an appointment within a fortnight: "GPs alone have 72 targets. Adding a 73rd won't help them or their patients because it's not more targets the NHS needs, it's more doctors."

Coffey's plan was released the day after a Care Quality Commission report on urgent and emergency care described it as a system in crisis, pointing out that, among many



**OPINION** Danny Dorling

## The "mini budget" will make the UK the most unequal country in Europe

The UK currently has the second highest income inequality of any OECD country in Europe. Only Bulgaria is more unequal. The government's economic announcements made on Friday 23 September may be what is required to ensure it now moves up to the unenviable top spot. This has implications for health because unequal countries tend to have worse health outcomes.

The changes announced included a tightening of the rules on universal credit "which will see benefit payments reduced if people do not fulfil job search commitments." This will make many already poorer families poorer still, increasing inequalities. Even before the announcements, benefit sanctions were being increased rapidly as more punitive policies were introduced. Those on the lowest of incomes will suffer the most.

The changes were designed to increase incomes the most for those at the top of pay scales, to increase them less for those just beneath the top, and to reduce incomes for those at the bottom. The indirect effects may well have a much greater impact on

### Unequal countries tend to have worse health outcomes

making the poor poorer. The pound fell to a 37 year low as the announcements were being made. Three days later it fell to its lowest ever value against the dollar and other currencies. This will increase the cost of imports of basic foodstuff, clothes, and other essentials that make up a much higher proportion of the spending of households on lower incomes. Furthermore, the tax cuts were unfunded, requiring the government to increase borrowing which makes interest rate rises more likely—increasing the costs of mortgages, and therefore also rents.

The changes will also widen policy differences within the UK. In Scotland the top tax rate will not be scrapped. The rate there was already higher than in England. Scotland is becoming more progressive, England more regressive. The Scottish government has recently announced that "emergency legislation will be introduced to bring in a freeze on rent increases and ban evictions



HORST FRIEDRICH/SALAWY



## Thérèse Coffey's announcement was threadbare and inconsequential

IAN DAVIDSON/LAIVY

other failures, the mean average time in April from a 999 call until arrival at hospital for a patient who has had a stroke was 1 hour 54 minutes. Evidence published in the *Emergency Medical Journal* in January showed that delays to patient admission from emergency departments cause additional deaths. Nothing in the health secretary's plan comes anywhere close to tackling these issues.

Even allowing for the fact that she has only just started the job, Coffey's announcement was threadbare and inconsequential. There was no indication that she has grasped the scale of the crisis in either the NHS or social care, and she offered almost nothing of substance to improve recruitment, retention, morale, or productivity. It's going to be a long winter.

Richard Vize, public policy journalist and analyst, London

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in the private and social rented sector in response to the cost of living." So rents in Scotland, unlike England, may well not rise as a result of the announcements.

We can only know the direct effects of these changes. We cannot know their unintended consequences, up to and possibly even including the shattering of market sentiment, further increasing government borrowing costs. Decreasing stamp duty might not strengthen the housing market, but instead cause people to question how safe the market is. There are many possibilities where the actions do not have the consequences planned. However, in the short term, a few people at the very top are about to become richer and therefore even more politically powerful. The large majority of us will be worse off from the rise in unsupported borrowing, the public services cuts to come to reduce that borrowing, or simply because incomes stagnate while prices rise.

Danny Dorling, Halford Mackinder professor of geography, University of Oxford

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## TALKING POINT John Launer

### The art of paying attention

I'm not sure I've ever been an exceptionally compassionate or empathetic doctor, and it would be for patients to say, rather than me. Possibly they'd have a range of views, depending on whether we got on well or my treatment made them better. Altogether, I'm a bit suspicious of training and publications that describe how to develop empathy and compassion (sometimes subtly implying saintliness in their authors), so in my teaching I generally try to avoid tackling them head on.

There are other qualities I prefer to focus on. Rita Charon, a New York physician and a pioneer in the field of narrative medicine, emphasises three qualities she believes we should promote in medicine: attention, representation, and affiliation. She describes attention as "the most pivotal skill with which to endow a health professional who wants to be a healer." By representation she means the capacity to give a faithful and accurate account of a patient's words, images, and thoughts. Affiliation follows from these, when we bring our full selves into our practice.

When teaching I like to focus on attention, although I prefer the term "attentiveness," as it implies something more continuous. It highlights the idea that defines narrative medicine: you can apply close reading to a patient's story in the same way you can to a literary text. Attentiveness carries nuances of both empathy and compassion, without the risk of judgmental overtones. Most important of all, it can be translated into skills for careful questioning, listening, and responding that you can readily teach and learn. Among the skills for attentiveness I find most useful to teach are "noticing the words we usually

ignore" and "taking the temperature of the conversation."

Regarding the first, I'm always interested in statements such as, "My headaches are driving me to despair." Ninety-nine times in 100 we ask about the headaches and never inquire about the "driving to despair." Why did that person, consciously or unconsciously, select that exact phrase—and what more will we learn about their life, and possibly even the cause of the headaches, if we're curious about this and ask them to unpack it?

