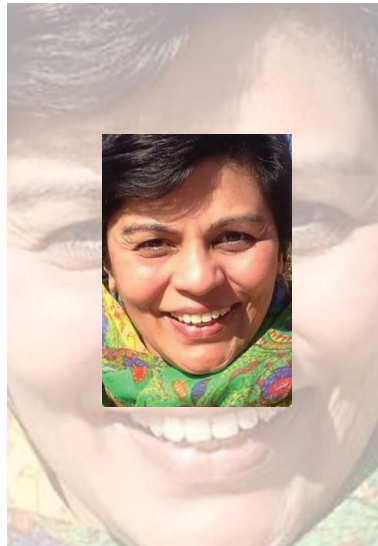


# this week

**BAD DREAMS** page 213 • **MIGRANT HEALTH** page 214 • **SCIENCE UNDER BREXIT** page 216



## “GMC wrong to pursue GP over laptop”

The dishonesty allegation against the GP Manjula Arora, who was suspended for a month over her use of the word “promised” when requesting a work laptop, should not have been taken forward, an independent review has found.

The report, published on 2 November, found that the GMC incorrectly applied a legal test when considering the allegations against Arora and “missed multiple opportunities” to assess whether the allegations were serious enough to be referred to a tribunal. Arora’s case sparked fury among doctors, with many calling the action against her “wildly disproportionate” and proof that the disciplinary process was biased against doctors who trained overseas.

However, the review made “no judgment in relation to bias,” concluding it found “no clear or conclusive evidence or data to suggest that biased thinking affected this case.” But it added that it found “no evidence or data that would definitively dispel the perception that it was affected by bias.” The report said, “We appreciate that in the context of a single case this finding won’t answer the concerns of those who believe black and minority ethnic doctors are routinely discriminated against by GMC processes.”

In May Arora, who trained in India before

moving to the UK in the early 1990s, received a one month suspension for dishonesty, after a nine day tribunal hearing. She had told her employer’s IT department that she had been “promised” a new work laptop when this actual word had not been used.

After a backlash from doctors, the GMC said it would not challenge Arora’s appeal and called for sanctions to be dropped. *The BMJ* understands they were officially dropped by the High Court in August. The regulator also launched a review into the case, appointing Iqbal Singh, a consultant geriatrician and chair of the GMC’s Black and Minority Ethnic Doctors Forum, and Martin Forde, a barrister who has regularly appeared in tribunals for doctors, as co-chairs.

Singh and Forde recommended that, in cases where there was no immediate risk to patients’ safety, concerns should be raised with either one of the GMC’s employer liaison advisers or a responsible officer, with the aim of resolving them locally. The GMC should also consider amending its referral form to include a requirement for the referrer to firstly discuss with the relevant responsible officer before any further action is taken.

The GMC should also encourage the Care Quality Commission to include assessment of

*(Continued on page 214)*

**The report by Iqbal Singh (left) and Martin Forde (right) said the case of Manjula Arora should not have gone forward**

### LATEST ONLINE

- Oncologist who attended surgery on two patients while he had covid is suspended for three months
- Efforts to limit global heating to 1.5°C are “well off track,” analysts warn
- Psilocybin reduces depression symptoms, trial results show



# SEVEN DAYS IN

## Give more children free school meals urgently, say doctors and campaigners



Healthcare professionals and campaigners have written to the chancellor and England's education secretary to back calls for all children from families that receive universal credit to be eligible for free school meals.

Signatories to the letter, who include David Strain, chair of the BMA's board of science, and Camilla Kingdon, president of the Royal College of Paediatrics and Child Health, said, "Research from the Food Foundation shows that levels of food insecurity among households with children have more than doubled since January, reaching 25.8% in September. This represents a total of four million children who live in households where access to nutritious food is under threat."

Currently 800 000 children living in poverty in England do not qualify for free school meals, said the letter, which emphasised children's need for good nutrition. "Without it, health outcomes worsen, as do children's life chances, as well as pressure on the NHS." The signatories quoted PWC analysis for the charity Urban Health that found free school meals for all children on universal credit would save the economy £8.9bn over 20 years by cutting food costs for schools and families, increasing earnings, and reducing obesity.

Zosia Kmietowicz, *The BMJ* Cite this as: *BMJ* 2022;379:o2613

### General practice

#### Ministers U turn on missed appointments charge

The government will no longer seek to charge patients who miss their GP appointments, in a move welcomed by the chair of the BMA's General Practitioners Committee, Farah Jameel. She said that patients may miss appointments for a wide variety of reasons and that punishing them during a cost of living crisis "would only deter the most vulnerable from seeking the help they need, worsen health inequalities, and ultimately undermine the essential trust between doctor and patient." She called on the government to focus on fixing problems hindering the GP workforce, such as punitive pension taxation.

### Workforce

#### NHS staff absences continue to rise

In June 2022 the overall NHS sickness absence rate in England was 5.2%, up from 4.9% in May and 4.6% in June 2021. The North West region had the highest rate (6%), while London had the lowest (4.6%). Ambulance trusts were affected most, with an average of 7.9% in June 2022. Anxiety, stress, depression, and other psychiatric illnesses were the most common reasons for absence, accounting

for more than 476 900 days lost and 23.2% of all sickness absence in June, down slightly from 24.6% in May.

### Multiple sclerosis

#### Obesity at diagnosis is linked to higher disability

Being obese when having multiple sclerosis diagnosed is linked to higher current and subsequent levels of disability in a relatively short time, research published online in the *Journal of Neurology Neurosurgery & Psychiatry* found. The analysis of 1066 participants from Germany with relapsing remitting MS found that obese patients reached 3 on the expanded disability status scale (EDSS) in just under 12 months on average, which compared with nearly 18 months in those who were not obese. Obese patients were also more than twice as likely to reach EDSS 3 within six years, irrespective of drug treatment.

### Politics

#### Barclay is reappointed as health secretary

Steve Barclay (right) has been reappointed as health secretary after Thérèse Coffey was made environment secretary by Rishi Sunak, the prime minister. Barclay briefly

served as health secretary earlier this year under Boris Johnson after Sajid Javid's resignation but was succeeded by Coffey, who served for a similarly brief stint during Liz Truss's short spell as prime minister. The NHS Confederation's chief executive, Matthew Taylor, said that Barclay was "no stranger" to the challenges facing the NHS" but warned, "In the short time that he has been away, these issues have intensified significantly."

### Mental health

#### Access to services deteriorates further

Patients' experience of community mental health services in England continues to deteriorate, with even more people finding access difficult than during the pandemic, a CQC survey found. Only 40% of respondents said they had "definitely" been seen by services enough for their needs, down from 41% in 2021. Fewer users also reported having enough time to discuss their needs: 45% in the 2022 survey, down from 56%.

### Covid-19

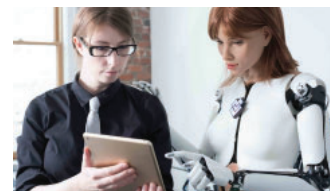
#### Racial inequalities persist in US care

The percentage of people with covid-19 aged over 20 in the US who were treated

with Paxlovid from April to July 2022 was 36% lower in black patients and 30% lower in Hispanic patients than in white patients, found an analysis by the US Centers for Disease Control and Prevention. Inequalities were seen among all age groups and in immunocompromised patients. The agency said that expanding programmes to increase awareness of and access to available outpatient treatments could help reduce the inequality.

