this week

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VOISIN/PHANIE/SIPA/ALAMY

Clots "leading cause of maternal death"

The maternal death rate in the UK is at its highest for 20 years, with 275 deaths recorded during or up to six weeks after pregnancy in 2020-22, says the latest MBRRACE-UK report. Blood clots were the cause of death in 16%, followed by covid-19 (14%) and cardiac disease (13%).

The report also examined the cases of 329 women who died between six weeks and one year after the end of pregnancy in the same period. Mental health related deaths accounted for a large proportion (34%) of these, with substance misuse and suicide the leading causes. The report, commissioned by the Healthcare Quality Improvement Partnership, showed inequalities in maternal mortality persist. Black women were almost three times as likely as white women to die during pregnancy or up to six weeks after (35 *v* 12 per 100 000 maternities), while Asian women had double the risk (20 per 100 000).

Women aged over 35 had triple the risk of those aged 20-24, while women in the most deprived areas had maternal mortality twice that in the least deprived areas. Some 9% of women who died had multiple disadvantages, such as mental ill health or experience of substance misuse or domestic abuse.

The overall maternal death rate in the UK rose from 11.66 per 100 000 maternities in 2017-19 to 13.56 per 100 000 in 2020-22.

The report said there were many reasons, some relating to the pandemic, such as delays in getting pre-hospital care. But it added that the maternity population was becoming more complex: many of the women who died were older than 35 and most were overweight or obese.

One in four of the women who died from venous thromboembolism were in the first trimester of pregnancy, emphasising the importance of early risk assessment. The report called for more research to restructure the VTE risk assessment tool so it is clear and easy to use. GPs should be able to obtain timely specialist advice, and there should be clear pathways for referral.

Ranee Thakar, president of the Royal College of Obstetricians and Gynaecologists, said, "It's vital multidisciplinary teams have the tools and training to identify quickly the onset of potentially life threatening health concerns in pregnant patients and ensure they have prompt access to treatment."

She added, "The data around deaths related to mental health is tragic. Investment is needed to make sure timely and holistic provision is there for everyone who needs it."

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;387:q2252

Ranee Thakar (inset), president of the Royal College of Obstetricians and Gynaecologists, has called for more investment in maternity services

LATEST ONLINE

- Food executives urged to commit to healthier, more sustainable products
- UK government must reform immigration system, say psychiatrists
- Mail apologises for accusing GP and nutritionist of spreading fake statin news

SEVEN DAYS IN

Police identify 24 opioid death suspects at Gosport Hospital

Police investigating the deaths of hundreds of patients who died after being given opioid painkillers at Gosport War Memorial Hospital in Hampshire have identified 24 suspects. Police told families they were 21 people suspected of gross negligence manslaughter and three of offences under the Health and Safety at Work Act. Interviews have been carried out under caution, but no arrests have been made.

The investigation was launched in 2019 after an independent review panel concluded that at least 456 patients between 1987 and 2000 had had their lives shortened by medically unnecessary doses of opioid painkillers at the hospital. The investigation, codenamed Operation Magenta and overseen by the Kent and Essex Serious Crime Directorate, has recruited serving and retired detectives from several forces.

An independent review, led by former bishop of Liverpool James Jones, concluded in 2018 that there was a "disregard for human life and a culture of shortening lives of a large number of patients" at the hospital. It said that there was an "institutionalised regime of prescribing and administering dangerous doses of a hazardous combination of medication not clinically indicated or justified."

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2024;387:q2245

Cancer

New funding for early diagnosis projects

The UK government announced £11m in funding for six projects aimed at increasing early diagnosis of cancer, including a blood test that promises to detect 12 common cancers. Mionco is a multicancer early detection (MCED) test developed by two researchers from the University of Southampton through their company Xgenera. It is designed to identify the presence and potential location of cancers (lung, breast, prostate, pancreatic, colorectal, ovarian, liver, brain, oesophageal, bladder, bone and soft tissue sarcoma, and gastric) by measuring microRNA expression in blood samples.