The other skill involves what are sometimes called "meta-questions." These are questions such as: "What are you hoping to get from this consultation?" "How are we doing so far?" "Have I missed out anything you asked?" "Is it OK to wind up now?" Almost every time I teach these and other similar skills, someone is bound to object that it will be unnecessarily time consuming. Yet almost everyone who applies them reports that it helps them get to the heart of things in consultations far more quickly.

The US physician and ethicist Jay Katz once criticised the "dogma" in medicine of "assuming an identity of interests and brushing aside the need to clarify differences in expectations and objectives through conversation." It's one of my favourite quotations. The antidote to this dogma is attentiveness. And whenever we apply it, I suspect that many patients experience it as empathy and compassion, even if we don't think of it as such.

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You can apply close reading to a patient's story in the same way as to a literary text



## A poor plan for patients

**A** new plan for the NHS was unveiled last week by England's recently appointed health and social care secretary, Thérèse Coffey. The service faces huge backlogs and a workforce crisis, so we're ready to welcome any measures that might relieve the pressure. Sadly, *Our Plan for Patients* is long on rhetoric but short on detail.

There are admirable ambitions to empower patients and improve outcomes, but it's not clear how. Where's the detail in the promise of 7000 extra beds this winter? The NHS in England currently has 47 000 nurse vacancies, so the immediate and obvious question is, "Staffed by whom?" There's an emphasis on improving productivity, but a friend of mine has commented that she's already doing the work of two nurses, so I don't know how much more can be squeezed out of an already exhausted workforce.

In general practice, the plan states that the government will "set the expectation that everyone who needs an appointment with their practice within two weeks can get one." Currently, 44% of appointments happen on the day they're booked and 85% within two weeks, although some areas clearly have problems with longer waiting times. We have a shortfall of 4200 full time equivalent GPs, and those we have regularly work 11 hours a day so it's hard to see how setting an expectation will magically produce more appointments or what this odd statement aims to achieve.

One casualty of the emphasis on access is continuity of care. It may be much better for a patient to be seen a few days later, by a doctor who knows them well, than sooner, by one who has an available slot within the two week period but will have time only to skim read their notes. However, the real shame of this plan is in its language: the not-so-subtle pitting of patients against GPs as the government reassures patients that it's on their side. I struggle to see who or what the government thinks is on the other side, but this looks suspiciously like a deliberate fuelling of the war on general practice waged through the media for the past few years. "The doctor MUST see you now!" bellows a headline from the *Daily Mail*, over an article with four references to Coffey's "laser-like focus."

None of this is helpful to doctors or our patients. Although there's a welcome nod to pension reform, for many GPs considering early retirement (and there are many) this is not the main factor in their decision. Workload, bureaucracy, and above all a hostile environment mean that we're losing colleagues faster than we can replace them, and the plan does nothing to tackle this. If the government was really on the side of patients it would pull out all stops to return us to an adequately funded, fully staffed NHS and social care sector. Alas, there are no signs that this is its intention.

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It's hard to see how setting an expectation will magically produce more appointments



## LATEST PODCAST



### Talk Evidence: Monkeypox

In this latest episode of the Talk Evidence podcast, Joe Ross, *The BMJ*'s US research editor, and Juan Franco, editor in chief of *BMJ Evidence-Based Medicine*, discuss new research on the effectiveness of antidepressants, industry sponsorship of trials, and pandemics.

Ross talks about a study on industry sponsorship of cost effectiveness analyses and seeing similar patterns of publication bias in randomised controlled trials:

"This is a good reminder of the sort of bias that still pervades the medical literature. These cost effectiveness analyses are relied upon by health technology assessment agencies and governments in deciding what to cover, what to pay for, and how to allocate their healthcare dollars. It's really important that we have the best data that are not biased when making these decisions."

Franco picks out a descriptive case series looking at the clinical features and presentations of monkeypox during the 2022 outbreak:

"It's a very interesting, descriptive case series in a clinic in the south of London of 197 patients who tested positive for monkeypox. These types of studies are so important because, while monkeypox has been around for a while, for this new outbreak we need to understand whether the presentation of cases has distinct characteristics. It's important as clinicians to raise awareness of how monkeypox may present. Of course, we will have to be alert to how this may change in time. But at the moment, in this case series, patients presented primarily with dermatological lesions, like pustules. Those who tested negative had other differential diagnoses. That's also important to highlight: syphilis or herpes, for example, have similar lesions that may confuse patients and clinicians."



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



## ANALYSIS

# Preparing for the next pandemic: reserve laboratory staff are crucial

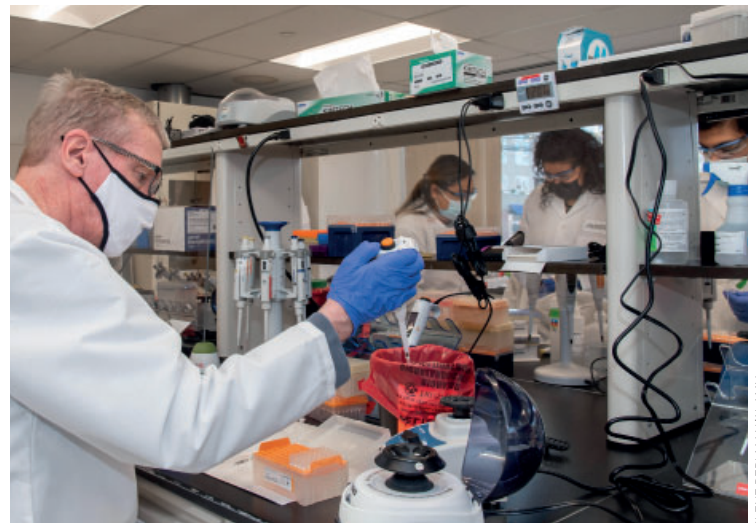
Lack of people to process tests was an important obstacle in scaling up covid-19 testing. **Jordan Skittrall and colleagues** consider how we can be better prepared