### Training

#### NHS staff could receive training in the use of AI

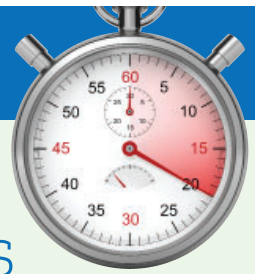


All health and care staff could soon be trained to use artificial intelligence, said new guidance from Health Education England and the NHS AI Lab. The guidance for training and education providers sets out how to plan, develop, and deliver AI training packages. It said some groups of health and care staff would require more advanced training, depending on their roles and responsibilities, such as using AI tools in clinical practice.



# MEDICINE

## SIXTY SECONDS ON... **BAD DREAMS**



### Health funding

#### Westminster chaos “risks worsening” NHS crisis

Healthcare leaders have warned that political turmoil in the UK government has led to vital “rescue money” being held up in government departments rather than being released to the NHS and local authorities to avert a winter crisis. The NHS Confederation said that further delays would mean thousands more elderly and vulnerable patients occupying hospital beds when medically fit to leave, with primary care and ambulance staff “having to pick up the pieces” because of inadequate community support.

#### Cuts threaten to “erode” public health

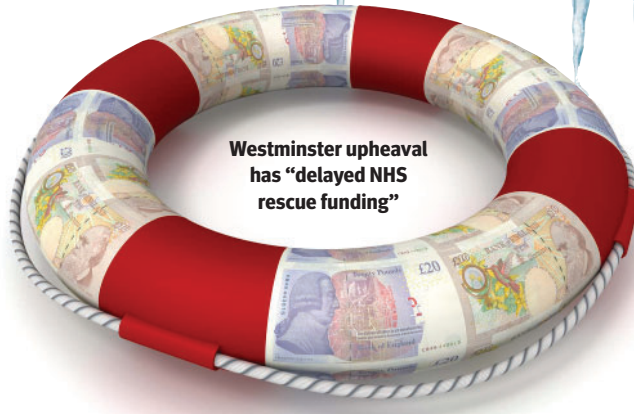
The public health grant paid to local authorities in England to fund preventive services has been cut by 24% on a real terms per person basis since 2015-16, the Health Foundation found. Some of the largest reductions in spending were for smoking cessation, drug and alcohol support, and sexual health services. Jo Bibby, the charity’s director of health, said, “If the government fails to fund vital preventive services, people’s health will continue to erode, and the costs of dealing with this poor health will be felt across society and the economy.”

### Safeguarding

#### Trust is fined for “unsafe care” of four babies

Rotherham NHS Foundation Trust was fined £200 000 after admitting putting four young babies at “significant risk of avoidable harm.” The four babies, all aged under 6 weeks, were sent home after staff at Rotherham

General Hospital failed to spot possible non-accidental injuries and



Westminster upheaval has “delayed NHS rescue funding”

to take safeguarding action. Only after further visits to the hospital, in some cases more than one, were the injuries identified. The trust pleaded guilty to providing unsafe care to the four and to “other unnamed service users” after a prosecution by the Care Quality Commission.

### Sight loss

#### Poor sleep may be linked to glaucoma risk



A UK Biobank study involving more than 400 000 participants found that poor quality sleep may be linked to an increased risk of glaucoma. In the study published in *BMJ Open*, normal sleep duration was classed as 7-9 hours a day, and 8690 cases of glaucoma were identified. The researchers reported that short or long sleep duration was associated with an 8% higher risk of glaucoma, while with insomnia the risk was higher by 12%, snoring 4%, and frequent daytime sleepiness 20%. “Potential ophthalmologic screening among individuals with chronic sleep problems [may] help prevent glaucoma,” the researchers said.

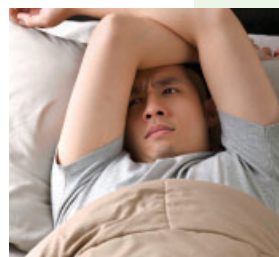
Cite this as: *BMJ* 2022;379:o2612

## PAPER WORK

The average clinician spends

13.5 hours a week on clinical documentation, 25% more time than seven years ago

[Survey of 966 NHS healthcare professionals by Nuance Communications]



#### IS THIS A HALLOWEEN THING?

No, although it does involve nightmares.

#### LIKE A NEW PM EVERY FEW WEEKS?

If only that were in the mind. More positive news awaits people with real nightmares. Researchers in Switzerland may have found a way to boost the effectiveness of a treatment for nightmares called imagery rehearsal therapy (IRT), where patients are asked to change their dream’s negative storyline to a more positive one. The technique doesn’t work for about 30% of patients, said the researchers in *Current Biology*, so they tried adding some piano tunes.

#### LIE BACK AND TELL ME EVERYTHING

In the study all 36 people with recurring bad dreams were asked to perform an initial IRT session in which they generated a positive outcome of their nightmare. Half were also exposed to a sound at the same time (the targeted memory reactivation (TMR) group), while the other half were not (control group).

#### DID IT STRIKE A CHORD?

The TMR group received a one second sound, such as a neutral piano chord, every 10 seconds through headphones while imagining their new positive dream scenario for five minutes. They were then asked to listen to the sound every day at home while they were rehearsing their positive scenario.

#### A REAL SNOOZEFEST

During the next two weeks, all the participants performed IRT every evening at home and were exposed to the sound during rapid eye movement sleep. This was done through a wireless headband that automatically detected sleep stages.

#### SWEET DREAMS?

It seems so. The study found the TMR group had less frequent nightmares and more

positive dream emotions after two weeks, with the average nightmares each week falling from 2.58 to 0.19, compared with 2.94 to 1.02 for the control group. They also had a sustained decrease in nightmares after three months.

#### SLEEP TIGHT

The researchers suggested the technique could be used as sleep therapy for other psychiatric disorders such as anxiety, post-traumatic stress, and insomnia.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2022;379:o2610

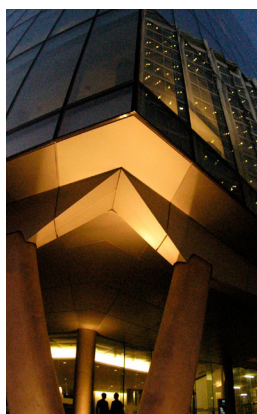
(Continued from page 211)

complaints handling as a part of its “well led” inspection framework, the report said.

In addition, it said the GMC should always ask its external council to consider the merits of a case and raise any concerns, while ensuring the aim of compassionate professional healthcare regulation. Also, the GMC must consider whether it offers enough support to doctors in any fitness to practise process and should encourage medical defence organisations to improve support.

The review called on the government to “bring forward legislative reform for the regulation of healthcare professionals at the earliest opportunity,” as this would allow the GMC to “dispose of appropriate fitness to practise cases consensually.”

Charlie Massey, the GMC’s chief executive, said, “The GMC accepts all of the recommendations without reservation. It is clear there were decisions we did not get right, and for those I have apologised to Dr Arora. I believe we must go further than simply comforting ourselves that bias is not apparent. The GMC is a collection of humans, each with their own



**The GMC is a collection of humans, each with their own biases. The challenge is to address them head on**

Charlie Massey

biases. The challenge for us is to continue to seek out potential bias and address it head on.”

The GMC is carrying out a regulatory fairness review, assessing how effectively it looks for the risk of bias and how it can embed better controls. It has also set a target to eliminate disproportionate numbers of complaints about ethnic minority doctors by 2026. This involves implementing an amended form to ensure organisations check a referral is appropriate before submitting it to the GMC and helping them understand thresholds for fitness to practise referrals.