**U**K laboratories conducted over 200 million SARS-CoV-2 polymerase chain reaction tests between January 2020 and April 2022.<sup>1</sup> Laboratory tests were used to diagnose disease, to inform public health actions such as isolation, and to reduce spread through testing asymptomatic people.<sup>2-4</sup> The rate of laboratory testing in the UK expanded rapidly at the start of 2020, from 100 tests a day on 4 January 2020, to 10 000/day on 23 March, to 100 000/day on 9 July.<sup>1</sup>

Although these numbers are substantial, demand for testing at that time exceeded availability, and only those meeting a strict set of criteria were tested. Despite government pledges to provide 100 000 tests per day by May 2020 as part of the UK test and trace scheme,<sup>5,6</sup> demand quickly outstripped capacity to set up testing safely in new laboratories, conduct quality assurance of the tests, and process samples. In short, surge capacity was already required by the time the first tests were available.<sup>7</sup> Availability of laboratory facilities and resources—from basic reagents to IT support—was a substantial challenge,<sup>8,9</sup> but aside from the distribution of positive control material (which was quickly solved) the biggest bottleneck was finding trained staff to carry out the tests.<sup>10,11</sup> Maintaining surplus laboratory capacity for emergencies is expensive, and therefore politically and economically unpalatable. Nevertheless, covid-19 has shown that effective surge capacity is a vital part of pandemic preparedness.

### KEY MESSAGES

- Reserve laboratory capability is needed to provide surge capacity for disease outbreaks and future pandemics
- Developing and establishing new tests requires highly skilled staff, who are expensive to maintain
- Large numbers of less skilled people are also needed to provide widescale testing
- Preparedness planning has to balance effectiveness with sustainability
- A hybrid of retained and voluntary reserves is recommended for the UK



LENE PERLMANALAMY

**Maintaining surplus laboratory capacity for emergencies is expensive, and therefore politically and economically unpalatable**

### Skills bottleneck

Highly trained scientists are required to get a new assay working in local diagnostic laboratories. Use of new tests involves many highly skilled manual steps and interpretation, and the initial job of a scientist is not only to run the assay but also to optimise it for a diagnostic laboratory and train others.<sup>12,13</sup> Over time, testing is increasingly automated, and skilled staff move from a hands-on role to supervision, including quality assurance.<sup>14,15</sup>

Because of the length and specialism of training required, laboratory staff are the hardest resource to increase quickly. As well as being a problem during the covid-19 pandemic, staffing was identified as a key weakness in laboratory preparedness after the 2009 influenza pandemic.<sup>16</sup> Unfortunately, most pandemic plans at national, European, and global levels give little attention to requirements for laboratory staff.<sup>17-24</sup> Germany's plans, as an exception, included a subsection on expanding diagnostic capacity,<sup>24</sup> and increased covid-19 testing rates faster than the UK.<sup>25</sup>

In order to improve our response to the next pandemic, we need to consider how to maintain enough laboratory staff with skills to provide surge capacity in infection diagnostics in sustainable, affordable, and politically feasible ways. This could be through raising staff when required or setting up a system of volunteer, retained, or permanent reserve staff.

### Raise emergency staffing when required

The most straightforward option is “do nothing” until there is a crisis, at which point a government or government body tenders for individuals or organisations to fill the gap.<sup>26</sup> Engaging private staff and entities when required is viable. The UK did this at the start of the covid-19 pandemic, both to slot into existing structures and by creating privately run diagnostic “lighthouse laboratories” that carried out SARS-CoV-2 testing in parallel to existing public health laboratories. The lighthouse laboratories

## The volunteer reserve approach is to identify a reserve team before an emergency and train them in advance

ran diagnostics in a production line industrial setting, housed in large spaces such as warehouses or repurposed laboratories. The extensive standardisation required for a production line approach meant these laboratories could be staffed by people without full public health scientist training. However, there was a long lead time in setting them up (the UK's first testing laboratory opened in June 2021<sup>26</sup>) and inflexibility, as shown when the pathogen mutated so that one of the tests no longer worked.<sup>27</sup>

Raising capacity when required inevitably incurs staffing, training, and material costs at a time of high demand and places responsibility for raising extra forces on private companies or individuals. Limited advance preparation may also impair effectiveness, but the model may be necessary in specific contexts.

For example, Nigeria generated extra laboratory staff as part of its covid-19 response by using a presidential task force to coordinate federal and direct funding from non-governmental organisations and the private sector.<sup>28</sup> By recruiting staff mostly from existing state hospital non-virology laboratories, university departments, and research centres, Nigeria expanded its decentralised laboratory capacity from a single reference laboratory with few additional laboratories, to each state having a SARS-CoV-2 testing laboratory. Before covid-19, competing calls on finances and variable prioritisation of public health expenditure across its 36 states made supporting a diagnostic laboratory workforce in Nigeria challenging.<sup>29</sup>

Despite the difference in national public health spending between Nigeria and the UK, the UK similarly did not build reserve capacity in advance and had to engage the private sector as the default option.