Forde said, “At the heart of this case was a misapplied legal test around dishonesty, but there was more besides that could and should have prevented this allegation from progressing. We know that investigations are hugely stressful for doctors, and an allegation of dishonesty is among the most serious. The evidence for such allegations must be credible and without nuance, and cases approached with an open mind.”

Singh added, “We hope our review will encourage modern regulation that is compassionate, caring, and fair. It is our belief we can make cases such as this into ‘never events.’”

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2022;379:o2619

## Diphtheria, diarrhoea, and scabies found in “unsafe” immigration detention site

Outbreaks of diphtheria and scabies and a case of MRSA have been reported at the immigration processing centre in Manston, Kent, which has been the subject of much scrutiny after it emerged up to 4000 people were being held in the site designed to accommodate 1600.

MRSA was identified in an asylum seeker who initially tested positive for diphtheria, the *Guardian* reported. They were moved to a hotel hundreds of kilometres away before the positive test result was received.

The Manston site, built as a short term processing centre, has at least eight confirmed cases of diphtheria, the *Guardian* also reported, although the Home Office would not confirm the figures. A spokesperson told *The BMJ*, “We are aware of a very small number of cases of diphtheria reported at Manston. Full medical guidance and protocols have been followed.

“We take the safety and welfare of those in our care extremely seriously and are working closely with health

professionals and the UK Health Security Agency to ensure the instances are contained and to support the individuals affected.”

Stephanie deGiorgio, a doctor who had been working at the centre, told the Radio 4 *Today* programme on 1 November that the people she was treating were extremely tired and scared. She said the team had seen cases of diphtheria as well as diarrhoeal illnesses and scabies. “These are people who are living in horrible crowded conditions, and they don’t have enough washing facilities and ability to keep clean, so the risk of diseases is significant.”

The site was designed to hold migrants for 24 hours until they were moved into detention centres or asylum accommodation, but at least one family was found to have been there for 32 days sleeping on mats in a tent.

Roger Gale, the Tory MP whose constituency includes Manston, told the House of Commons on 31 October that the centre had been working efficiently until last month. He accused the home secretary, Suella Braverman, of taking

## Ministers’ anti-GP narrative eases, but crisis is ignored, says leader

The outgoing head of the RCGP has defended going public about the crisis.

Martin Marshall, chair of the college and professor of healthcare improvement at University College London, told the virtual RCGP meeting on 27 October he had been

criticised for speaking out about GPs’ problems. But, reflecting on his tenure, he said he had no regrets and that it was his duty to tell the truth.

“I’ve been criticised by some for calling out this crisis when I speak to the media,” he said. “They say I’m scaremongering,

talking down general practice, and that I risk damaging public trust and turning off the next generation of GPs.

“But I’m clear I have a professional obligation to say it as it is, not how we’d like it to be. General practice isn’t a catastrophe yet, but



**FULLY TRAINED**  
GPs had fallen by nearly 1800 (6%) since 2015 when the government promised 5000 more GPs



## Manston is overcrowded and unsafe, and there is, as appears inevitable in such conditions, an outbreak of infectious disease

Emma Ginn

the policy decision not to commission further hotel accommodation, which would have reduced the overcrowding. But Braverman has denied blocking the procurement of hotels or vetoing Home Office advice and said the government had been “working tirelessly” to find facilities.

Charlie Taylor, the chief inspector of prisons, urged the Home Office to “get a grip” on Manston. At the 1 November launch of his latest report he said, “The current situation at Manston has significantly deteriorated since our July inspection. We are hearing that detainees are now being held in greater numbers and for much longer periods of time in cramped and uncomfortable conditions, often supervised by staff

who have not been suitably trained.”

The report on the July inspection found that the centre had improved since earlier inspections but that there were early signs of risks materialising, including weak governance of healthcare processes. It said that the management of controlled drugs was particularly poor and breached standards for safe storage. The care pathway lacked coordination or clinical leadership.

Emma Ginn, a spokesperson for Medical Justice, which works for the health rights of detainees, told *The BMJ*, “Manston is overcrowded and unsafe, and there is, as appears inevitable in such conditions, an outbreak of infectious disease. The diphtheria outbreak highlights just one of the ways that such overcrowding and inadequate conditions endanger health.”

Jacqui Wise, Kent

Cite this as: *BMJ* 2022;379:o2615

it’s heading in that direction, and we have limited time to turn it around.”

Marshall, a GP in Newham, east London, said the crisis, which had been building over a decade, had become “deep and multifaceted.” It boiled down to a demand and supply imbalance that was easy to describe but “far from simple” to solve because of the “absence of a plan or even much interest from policy makers.”

The number of consultations delivered was rising above pre-pandemic levels, he said:

GPs now worked 11-12 hour days on average, with 50 patient contacts. Consultations were more complex and intense, with an average of three problems presented in 9.8 minutes. He added that on the supply side numbers of whole time equivalent, fully trained GPs had fallen by nearly 1800 (6%) since 2015, when the government promised 5000 more GPs, and by 2.5% since 2019, when 6000 more GPs were promised.

Although RCGP lobbying meant the “toxic anti-GP narrative is at last turning

around,” he said, “government solutions remain poorly informed and insubstantial.”

Nevertheless, he told the virtual conference he was optimistic, saying, “Politicians eventually realise our patients—their electorate—value general practice, that communities rely on us, and that the NHS is unsustainable without us. I’m confident we’ll return to the days when being a GP was a stimulating, satisfying, and doable job.”

Adele Waters, *The BMJ*

Cite this as: *BMJ* 2022;379:o2595

● EDITORIAL, p 220

## Safety fears pause rollout of patients’ access to records

The health secretary has said the scheme to allow patients in England access to prospective GP medical records will launch before the end of November despite doctors raising safety concerns about the rollout.

EMIS and TPP, companies that supply IT systems to general practices and were to switch on the citizens’ access patient data programme from 1 November, announced a pause until there was full confidence in it.

On 25 October the BMA’s General Practitioners Committee called for a halt to the rollout, saying some practices needed more time to prepare to offer their patients the scheme in line with the Data Protection Act and safeguarding measures.

The scheme, led by NHS England, will automatically give patients the ability to see new entries to their GP medical record through the NHS app. But the

**THE CONSENSUS AMONG GPs IS THAT THE BULK SWITCH-ON IS NOT SAFE**

Jackie Applebee

BMA instructed practices that were not ready to launch to write to their system supplier asking them not to convert their practice until they were fully prepared.

As part of safeguarding practices, GPs are required to review each record to identify any safety concerns related to providing patient access, such as in cases of domestic violence or coercive relationships, and to prevent access in cases of concern by adding a specific SNOMED code to the patient’s record.

In the House of Commons on 1 November health secretary Stephen Barclay said the full switchover would go ahead by 30 November.

David Wrigley, deputy chair of the BMA’s GPC England, described the frequent changes as “incredibly concerning” and “absolutely not the way to handle such an important matter.” He added, “The health secretary’s announcement has brought little clarity, and practices are understandably worried about what this means for them and their patients.

“Fundamentally, the matter of safety remains. Safety for patients and safety for practices. Implementing technical changes within live clinical environments in a way that could negatively impact patients’ lives is unacceptable. We urge NHS England not only to communicate, in detail, with the profession about what is happening but also to reconsider the patient safety implications of hurrying out a programme like this.”