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### Voluntary reserves

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Unlike efforts to assemble ad hoc staff when required, the volunteer reserve approach is to identify a reserve team before an emergency and train them in advance. However, because training is typically unpaid, it is not possible to get reserves for highly skilled roles by this route. Unlike emergency recruited staff, voluntary reservists tend to work alongside existing staff.

This approach has also been used before. For example, in England and Wales, St John Ambulance has existed since the late 19th century, originally to provide voluntary medical assistance.<sup>30</sup> In the United States, the Medical Reserve Corps, established after September 11 2001, provides volunteer emergency support and assisted with the health protection response to covid-19.<sup>31 32</sup> The extent to which partial financial compensation is offered for training or active duty shifts varies between reserve forces, but the teams primarily act on a voluntary basis. Consequently, this model is still subject to the availability of its reserve staff and employer support, for training as much as for activation.

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### Retained reserves

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One approach used extensively outside the healthcare sector is a retained reserve corps for skilled roles. Staff are paid to train and when called out but are otherwise not employed in the role. Often, they are committed to respond when called, with only limited exemptions.

Like voluntary reserves, retained reserves work alongside full time employees where appropriate, rather than forming a parallel infrastructure. Some modern military reserves, including the UK's, use this approach.<sup>33</sup> The UK also uses retained or on-call firefighters, solving the need for geographical coverage without the need for full time intensity, especially in rural areas.<sup>34</sup>

Retained reserve staff typically have more training than voluntary reserves or emergency staff and are better integrated with the regular workforce, but because of the effect of compulsory callouts on reservists' other employers, a societal agreement codified in legislation is required.<sup>35</sup> This makes it harder to set up a retained reserve.

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### Permanent reserves

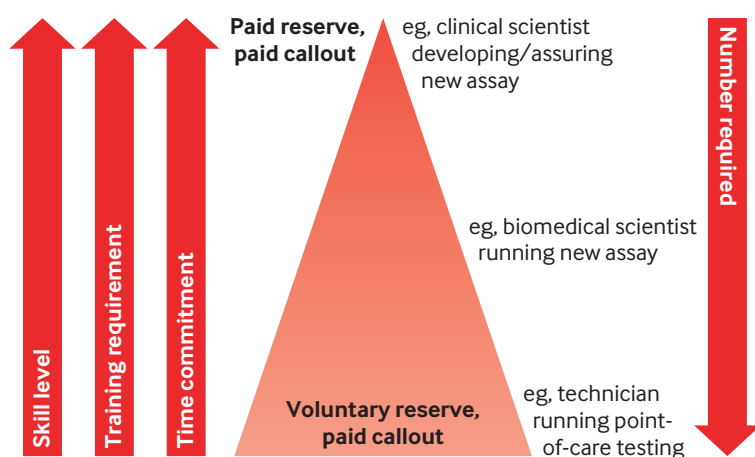
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Finally, additional capacity can be generated by keeping trained reserve staff permanently available, ready to function independently when required rather than relying on voluntary action or competing with other health sector needs. The UK public health laboratory service used to have such extra capacity until the 1990s,<sup>36</sup> but reorganisation of public health and cost pressures reduced the number of laboratories.<sup>37</sup> The initial German response to covid-19, which saw faster expansion of testing capacity than in the UK, called on existing trained staff.<sup>23 24</sup>

Singapore provides another example. After the 2003 SARS outbreak, "always on" pandemic readiness has included additional laboratory staff dedicated to providing diagnostic capability in one centralised laboratory.<sup>38 39</sup> A single laboratory is feasible because the country is small, allowing for short transit times. Staff may undertake other functions, but the first call on their time is providing diagnostic response.

Other sectors have used permanent additional infrastructure models for some time—for example, the United States Air National Guard, which customarily trains and deploys in operational units, as opposed to integrating individual staff within other units for deployment.<sup>40</sup> Compared with the other approaches, the permanent reserves model is costly, but it is effective if that cost is sustainable. In Singapore, for example, sustained political will for centralised laboratory capacity has so far enabled the model to be resourced since 2009 using financing from central government through the Ministry of Health as part of a wider pandemic preparedness strategy.<sup>39-42</sup>

**Retained reserves work alongside full time employees where appropriate, rather than forming a parallel infrastructure**



Hybrid model of reserve staff contributing to diagnostic services

## Workers in sectors likely to experience job insecurity in an emergency could be candidates for voluntary reserve roles

### Hybrid solution

The UK seems unlikely to commit to the budget required to recreate a permanent reserves model.<sup>43 44</sup> However, the 2020 strategy of raising staff when required led to a prolonged phase of increasing diagnostic testing at the expense of unmet testing needs, continued viral transmission (without the ability to accurately identify and isolate people with covid-19), and thus higher mortality and morbidity.<sup>445</sup> The voluntary reserves model requires fewer resources than the retained reserves model because it pays reservists less. However, because volunteers do not have to commit to training or receive a financial incentive, it is harder to develop advanced skills using this model.

We suggest that a hybrid retained reservists and voluntary reserve model would best meet the UK's requirements for diagnostic surge capacity across the different phases of a pandemic (figure). Typical models of voluntary reserves and retained reserves cover a spectrum of skill levels, training, and time commitments. Highly skilled staff such as clinical and biomedical scientists, who require substantial training and regular practice to develop and maintain their skills, are required in smaller numbers, typically in the earliest stages of an emergency response. This small, select group should be assembled and paid on retainer. For example, people from academia and industry and those who recently retired with appropriate skillsets could be employed as retained reservists to help in the initial phases of an emergency.

Many more staff members with less specialised skillsets are needed, including a large number of technicians to process tests locally in an outbreak, epidemic, or pandemic scenario. Such staff could be given training relatively quickly with only periodic training refreshers.<sup>46</sup> These staff are essential and should be recruited to a large volunteer reserve that can be quickly accessed during an emergency in a way that is relatively low cost and does not generate parallel infrastructure. People working in sectors of the economy likely to experience job insecurity during an

emergency (such as the entertainment and hospitality industries) could be candidates for voluntary reserve roles. In all cases, people would be paid to fill roles to support diagnostic services as they come under pressure, rapidly expanding the capability of services.

We are not aware of any widespread use of the hybrid option we propose in laboratory diagnostic services, although a mix of retained and voluntary reserves are used in other sectors to good effect. The UK fire services, for example, engage a hybrid of retained and unpaid volunteers to cover different roles depending on skill level.<sup>34</sup> In England in 2021, 35% of firefighters, representing 28% of whole time equivalent employment, were retained reservists.<sup>47 48</sup>

Demands on the time of reservists are likely to be minimal outside a pandemic, with the possibility of small scale deployments supporting local surges in need. Economic analyses supported by pilot projects are required to determine the optimal mix of a diagnostics reserve for the UK.

### Building reserve capacity for the future

The covid-19 pandemic has challenged 21st century public health microbiology. Having seen how the UK responded to this challenge, we are well positioned to make recommendations to improve our response to the threat of pandemic diseases, within and between future emergencies.

Three specific developments now make the possibility of reserve workers in laboratory diagnostics more feasible in the UK than in the past. First, the advances in molecular diagnostics mean reserves need training in a smaller number of techniques to make a meaningful impact.<sup>49 50</sup> Second, the scale of testing during the covid-19 pandemic in countries such as the UK shows that high demand for testing capacity is likely in future. Third, expanding biotechnology sectors within industry and academia provide larger pools from which reservists can be trained.<sup>51 52</sup>

Responding to future challenges will require people; preparing people requires a long lead time. The UK public health system must now work towards building a fit-for-purpose hybrid laboratory reserve that combines a small but highly skilled retained reserve with a larger, more flexible volunteer reserve as part of its pandemic preparedness and response. This model would strike the right balance between sustainability, especially outside times of reserve activation, and effectiveness when required.

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# LETTERS Selected from rapid responses on bmj.com

## LETTER OF THE WEEK

### Are people choosing between oxygen and heating?



While NHS leaders warn of “intolerable” winter pressure from rising energy prices (This Week, 3 September), and hospitals are due to be hit with “eye watering” bills, we need to look at the energy costs of the medical equipment we provide to patients at home.

UK inflation is at the highest rate in 40 years, and the cost of living crisis is biting. This winter is going to be hard for many.

At the end stages of life, a lot of medical equipment is used in people’s homes, provided by those of us in healthcare. The most basic things are a hospital bed (one available type, up to 0.27 kWh) that allows the patient to be positioned; an air mattress (one available type, 3.0 kWh) that is constantly inflated to avoid pressure sores; and an oxygen concentrator (around 2.88 kWh) to maintain comfortable breathing. This adds up to 6.15 kWh—and that’s before factoring in many other vital medical appliances such as nebulisers, hoists, cough assists, non-invasive ventilation, riser-recliner chairs, and many other energy consuming appliances. This comes on top of the cost of energy needed to keep houses warm.

By the end of 2022 the estimated cost of electricity in the UK will rise to 51p/kWh. (The average cost was 18.9p/kWh in 2021.) For many patients—and particularly those at the end of life—this is simply an impossible cost to bear. Most patients are concerned about leaving their loved ones in financial difficulty.

It is not acceptable to provide equipment and then forget about the ongoing costs it inflicts on our patients. This winter many people might have to choose between vital equipment, even oxygen, and heating their home. Can we subsidise the energy costs of equipment given out?

Matthew P Doré, consultant palliative care, Belfast

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## NEW ZEALAND CURATES LIVING HISTORY OF COVID

### Covid craftivism belongs in national galleries

I love that the New Zealand government is actively incorporating a national artistic response to the pandemic in its most prestigious museum (The Big Picture, 3 September). It is difficult to imagine the UK government doing the same, as it attempts to rewrite history along the lines of “we got all the big calls right,” despite evidence to the contrary.

Quilts made in response to covid-19 by more than 140 people from different communities are currently being shown around the UK. These are amazing pieces, displaying fear, isolation, loneliness, courage, empathy, and hope, tempered with anger at the political mismanagement that has been so costly to our health.