Jackie Applebee, a GP and chair of Doctors in Unite, said general practice supported patient access but added, “Among the profession there is consensus, even among practices that are record sharing enthusiasts, that the bulk switch-on is not safe. This has been communicated repeatedly to NHS England and government. One wonders why they never listen and whether they care their position breaks data protection law.”

NHS England did not reply to a request to comment.

Zosia Kmietowicz, *The BMJ* Cite this as: *BMJ* 2022;379:o2622

● HELEN SALISBURY, p 234



# NO LONGER INVITED **How politics is threatening the UK's science landscape**

Brexit and the current row over the Northern Ireland protocol are having a profound effect on British science, reports **Jacqui Wise**

**This is a recognition that Brexit has consequences, and the form of Brexit chosen has more severe consequences than were necessary**  
Martin McKee

Scientists working in the UK have been told that they can no longer participate in meetings organised by the European Centre for Disease Prevention and Control (ECDC) because of the breakdown in relations with the European Union.

The move is the latest example of how Brexit is affecting UK science and leading to a loss of collaborative opportunities and research funding. The situation is unlikely to improve while the dispute over the Northern Ireland protocol continues.

A leading infectious disease expert told *The BMJ* that they had been invited to participate in two separate advisory meetings held in Europe. But they were subsequently contacted by the ECDC and told, "Unfortunately,

due to the recent developments in the European Union-United Kingdom relations, we are requested to cancel this invitation and we have thus not sent you the supporting documents and link to join the meeting online."

The ECDC has confirmed to *The BMJ* that UK scientists are not now invited to its meetings, adding however that this was not an isolated decision by the ECDC but part of a wider EU policy.

A European Commission official told *The BMJ*, "As you know, the UK has left the European Union. Therefore, it is no longer invited to meetings of union institutions and bodies, including European Union agencies." He added that EU agencies were financed by the EU budget and that they supported member states in shaping and implementing EU policies.

Commenting on the decision, Martin McKee, professor of European public health at the London School of Hygiene and Tropical Medicine, told *The BMJ*, "This is a recognition that Brexit has consequences, and



the form of Brexit the UK has chosen has more severe consequences than were necessary.

"The situation with the ECDC is very regrettable but can only be fixed by British ministers showing that they can be trusted. This will not be easy, given how some have behaved to date."

Medical research and regulation have already been severely affected by Brexit, with the European Medicines Agency relocating from London to Amsterdam and the UK being left out of the new EU portal for approving clinical trials.

There has also been a fall in the number of clinical trials being carried out in the UK, the Association of the British Pharmaceutical Industry (ABPI) recently reported. The number of trials initiated in the UK each year fell by 41% over 2017-21, its report showed.

## Horizon Europe

One of the greatest concerns for scientists based in the UK is that accession to the Horizon Europe

**THE REPORT** showed that the number of trials initiated in the UK each year fell by **41%** in 2017-21

## Political turmoil in Northern Ireland spells "disaster," doctors warn

The lack of a functioning government in Northern Ireland is damaging care of patients and undermining staff in the health sector, the Royal College of Physicians has warned.

Excessively long waiting lists, vacant posts, and deteriorating quality of care were

**When staff are in such a distressed state more mistakes happen**

Siobhan O'Neill

all highlighted in an RCP report, as well as by medics who spoke to *The BMJ*. These sources noted how political instability was delaying much needed reform to the health system.

The legislative assembly was recalled last week but failed to meet the deadline to restore the executive. The largest unionist and nationalist parties must agree to share power under the terms of the Good Friday Agreement, but since February the Democratic Unionist Party has refused, in protest over the terms of the Northern Ireland protocol with the EU.

With no executive, Westminster's Northern

Ireland secretary, Chris Heaton-Harris, was forced to call an election for the assembly but, at time of publication, had not named a date.

"Patients will come to harm and patients will die prematurely, there's no doubt about that," said Tom Black, chair of the BMA's Northern Ireland council. He praised the RCP's report and explained how, in Northern Ireland, patients can wait as long as 11 years for a hip replacement. "That's not even a service—that's us pretending we have a service," he said.

Black added that pressure on emergency departments was extreme, with some patients waiting four days or more to be admitted.

"I've seen nurses break down and cry," said Aidan O'Neill, a consultant acute physician and rheumatologist who is also on the RCP's



ROBERT KINESCHKE/ALAMY

relations in science still further,” he said. “For example, achieving the information sharing with the ECDC which was implemented during covid-19 could be more challenging in a future pandemic.”

#### Exodus of scientists

The UK government has promised it will match the Horizon Europe funding if the dispute is not resolved. However, a plan has not yet materialised, and many scientists have already moved to EU institutions to retain funding.

“Two years on, we are still waiting,” said Robin Grimes, foreign secretary of the Royal Society. “While we wait, confidence in and around UK science is ebbing away and we are losing talent. We need to secure association as a priority if the UK is to remain at the forefront of research and innovation.”

If scientists are excluded from European meetings the worry is that there could be a knock-on effect on international collaboration. Jennifer Harris, director of research policy at ABPI, said, “Pursuing deeper relationships with research and innovation powerhouses across the globe, through effective bilateral and multilateral frameworks, will be key to the UK’s continued scientific success.”

“Alongside this, the government needs to focus on attracting and retaining research talent, investing in high quality health data infrastructure, and ensuring science and research are at the heart of its trade strategy.”

Jacqui Wise, Kent  
Cite this as: *BMJ* 2022;379:o2604



**Confidence in and around UK science is ebbing away and we are losing talent**

Robin Grimes



**Having deeper relationships with research powerhouses across the globe is key to scientific success**

Jennifer Harris

## Scotland closer to simplifying legal process to change gender

Legislation that would allow people to change their gender by self declaration without the need for a medical diagnosis has moved a step closer in Scotland.

The proposals, which have been five years in the making, passed the first stage of the legislative process at the Scottish parliament despite a rebellion by nine members of the Scottish National party government.

The bill, which is backed by all parties at Holyrood apart from the Tories, aims to improve and simplify the process of applying for a gender recognition certificate. It removes the need for a medical diagnosis of gender dysphoria, allows people to change their gender by signing a declaration, and reduces the time they must live in their “acquired gender” from two years to three months. And the minimum age of applicants drops from 18 to 16.

Critics say the proposed system could be abused by people not seeking genuine gender change.

The UK government consulted on similar changes in 2018 but took no action. Scotland’s bill now goes onto its second stage, before returning to the parliament for the final vote.

Bryan Christie, Edinburgh  
Cite this as: *BMJ* 2022;379:o2608

funding programme as an associate member has been put on ice. Access to the international research funding programme, which has a €95.5bn (£82bn) budget, was agreed as part of the Brexit agreement, but the EU says it isn’t willing to give UK membership final sign-off while the Northern Ireland protocol remains in dispute.

Mark Dayan, a policy analyst and Brexit programme lead at the Nuffield Trust, said, “The agreement signed with the EU in 2021 leaves the door open for cooperation in several key scientific and medical areas, but the bad tempered dispute over the Northern Ireland protocol has made these a tempting target for the EU as it seeks to retaliate against UK threats to break its commitments.”

Dayan said that the Northern Ireland Protocol Bill passing through parliament was designed to unequivocally breach the withdrawal agreement with the EU. “This is likely to open up further avenues for retaliation, potentially damaging

Northern Ireland committee. He described having to examine patients in corridors because of a lack of space on wards.