It is an inspiring example of “craftivism”—activism that typically incorporates elements of anti-capitalism, environmentalism, and solidarity that is centred on craft or “domestic arts.” This exhibition articulating our collective pain should find a permanent home in one of our national institutions.

John Puntis, retired consultant paediatrician, Leeds

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## LOSING GENERAL PRACTICE'S SPECIALNESS

### Yet another blow to continuity of care

I too have reacted with dismay to the (understandable) change in policy that takes antenatal care away from GPs (Helen Salisbury, 3 September). It bears repeating that this is yet another setback to continuity of care, the value of which is hard to measure and easy to underestimate.

The relationship built up with a GP during the antenatal period can be vital. Health problems such as postnatal depression might not present until long after midwives have discharged the patient, and a trusting relationship with a GP might make the difference between early presentation and identification of a problem and not.

No doubt, as in many other areas where continuity with our patients has been eroded, new systems, pathways, and protocols (and staff) will spring up to plug this loss. But this is another blow to what helped make British general practice such a strong model of primary care.

Daniel A Faller, GP, Thame

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### Where are we going?

What will be taken from GPs next? We have GPs in training who haven’t done paediatric, psychiatry, dermatology, otorhinolaryngology, or neurology jobs. Is general practice turning into a signposting service?

Shared antenatal care was continuity building for the future, with any problems moved on to obstetric teams. GPs will now stop learning about symptoms, such as causes of itch in pregnancy, and recognising serious but rare problems. Healthcare practitioners will end up arguing over who is “responsible” for women whose symptoms may or may not be pregnancy related.

I realise that, as a GP working part time at the end of my career, I am out of touch with many of the advances in care coming from integrated care boards, networks, and (privately supplied) psychiatric services. But, with public satisfaction with primary care at an all time low—and a political landscape that is unlikely to help—where are we going?

John Sharvill, GP, Deal

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## REGIONAL VARIATION IN CARDIOLOGISTS' EFFECTIVENESS

### Patient access to treatment is what varies

The Institute for Fiscal Studies' report attributes different outcomes of treatment for myocardial infarction to the variable quality of cardiologists (Seven Days in Medicine, 20-27 August). But it does not consider the effect of travelling to hospital from the location where symptoms were first experienced.

Cardiology centres in urban teaching hospitals provide an interventional cardiology service, readily accessed by those living and working nearby, whereas other hospitals diagnose myocardial infarction in the emergency department and might deliver thrombolysis before transferring the patient to the cardiology centre. The passage of the patient through the system might be delayed at several points, which are important in assessing how patients gain access to treatment.

The inferior outcomes in rural north eastern and south western parts of England are likely to be related to long travel times. The study therefore describes differences in access rather than differences between cardiologists.

S Michael Crawford, clinical lead for research, Keighley

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### Confounding factors in affluent patients

To blame individual cardiologists' effectiveness in a limited system that is out of their control is misleading and unfair.

The study also concludes that "the most effective doctors are treating patients in more affluent, urban areas." These patients are likely to be healthier, have better access to healthcare, and be more health literate, perhaps being more likely to recognise symptoms and access care more promptly. Patient characteristics such as previous ST segment elevation myocardial infarction and Charlson index for comorbidity were recorded, but not factors such as socioeconomic status, education, and income, which might shed light on other confounding variables contributing to the outcomes in affluent patients.

None of this is purely down to the weakness of an individual cardiologist. The wider structural limitations that cardiologists, and all doctors, work under should be recognised rather than assuming that they are simply not working effectively enough.

Inseo Yun, locum senior house officer (post-foundation year 2), London

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## TOBACCO USE IN LOW AND MIDDLE INCOME COUNTRIES

### Completely ban cigarette advertising

Achieving tobacco control in low and middle income countries will require input from multiple stakeholders (Research, 3 September). But, more importantly, governments must implement recommendations already in place.

Advertisement hoardings are seen along national highways across India, despite the Ministry of Road Transport and Highways saying that they are not permitted. In 2002, the Supreme Court fined the state government of Himachal Pradesh for its dereliction of duty and inability to check commercial companies painting advertisements on eco-fragile rocks on its highway. But roadside advertisements continue, not for books and beverages (as was the case in 2002) but for tobacco related products, and not on rocks but on large billboards.

WHO's Framework Convention on Tobacco Control envisions a full advertising prohibition within five years of its implementation. But only 19 nations (6% of the worldwide population) have a complete ban on tobacco advertising, promotion, and sponsorship. Governments need to act.

Sunil Kumar Raina, professor and head of community medicine; Sakshi Supehia, project coordinator, Tanda, India

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## EFFECTS OF REMIFENTANIL SHORTAGE

### System resilience: from crisis to opportunity

Mahase reports that the remifentanyl shortage is forcing anaesthetists to relearn old techniques and that the health service needs to work with manufacturers to prevent future drug shortages (This Week, 20-27 August). A chain is only as strong as its weakest link, and excessive reliance on one or two drugs is not a hallmark of resilience.

"Relearn" is a strong term because anaesthesia is generally based on applied principles rather than rigid protocols. "Refamiliarise" might be more appropriate, although some junior anaesthetists might not have the breadth of experience.

The remifentanyl shortage is an opportunity for anaesthetists of all grades to diversify their use of alternative agents. The old joke about practice preferences among anaesthetists—"There are 100 ways of doing everything in anaesthesia, but the 99 that aren't what I do are all wrong"—should really have the second number reduced a bit, but that would miss the point.

David Lindsay, anaesthetics registrar, Manchester

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## MEDICAL GASLIGHTING

### Considering psychological factors is not gaslighting

The news article on medical gaslighting raises the important point that doctors should always accept patient concerns about symptoms and never dismiss them as imaginary (Sixty Seconds On . . ., 20-27 August). But it also risks making the error of conflating the consideration that psychological factors might have a role in the aetiology of symptoms with dismissing them and implies that the ordering of biomedical investigation is a key indicator of acceptance.

The consequences of this line of argument are potential iatrogenic harms from denying patients a full understanding of their illness and the potential benefit of psychological treatments, as well as increasing the risk of adverse consequences of unnecessary biomedical investigation. To say that invoking psychological factors is equivalent to dismissal is to retreat into a narrow biomedical reductionism that many of us hoped we had escaped long ago.

Michael Sharpe, professor of psychological medicine, Oxford

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## OBITUARIES

### Richard Matthew Dodds

Academic geriatrician (b 1981; q St George's Hospital Medical School, London, 2005; PhD), died from undisclosed causes on 25 May 2022

Richard Matthew Dodds moved to Southampton in 2009 to pursue a career in academic geriatric medicine. His PhD research—defining normal ranges for hand grip strength across the life course—has had huge impact. He returned to clinical work in Wessex and completed higher specialty training in geriatric medicine. Richard subsequently joined the newly established AGE Research Group led by his supervisor and mentor, Avan Sayer, in Newcastle. Over the following years he was at the heart of a rapidly expanding theme of translational ageing research. An inspirational teacher and mentor to students and junior colleagues in his academic role, he also had numerous external responsibilities and was secretary of the UK Academic Association of Geriatric Medicine. Richard leaves his partner, Chris; his mother; and his sister.

Miles Witham

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### Elizabeth Johnson

Consultant haematologist (b 1952; q Welsh National School of Medicine, Cardiff, 1976; FRCPath, MRCP, MBA), died from covid-19 on 16 February 2021

Elizabeth Johnson (“Liz”) enjoyed the

busy combination of clinical and laboratory medicine offered by a career in haematology and was never afraid to question and, if necessary, challenge accepted orthodoxies. Her interest in improving practice and outcomes was amplified during her rotation to Bradford Royal Infirmary. She pursued an MBA at the business school of the University of Leeds, which she successfully achieved in 1992. She held locum consultant haematologist posts at several hospitals in the Yorkshire region and at the Wrexham Maelor Hospital. Liz married Johnny, a psychiatrist, and had three sons, after which she became a full time mother. In 2008, she was seriously ill but recovered. She was admitted to hospital with covid-19 in January 2021. She leaves her husband and sons.

Johnny Nehaul, Derek Norfolk

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### John York Moore

GP Sawston Medical Practice, Cambridgeshire (b 1922; q London Hospital Medical College, London, 1945), died from old age on 22 March 2022

John York Moore did his medical training at the London Hospital Medical College, some of which time he also spent in Cambridge. While in Cambridge he also followed his other interest—he learnt to play the organ in King's College Chapel. He did house jobs at Brentford, followed by two years' national service in the Royal Air Force. He returned to the London Hospital, where he met Helen Tremaine, an almoner. They married in 1950 and he joined his father's former practice in Sawston. He continued working there and in the nearby villages until he retired in 1983. On retirement he and Helen moved to Penzance in Cornwall. John was predeceased by Helen and one son. He leaves four children and 12 grandchildren.

David York Moore, Tim Robinson

Cite this as: *BMJ* 2022;378:o2228



### Shirley Emerson

GP (b 1935; q Durham 1958), died from aortic heart disease and infirmities of old age on 13 April 2022

(Margaret) Shirley Emerson (née Atkins) was a Geordie from a family of pharmacists and the first of the family in medicine. She married David and together they served as GPs in Cambridge for 30 years. Their Mill Road practice was renowned for lunchtime meetings and constant filter coffee. Shirley founded Cambridge Advisory Centre for Young People and championed women's and young people's health. She loved the company of family and friends, especially when cooking and Burgundy were involved. She walked across Scotland 14 times and ventured to the Himalayas. At 50 she started running marathons, participating in triathlons, becoming the national netball team doctor, and inspiring many women into sport. Predeceased by David in 2020, Shirley died at home and leaves four children and seven grandchildren.

Bruce Emerson

Cite this as: *BMJ* 2022;378:o2225



### Paul Robert Hepburn

GP (b 1947; q Bristol, 1971; MRCP), died from an intracerebral haemorrhage on 3 September 2022

Paul Robert Hepburn was senior GP principal at the Old School Surgery in Fishponds, Bristol.