#### Undervalued and overworked

The RCP’s report included findings from a survey of 186 higher specialty trainees in Northern Ireland, which found that 41% almost never felt valued by their trust or hospital management. More than half reported working excessive hours, and a similar proportion described daily or weekly gaps in trainee rotas.

Staffing problems look set to worsen, as the RCP report has noted that more than a third of consultants in Northern Ireland will reach retirement age during the next decade. Meanwhile, only about a quarter of foundation

trainees in the region were currently continuing to higher training.

Siobhan O’Neill, professor of mental health sciences at Ulster University, said the RCP’s findings were “extremely worrying.” She expressed concern for the mental wellbeing of staff and highlighted the potential consequences for patient care. “We know that when people are in that distressed state more mistakes happen,” she said. Patients with physical ailments could find their mental health suffering as a result of delays, she added.

A Northern Ireland Department of Health

**Patients will come to harm and patients will die prematurely, there’s no doubt about that** Tom Black

spokeswoman said in a statement that the health minister, Robin Swann, welcomed the RCP report. “He has repeatedly pressed the case for guaranteed multiyear funding to ensure sustained investment and longer term planning,” she said, adding that the health service in Northern Ireland had had no confirmed budget for all of 2022 so far.

She did not respond to the report’s criticism of the department. One consultant commented, “You have to fail [in order] to actually get the Department of Health to take notice of you.”

The *BMJ* approached Sinn Féin, the Democratic Unionist Party, and the Alliance Party for comment, but none responded.

Chris Baraniuk, Belfast  
Cite this as: *BMJ* 2022;379:o2581

## THE BIG PICTURE

# Turkish doctors' leader is arrested

Demonstrators protest in Istanbul against the arrest of the president of the Turkish Medical Association (TTB) for calling for an investigation into claims that the army used chemical weapons against Kurdish militants in Iraq.

The TTB and its president, Şebnem Korur Fincancı (below), have for years been targeted by President Recep Tayyip Erdoğan and his political allies.

Fincancı made her comments after media outlets affiliated to the Kurdistan Workers' Party (PKK) released footage purporting to show a chemical weapons attack on two PKK militants in a cave.

Asked to comment while in Germany on 19 October, Fincancı said, "The involuntary movements of the individuals in the footage may indicate the nervous system is affected." She added that "the allegations should be investigated by independent committees."

On her return to Turkey Erdoğan said, "The fact that such a person, who humiliates her country and army by speaking the language of a terrorist organisation, is at the head of an institution whose name begins with 'Turkish' disturbs every member of our nation." Fincancı was arrested on 26 October.

Owen Dyer, Montreal [Cite this as: BMJ 2022;379:o2587](#)







ONUR DOĞMAN/ SOPA/ALAMY; M. VELLA/SOPA/GETTY

# The future of general practice in England

MPs on the Health and Social Care Committee shows leadership where government has failed to act

**N**o one who works in general practice, and few patients attempting to access care, would deny that it is struggling. The underlying cause is clear—a mismatch between the need and expectations of the public for general practice services on one side and the shortage of supply of those services on the other. The problem has been building for more than a decade and has been exacerbated by the pandemic.

However, a recent report from the House of Commons Health and Social Care Select Committee into the future of general practice suggests that government has its head in the sand.<sup>3</sup> The report reprimands ministers for failing to recognise or accept the scale of the challenge they face: “The first step to solving a problem is to acknowledge it and we believe that... despite the best efforts of GPs... general practice is in crisis.”

The insightful and hard hitting independent report deserves to be taken seriously. It presents a detailed analysis of the nature of the crisis, describing the rising number and complexity of consultations as a consequence of a growing and ageing population, and increasing expectations of what general practice can do for patients and the health service. It highlights the inadequate workforce to meet those needs and the lack of investment over many years in premises and technology. It identifies how these pressures are resulting in a demoralised workforce and in unhappy patients because of poor access in general and, in particular, loss of continuity of care from clinicians that they know and trust.

The recommendations of the committee are many (28 in total) and varied. Most rightly focus on building the capacity and capability of the workforce. Increasing the



**The report reprimands ministers for failing to recognise or accept the scale of the challenge GPs face**

number of GP training places, expanding and reinvigorating doctor retention schemes, and revising the resource allocation formula to better weight for deprivation are all familiar solutions. So too are making it easier to recruit and support allied health professionals and non-clinical staff, removing disincentives associated with the doctors' pension scheme, reducing time spent on administrative activities that can be done by others, and increasing investment in technology and estates.

The “what” as far as the workforce is concerned is clear, the “how” less so, but that’s the job of government and its arm’s length bodies, not a parliamentary committee.

## Continuity of care

Several recommendations emphasise the importance of preserving the traditional values and ways of working of British general practice, much copied and envied by other countries.<sup>4</sup> For example, the report emphasises the importance to both patients and clinicians of continuity of care, and the extent to which this is being damaged by what the chair of the committee has called the “uberisation” of general practice.<sup>5</sup>

To support this call the report recommends encouraging the

growing number of locum doctors currently working in general practice into regular employment by introducing more flexible contracts. It also recommends increasing the duration of general practitioner training from three to four years so that early career practitioners feel better prepared for the complexity of independent clinical practice.

The authors call on the government to reaffirm its commitment to the merits of the independent contractor model, after recent reports suggested that GPs should be employed by the NHS.<sup>6</sup> The recommendation to replace the current GP contract, which micromanages clinical activity using targets and financial incentives, with one that trusts clinicians to do the right thing will go down well with most health professionals.

The number and breadth of the recommendations in the report are a strength rather than a weakness. The problems facing general practice are now so deeply embedded that there is no simple, quick, or cheap solution. There is certainly no substantive answer that can be aligned to the political electoral cycle, which might be why politicians are finding it so difficult to act. The select committee report recognises that the crisis in general practice will not be turned around quickly and demands that politicians act boldly and with vision.

Will the report lead to action? The immediate political context is unhelpful. Rome is burning but the attention of politicians is elsewhere; general practice and the wider NHS are not the only public services in crisis. But the health select committee report provides a clear pathway to a time when the job of a GP is not just manageable but once again fulfilling and enjoyable.

Cite this as: *BMJ* 2022;379:o2554

Find the full version with references at <http://dx.doi.org/10.1136/bmj.o2554>

Martin Marshall,  
chair, Royal  
College of General  
Practitioners,  
London  
[martin.marshall@ucl.ac.uk](mailto:martin.marshall@ucl.ac.uk)

# BMJ journals collect diversity data on submissions

Capturing the diversity of our contributors will enable better decision making

**E**quity, diversity, and inclusion (EDI) are at the heart of BMJ's mission to create a healthier, more equitable world. Research has shown that greater gender, racial, and ethnic diversity; representation of disadvantaged voices; and inclusion of different perspectives enable better decision making.

On 1 October, BMJ journals began asking all users of our manuscript submission sites (editors, authors, and reviewers) to self-report their gender, race, and ethnicity. The data will always be aggregated and not linked to individual users, contributors, or manuscripts. BMJ uses appropriate measures, including encryption, to safeguard diversity data, which are collected through our manuscript submission sites but stored in a separate database with access controls. Self-reported diversity data cannot be seen, accessed, or used by anyone during the manuscript submission or peer review process, and they will be used by BMJ only for reporting on our EDI performance and progress.

Collecting and reporting EDI data are now industry standards in scholarly publishing. All BMJ journal contributors will be prompted to complete this information, but they can opt out by selecting "prefer not to disclose."

## Benchmark

Collecting these data will enable BMJ to benchmark the diversity of the contributors to all our journals. We acknowledge that journal publishing is not impervious to the biases that exist in academic research, funder environments, clinical practice, and in broader societies. These biases, not limited to gender and race, create and sustain an unequal playing field and restrict journals' abilities to break away from status bias in peer review (peer reviewers favouring or not wishing to discredit senior researchers), Western



**We want to ensure that we are not perpetuating barriers to publication that hold back career progression**

bias (favouring research conducted in and applicable to Western populations), and colonial approaches to clinical research and public health (also known as "helicopter" or "parachute" research, conducted on rather than in collaboration with populations in lower income countries). These biases have shaped scientific research and dissemination since the establishment of scientific journals in the 17th century.

BMJ journals want to publish the best research, regardless of the gender, race, or ethnicity (or any other personal characteristic) of the authors, and we want to ensure that we are not perpetuating barriers to publication that hold back career progression.

Studies published in *The BMJ* and elsewhere show that women are under-represented in the authorship of academic research. The percentage of women researchers published in academic journals further decreased during the covid-19 pandemic. Collecting self-reported data on gender, race, and ethnicity of contributors will give us a more accurate picture of author characteristics and, for the first time, enable us to report on the ethnic diversity of our contributors.

These data will help BMJ monitor the outcomes of interventions to

the editorial process; for example, we will be able to assess whether having more diverse editorial boards improves the diversity of peer reviewers as well as the authors we commission for commentary articles.

## Me too

After #metoo, #timesup, LancetWomen, and other international and cross industry social justice campaigns, *The BMJ* and our specialty journals need a way to capture the diversity of our contributors systematically. We want to understand the diversity of authors, reviewers, editors, and editorial advisory board members, and we have publicly committed to doing so. The joint commitment for action on inclusion and diversity in publishing, founded by the Royal Society of Chemistry in 2020, took up the challenge of setting standards to introduce EDI data collection on article submission systems. The group also designed and tested an international list of race and ethnicity terms (<https://www.rsc.org/new-perspectives/talent/joint-commitment-for-action-inclusion-and-diversity-in-publishing/>).

BMJ will review these data in six months' time, and we hope to present and publish journal and portfolio level summaries of the data. We also hope to use these data to begin publicly stating the gender ratios of our journal editorial boards to support our mission of achieving at least gender parity among members of our journal editorial boards.

If you have any questions, please find answers to FAQs here: [authors.bmj.com/policies/gender-identity-and-race-ethnicity-data-in-scholarone](https://authors.bmj.com/policies/gender-identity-and-race-ethnicity-data-in-scholarone), and you can contact Mark Richards at [policy.edi@bmj.com](mailto:policy.edi@bmj.com).

Cite this as: *BMJ* 2022;379:o2542

Find the full version with references at <http://dx.doi.org/10.1136/bmj.o2542>

Mark Richards,  
article transfer  
service manager,  
BMJ Journals  
[mrichards@  
bmj.com](mailto:mrichards@bmj.com)

# Revitalising mental healthcare after covid

The pandemic provided the impetus to set up and scale up innovative service models rapidly – which is much needed in an era of record demand, writes **Kathy Oxtoby**

**A**t the start of the pandemic, mental health services needed to maintain access to support while protecting patients and staff from the virus. In May 2020, NHS mental health trusts in England opened 24/7 helplines offering advice and support. Some trusts created alternatives to emergency departments, with calmer environments for urgent assessment.

More than two years later, record numbers of people are seeking help. In July 2022 more than 1.6 million people in England contacted NHS mental health services—up 22.7% from April 2020, in the first peak of the pandemic. Children and young people open referrals are 66% above pre-pandemic levels.

This may represent just the tip of an iceberg. In a Royal College of Psychiatrists survey in March 2022, a third of people reported worsened mental health owing to the pandemic. The Centre for Mental Health charity estimates that 10 million people in England will need mental health support because of the pandemic in the next three to five years, including people with complex grief, trauma, and burnout.

The past two years have also taken their toll on overstretched mental healthcare staff, with many feeling burnt out and exhausted. A depleted workforce and underinvestment have presented ongoing challenges for the sector, the royal college says. Children's services are also under severe strain.

Despite the bleak statistics, however, innovation in delivering support, tackling

waiting times, and preventing mental health problems from escalating give some cause for optimism.

In the past two years video and telephone consultations have become the norm, “saving time, increasing accessibility, and helping staff deal with the growing numbers of people in need of help,” says Adrian James, president of the Royal College of Psychiatrists. And they seem set to be adopted for the long term.

These approaches have been welcomed by many patients, he tells *The BMJ*. “They feel more comfortable accepting care from home. If you have paranoia or depression, for example, you naturally have more concerns about getting out and meeting people.”

However, they are not a blanket solution for rising demand. James adds, “There are sometimes issues you pick up in the consulting room about people's emotions that you don't notice online.”

## Digital offerings

The charity Mind notes that some service users may find digital offerings unsuitable. “People need a choice, so that if a digital offering doesn't suit them they can get to see a practitioner face to face,” says Paul Spencer, head of health policy and campaigns. However, not everyone who wants an appointment face to face can have one—Spencer says that waits can be as long as a year.

Before the pandemic Cumbria, Northumberland, Tyne and Wear NHS Trust had offered video consultations as part of a small pilot scheme carried out for three months



**There can be issues you pick up in the consulting room you don't notice online**  
Adrian James

in 2019. Use was low, owing to clinician and patient choice. The trust was planning to extend the pilot scheme to other services, but the pandemic hit, and in April 2020 the solution was provided to all community areas. An average of 2500 online video consultations now take place each month.

An evaluation of the trust's scheme by Sheffield Hallam University found that patients tended to prefer video calls to attending clinics or home visits, and 93% of patients wanted to receive future mental healthcare this way. Patients who would have attended a clinic typically saved as much as 60 minutes and £6 in travel costs for each consultation. When compared with home visits, staff reported saving 25 minutes per appointment.

The trust's chief clinical information officer, Jonathan Richardson, says that staff and user engagement depends on digital teams, clinical teams, and service users working closely to shape how technology is used. As part of the pilot scheme the trust engaged with service user groups and held engagement sessions with the pilot teams, working with them

## Early intervention for under 18s



**The service removes many barriers to accessing support**

Since March 2020, NHS Grampian's Psychological Resilience Hub has offered early support to more than 600 children and their families. This virtual service aims to prevent mental health problems related to the pandemic, such as experiencing anxiety and reaching crisis point, to reduce demand on child and adolescent mental health services and GPs.

Gillian Strachan (left), a consultant clinical psychologist who manages the hub and helped set it up, tells *The BMJ*, “Our service uses psychological first aid—an approach designed

to support people during or in the aftermath of a serious event—ensuring early intervention, in an easy to reach manner, via online self-referral. This approach removes many barriers to accessing support, such as the need for multiple referrals.

“Helping a young person manage their panic attacks through cognitive behavioural therapy, preventing a more severe disorder down the line, is one example of many interventions this service has made.”

One service user says of the hub's approach, “My feelings and emotions

were validated, and I never felt judged by my struggles during this time. Coping techniques were given, and just having someone to acknowledge and listen helped hugely for me.”

In the past few months the initiative, which was developed as a time limited support in response to the pandemic, has ended. Referrals to the service began to fall, and staff supporting the initiative returned to their substantive roles. However, Strachan says that it could be adapted as an early intervention psychological service for children.

## Patient commentary

Darren McCartney, 40, from the south east of England, found video consultations during the pandemic helpful for continuity of care.