After qualifying he started a career in general medicine. While working a bruising 1:2 rota in nephrology at the Royal Victoria Infirmary in Newcastle in 1977, he was offered a position as partner in a GP practice in Bristol and moved back home. Much loved by colleagues and patients for his polite, sensitive, and gentle nature he was postgraduate organiser for Frenchay Hospital and continued his interest in respiratory medicine in hospital outpatient sessions. He retired in 2010 but developed progressive vascular and Alzheimer's dementia. He had a fatal intracerebral haemorrhage in his sleep on his 75th birthday. He leaves his wife, a theatre sister; two children; and five grandchildren.

David Hepburn

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### Balkrishna Kantilal Parikh

Consultant in accident and emergency medicine Calderdale (b 1933; Kasturba Medical College, India, 1958; FRCS), died from complications after a stroke on 19 April 2022

Balkrishna Kantilal Parikh (“Bal”) arrived in the UK in 1959 to do his surgical training. He met his future wife, Anne, at Wolverhampton's New Cross Hospital, where she was a theatre sister. In 1965 they went to India, to establish a plastic surgery practice in Mumbai but returned to the UK in late 1968. Bal took a surgical registrar post at St Lawrence's Hospital for specialist plastic surgery and burns in Chepstow in 1969. He switched to accident and emergency medicine, started at Bradford Royal Infirmary in 1971, and moved to Halifax in 1977. He retired in July 1998. Bal spent lockdown in the Netherlands with his daughter and her family. Predeceased by Anne, he leaves two children and two grandchildren.

Rajgopalan Menon

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# Gisela Boss

Indefatigable tuberculosis doctor

Gisela Boss (b 1928; q King's College Hospital, London, 1952; MRCS Eng, LRCP Lond, DCH), died from frailty of old age on 29 May 2022

In 1938 10 year old Gisela Boss took the most momentous journey of her life. Leaving her parents in Breslau (now Wroclaw in western Poland) she boarded the Kindertransport train, travelling for many hours through Europe to Bremerhaven and on to London. Here she was welcomed by the Pollitzers, a young childless couple from Belsize Park in north London, who had agreed to foster her.

## Early life

An only child, Gisela was born on 1 June 1928. Her parents were well respected in Breslau: her father, Leo Boss, an otolaryngologist, was a war hero, awarded the Iron Cross in the first world war. Nevertheless, as Jews in the 1930s the family were in imminent danger from the Nazis. As rumours about a new war circulated, friends urged Gisela's mother, Grete (née Rothstein), to get the little girl away to safety in England.

Gisela quickly mastered English, attending Parliament Hill Grammar School in Hampstead, and matriculated in 1944. An influx of returning servicemen delayed her entry to medical school, so she stayed on at school for a further year, becoming head girl and captain of tennis.

She studied medicine at King's College London, where she was one of just a handful of female undergraduates, and said it was love at first sight when she met fellow student Charles Esmond Langham. The couple married in 1953 and had three boys: John, Tom,



**Described as “a very discrete kind of rebel,” Boss took her own path in life**

and Max. After a short time in Crystal Palace, the family moved to Lewisham in south London, where Boss lived for the next 60 years. Throughout her life she had an adventurous spirit and in 1966 she and Esmond with their three sons drove to Athens and back in an old VW camper van.

## Career in tuberculosis

Described as “a very discrete kind of rebel,” Boss took her own path in life, both in “marrying out” of the Jewish faith and in her career, which took her from comfortable Belsize Park to working with some of the most disadvantaged people in the grittier parts of south London.

After qualifying in 1952 she took house officer jobs at St James' Hospital, Balham, and Queen Elizabeth Hospital

for Children in Bethnal Green. She met Mary Farquharson, who had set up the chest clinic at Lewisham Hospital. Here Boss found her vocation, becoming an associate specialist in charge of tuberculosis (TB) services at Lewisham and Grove Park hospitals.

In the 1950s the incidence of TB in poorer parts of London was still high and treatment was lengthy: it could take 18 months to two years to clear the infection, involving a combination of streptomycin, para-aminosalicylic acid, and isoniazid. Patients were often hard to trace—some did not speak English and many were homeless or living in hostels. As well as treating patients, Boss managed a team of health visitors and social workers who did the contact tracing. It was a job that required huge

patience, but her colleague, Noemi Eiser, said, “It suited Gisela's temperament: she ran an efficient service and was very particular and straightforward.” She also liked to keep up standards and formalities, scrupulously addressing clients by their title rather than just their first name.

During her career, she witnessed a transformation in TB treatment, with the introduction of the antibiotic rifampin (rifampicin) in the 1970s, which cut treatment time to nine months, and then the addition of pyrazinamide in the 1980s, which further reduced it to six months.

Despite Farquharson's coaxing, Boss did not take the membership exam to become a consultant. Apart from anything else, she was busy with her family. Her husband died suddenly in 1967, and she was bringing up her three sons as a single parent. In 1974 she married William (“Bill”) Ashton and became a stepmother to his son, David.

In 1993 she retired from the Lewisham chest clinic, but continued her career teaching the interpretation of chest radiographs to students at Guy's Hospital, where she was valued for her caring and mildly eccentric manner, remembered as keeping students standing so they kept awake and rewarding them with sweets for correct answers.

In 1988 Bill died. Boss's final love was an old friend, John Warren, with whom, among other things, she enjoyed trips to Glynedebourne.

Boss died in Lewisham and leaves her three sons, her stepson, and five grandchildren.

Penny Warren, Salisbury  
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