"I've experienced mental health problems since I was around 16 years old," he says. "I have been diagnosed with complex PTSD, OCD, and clinical depression. Talking therapies, as well as EMDR [eye movement, desensitisation, and reprocessing] therapy, have helped me get to the root of

some of my problems. "When the pandemic hit, my therapist was very proactive in making the decision to switch our weekly face-to-face appointments to video calls and the service was adapted quickly. I was very thankful for every call.

"Video consultations were not the same as a personal visit, because I wasn't able to be as emotionally open and 'present': sometimes I would lose concentration. It's also more difficult to understand

the therapy techniques via video than in person.

"But the remote sessions were valuable because they ensured the service was consistent—and when you have mental health issues, consistency is key."

He adds, "At my lowest points, I've picked up the phone to crisis services. But their responsiveness varies, and some 'emergency' apps that require you to text can take hours to reply. I've also had phone consultations, which can feel mechanical.

## The remote sessions were valuable because they ensured the service was consistent

"During the pandemic, my talking therapy came to a natural end, and I was referred to a trauma based service for specific therapy for my PTSD. However, due to pressures on services because of covid-19, I was on a waiting list for seven months. Since March I've been having weekly face-to-face appointments.

"It's hugely positive how mental health services have

evolved, particularly the way remote consultations have opened up new ways of communicating with health professionals and are helping with demand.

"Post pandemic, a one size mental health service won't fit all. Services will need to continue to be varied, based on individual need. But, however a service is delivered, it must be regular and reliable."



**Schemes rely on digital and clinical staff and service users working closely**  
Jonathan Richardson

and the trust's Patient Information Centre to develop supporting materials.

Using their clinical judgment, clinicians identify patients to offer an online consultation as another option for receiving care. One service user describes how video online consultations have "given me my life back—it has been just as effective as previous face-to-face appointments."

Another positive development accelerated by the covid pandemic is a culture change in community mental health services, where healthcare, social care, and the voluntary sector work more collaboratively.

Since 2020, Somerset's Open Mental Health service has brought together Somerset NHS Foundation Trust, the charity Rethink Mental Illness, and social care, as well as local and national voluntary, community, and social enterprise organisations. Initially funded by NHS England, services are commissioned by Somerset Clinical Commissioning Group, and the partnership aims to avoid repeated referral and reassessment of patients.

Jane Yeandle, the Somerset trust's service director for mental health and learning disabilities, says that a "no wrong door" approach means that, wherever someone presents, they will always be directed to the help they need. The Open Mental Health

service provides not only interventions such as talking therapies but also support regarding wider determinants of mental ill health, such as referral to Citizens Advice for help with benefits and housing.

Open Mental Health has 10 peer support workers who have experience of mental health challenges and are paid. A further five are in training, and four more have been recruited. These "experts by experience said that too often they were 'bounced around' a complicated system," says Yeandle.

Sue Harbor, an "expert by experience" leader who has had major depressive disorders, knows at first hand that it can be a "big struggle" to access services. She waited a year before seeing a psychiatrist and receiving treatment in 2019. "When you're in crisis this is compounded by the fact you can't get help—you feel desperate and hopeless," she says.

### Peer workforce

Harbor uses her experience of mental health services to support Open Mental Health in engaging with people with serious mental illness, including looking at how to encourage patients to take up physical health checks. She says that Open Mental Health's approach means service users are "directed to the right services for them at that time, without them having to tell their story over and over again."

Knowing people are benefiting from her experience has been "amazing for my confidence," she says. "I'm in a much better place. My involvement with Open Mental Health has made me feel listened to and valued."

On average, 3600 contacts a month are seen by Open Mental Health—and promptly: people wait an average of two days from contacting the service for support, while the national standard is four weeks.

Working in alliance, including local meetings held at least weekly, has been a "huge cultural change for all our staff," says Yeandle. "It's been important to learn to trust and work with one another and not work in silos."

Trusts should "scope their local stakeholders and voluntary organisations, build those relationships, and see what opportunities there are... listen to the people who use your services, and allow them to develop them," she advises.

Will Higham, associate director of programme innovation at Rethink Mental Illness, tells *The BMJ*, "Post pandemic, the community approach is the right approach. In particular, the peer workforce can be a pathway to recovery for people, as well as being crucial to helping solve the workforce shortage, as there simply aren't the clinical hours to deal with the level of need out there."

Doctors can be "powerful leaders" for mental health in their communities and can help drive service innovation, says Higham. He explains, "Find willing partners in your community to help meet the wave of need we're facing. Meet mental health charities, find out what 'transformation plan' your trust is putting together and feed into that, and look at what resources you can unlock to make a difference."

To help deal with the huge pressures facing community and specialist services, Andy Bell, deputy chief executive for the Centre for Mental Health, tells *The BMJ*, "We need to prioritise early intervention—for example, by investing in open access youth advice and counselling services, and by locating more mental health support in GP surgeries."

Kathy Oxtoby, freelance journalist, London  
kathyoxto1@gmail.com

Cite this as: *BMJ* 2022;379:o2122

## THE NEW NORMAL

# Doctors working from home: the good, the bad, and the barriers

Many medics dream of remote working—but it has downsides as well as upsides, and there remain obstacles to overcome, reports **Jo Best**

**W**hen the covid pandemic began, doctors across the UK, just like other professionals, found themselves working increasingly from home. Is flexible working here for the long term, or is the hybrid model just a pandemic phenomenon—and how does it work for doctors?

Even before the pandemic, remote working in medicine had been growing, with GP appointments by telephone and video perhaps one of the more visible examples of the change. Around a third of GP appointments are now remote, up from 15% before the pandemic.

Secondary care doctors are also increasingly working outside hospital settings. A 2021 Royal College of Physicians survey of just over 1500 members found that 57% of respondents were working remotely

in some capacity. That figure could be set to grow: the RCP survey also found that 76% of doctors would like to work from home.

While there is no national guidance specifically for doctors on working from home, like all other UK employees doctors have the right to request flexible working, including remote working, and the right to have such requests considered. Employers should have policies setting out how to apply for a change to flexible working. Currently, for doctors who have the ability to work remotely, this is less likely to be patient facing.

An unpublished RCP survey of members showed that continuing professional development was the most popular activity among those working remotely, followed by patient administration, education, audits and quality improvement, and virtual clinics.

## REMOTE WORKING AT GOSH: MORE CLINICAL TOUCHPOINTS, FEWER DNAS

Like most employers, Great Ormond Street Hospital for Children had dabbled with remote working before the covid pandemic, with a handful of subspecialties offering video consultations.

But, having introduced a single patient record system back in 2019, when covid hit the UK GOSH partnered with the video conferencing company Zoom to roll out “video visits” across 5000 staff and all subspecialties in a matter of days. Laptops with webcams were rolled out to staff,

while cameras were put into outpatient suites for patients.

Now, although the covid threat seems to be receding, remote working has not diminished. And, with GOSH declaring a climate emergency, remote working offers a more sustainable alternative for the hospital’s patients and staff, by reducing the need for repeated travel to and from the central London hospital.

However, despite the introduction of remote working and online consultations,

patients are seeing more care overall, not less: there are more clinical touchpoints than before the virtual visits were rolled out. “Our job isn’t to give [patients] a video visit. The video visit is just a tool. Our job is to provide care. And at the moment this is just a really good mechanism for us to facilitate care,” says Catherine Peters, one of GOSH’s consultant paediatric endocrinologists and its medical information officer.

The new system means fewer instances of DNA (“did not attend”) among patients and their families, who no longer have to take whole days off school or work to attend outpatient appointments. The running of the hospital is also smoother, as all meetings are now hybrid. “It’s increased our attendance and our ability to be a team because we’re no longer restricted by geography,” says Shankar Sridharan, a consultant paediatric cardiologist and GOSH’s chief clinical information officer.

Although working from home is not typically available to junior doctors, because of the nature of their day-to-day work, during the pandemic it enabled those who needed to shield to work remotely on administration, phone calls with patients, or outpatient related work.

For those doctors who do regularly work remotely it has enabled greater flexibility, with job plans adjusted to take account of personal commitments outside work. Doctors doing non-resident on-call duties have access to all the same patient information whether at work or at home; they can quickly get a clearer picture of any cases they are contacted about.

“We’ve moved to this very, very quickly, and it’s now such a standard part of our care. I think, fundamentally, video meeting capability isn’t a nice-to-have thing,” Sridharan adds. “It’s nearly as essential as having a stethoscope. I don’t think we could ever go back.”





A 2021 Royal College of Physicians survey of just

over **1500** members found

that **57%** were working remotely in some capacity.

That figure could be set to grow: the RCP survey also found

that **76%** of doctors would like to work from home



**We're no longer restricted by geography**

Shankar Sridharan



**This is just a really good mechanism for us to facilitate care**

Catherine Peters

## Benefits—for doctors, employers, and services

Before she started working remotely, Lola Ogunbowale, a consultant ophthalmologist, would commute every week between her home in Switzerland and London's Moorfields Eye Hospital. Now, she rotates between periods of two weeks working in person at Moorfields and two weeks working from home, including conducting virtual clinics and A&E sessions. "I get to spend more time with my family here in Switzerland, rather than jetting here and there, which is quite draining," she tells *The BMJ*. "I also find that I actually get more work done, because there are fewer distractions. You log on in the morning and just focus on work, whether it's responding to emails, outstanding appointments, or writing letters. You can just get a lot more done when you're remote. It works very well for me."

Allowing doctors to work from home offers benefits

to employers too, including broadening the pool of staff they can employ or retain. As the pandemic proved, remote working enabled those with significant health conditions who might otherwise have been unable to work face to face to continue working, and a recent BMA inquiry called hybrid working "hugely beneficial" to doctors with disabilities or long term health conditions. "A hybrid working model for doctors must be more seriously considered within the NHS," the report added.

Remote working also allows doctors who might be unable to work on site to still do their jobs, including those in the later stages of pregnancy, those recovering from surgery or isolating for covid reasons but who still feel well enough to work, and those who can't get to work because of transport disruption or family emergencies.

Working from home also

offers other ways for employers to increase service provision: one doctor working remotely can conduct clinics for any number of geographically disparate facilities in a single day in a way they couldn't if they had to deliver sessions in person.

Consultant forensic scientist Neeraj Tripathi works for HM Prison Service in the Hertfordshire area and provides services to several facilities to which he would previously have driven up to an hour and a half to reach. "I would rather spend those hours providing consultations as opposed to wasting them commuting," he says. "A part of my work is face to face, but because these prisons are scattered around the country I rely heavily on remote working." Remote working has also allowed Tripathi to deliver services when facilities' on-site staff were unavailable at short notice, bridging last minute gaps in staffing.

---

## Disadvantages—blurred boundaries and overtime

---

Physically leaving a hospital or GP surgery and commuting creates a clear division between work and home and gives time to decompress from the working day. But for remote workers the boundary between the two can blur. Having access to hospital IT systems at home and no clear delineation between work and personal space can create the temptation to log in and check how a patient is doing overnight or just to finish a couple more clinic letters before clocking off for the day.

Consequently, it can mean doctors working above their contracted hours without attracting any additional pay. According to the RCP, the average full time consultant works 10% more than their contracted programmed activities (PAs), while one who works less than full time will work 20% more, usually by catching up with work at home. “What the healthcare sector is getting at the moment is a lot of consultant physicians doing a lot of extra unpaid work remotely,” says Sarah Logan, director of the RCP’s medical workforce unit. “As a healthcare workforce we really need to address how we value and remunerate remote working in a transparent way, especially so that the people who do a lot of it and aren’t full time are not essentially propping their own working pattern up to full time.”

For now, remote and home working is largely done by consultants and GPs (and to a lesser extent by higher specialty trainees). Fewer doctors at more junior levels work from home regularly, because of the nature of their jobs—reviewing a patient with a spiking fever or putting in a difficult cannula clearly doesn’t lend itself to remote working—and junior doctors are less likely than senior colleagues to do clinics, some of which can be done remotely.

However, that may be about to change. The government has committed itself to increasing the number of virtual ward beds to between 40 and 50 per 100 000 population by December 2023. In many of the virtual wards that are currently up and running, the day-to-day work is done by junior doctors, in much the same way as in bricks and mortar wards. As virtual ward patients are monitored without the need to be in hospital, the expansion of virtual wards will increasingly open up the possibility of remote working for junior doctors.



**We really need to address how we value and remunerate remote working**

Sarah Logan



**Remote working is here to stay so we can expect investment in tech that supports it**

Tola Sargeant

---

## Barriers—training and technology

---

For home working to become more widespread, particularly among junior doctors, training will need to adapt accordingly. The RCP’s Logan highlights the lack of requirements in current training curriculums that are specific to remote working. “For example, having specific SLEs [supervised learning events] in portfolios for doctors at all levels on how they conduct themselves in a telephone clinic would be really valuable. I don’t think that the relevant curriculum boards have necessarily quite got up to speed with that yet,” she says.

Technology may present another barrier to increased remote working, particularly in patient-facing work. Seeing patients remotely may require extra hardware. Tripathi, for example, turned to a particular videoconferencing display with noise cancelling to prevent prison inmates, who may not have family contact, from hearing his children playing at home during consultations. Meanwhile, Moorfields is trialling virtual “pods” at one of its satellite locations, at Brent Cross in north London, with assistants to help patients who may not themselves have ready access to videoconferencing technology to speak to its doctors remotely.

Doctors working from home face the challenge of gaining access to the same IT systems they have when in the hospital, which often implies access to a single unified electronic patient health record, stored in the cloud, and need the same level of security to be guaranteed around sensitive patient information. That may involve a laptop provided by the trust with the appropriate software and a means of security authentication, such as a smart card reader or two factor system, or a virtualised desktop infrastructure with access to critical software and services, whether on a personal device or one provided by the trust. In this way, a remote desktop protocol allows the remote machine to “take over” a physical host machine at the trust, which has to be on and available (potentially creating problems if it’s not).

An alternative is to “bring your own device” (BYOD), where doctors use their personal laptops for work, but only “where there is no practical alternative,” says NHS England guidance. While BYOD overcomes some of the IT challenges associated with working from home, notably hardware availability and associated costs, it does present others: employers consider BYOD to present more security and governance challenges, particularly around handling sensitive patient information, than machines supplied by the NHS.

Overcoming the technology barriers to remote working will necessitate greater overall IT investment. Tola Sargeant, managing director at the analysts TechMarketView, says, “Remote working is here to stay across all professions, and the NHS shouldn’t be any different, so we can expect ongoing investment in tech that supports remote working, including trust laptops, and increased server capacity.”

---

Jo Best, freelance writer and doctor, London, UK  
jo.best@journalist.com

Cite this as: *BMJ* 2022;378:e2127