Ranitidine

GSK settles most US lawsuits for $2.2bn

The UK based drug company GSK has agreed to pay as much as $2.2bn (£1.7bn) to settle 93% of claims against it in the US courts alleging that the heartburn drug ranitidine (previously marketed in the US as Zantac) caused cancer. GSK will also pay $70m to settle a lawsuit from Valisure, a Connecticut testing laboratory. In 2019 Valisure found that ranitidine could degrade into a carcinogenic compound called NDMA—a concern that led the US Food and Drug Administration to pull ranitidine from pharmacy shelves in 2020. The UK recalled four GSK ranitidine products in 2019. GSK has not admitted any wrongdoing.

Severe mental illness

Psychiatrists urge action on preventable illness

Data from NHS England and the Office for National Statistics showed that 130 400 adults with severe mental illness died prematurely (before age 75) from January 2020 to December 2022. Of these deaths, the Royal College of Psychiatrists estimated that around two thirds (86 934) were from preventable conditions such as respiratory disease, heart disease, and liver disease. The college urged the government to take immediate action to "close the mortality gap between people with severe mental illness and the rest of the population."

AMR

Increased vaccine use could cut antibiotics

Increasing the use of vaccines could help tackle the growing threat of antimicrobial resistance by reducing the need for antibiotics by 22% worldwide—equal to 2.5 billion defined daily doses—every year, said the World Health Organization. It estimated that increasing the use of the vaccines already available, as well as developing new ones, could prevent 515 000 deaths a year by reducing infections, transmission of pathogens, antibiotic use, and evolution of resistant genes. In 2019 around five million people died because of AMR. Last month leaders around the world committed to reducing human deaths from AMR by 10% by 2030.

Pensions

BMA calls for ministers to extend tax deadline

The BMA urged the government to extend the January deadline for doctors affected by the McCloud judgment on age discrimination to determine their tax position, as thousands of doctors had not received their pension statements on time. Without these statements any doctors affected would find it "impossible" to plan their work, said the BMA. This year all doctors affected by the "McCloud remedy" were supposed to have received "remedial pensions savings statements" by the statutory deadline of 6 October. But the BMA said that several pension schemes had failed to meet this deadline.

Repeat prescribing

Guidance aims to reduce errors and waste

GPs in England are being urged to review their repeat prescribing systems to ensure these are safe and efficient, the first such guidance issued for 20 years. The Royal College of General Practitioners and the Royal Pharmaceutical Society launched a toolkit to help GP teams improve their repeat prescribing, working with local community pharmacists. Commissioned by NHS England, the new framework follows concerns about the lack of regular reviews for some users of long term medicines and cases of patient harm arising from inadequate monitoring or review of repeat prescriptions.

MEDICINE

Public health

Doctors call for levy on tobacco industry

Nearly 200 leading doctors, professional bodies, and charities are calling on chancellor Rachel Reeves to use the forthcoming budget to introduce a "polluter pays" levy on the tobacco industry. In an open letter published by *The BMJ* they warn that unless smoking is tackled the Labour government has no prospect of delivering its manifesto commitment to halve the gap in healthy life expectancy between the richest and poorest regions. They argue that investing in a smoke-free UK will improve public finances, citing the £93bn annual cost of smoking to individuals, public services, and the wider UK economy.

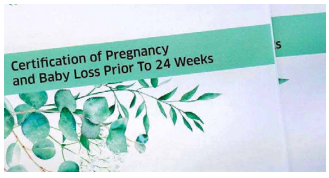
Experts have called for Rachel Reeves to tackle smoking in her budget this month

Ministers are urged to boost public health grant

A group of health experts and organisations urged the government to increase funding for public health in this month's budget. An open letter to the prime minister and the chancellor, written by the Association of Directors of Public Health and signed by 47 organisations including the Faculty of Public Health, the NHS Confederation, and the Royal Society of Medicine, said a £1.4bn increase to restore the public health grant in England to the real terms equivalent of 2015-16 levels per person would help to tackle the "root causes of physical and mental ill health."

Miscarriage

More parents can apply for baby loss certificates



All parents who have lost a baby early in pregnancy will now be able to apply for a certificate formally recognising their loss and their child's life, the government has announced. Baby loss certificates, first launched in February, were available only to parents who had experienced a loss since September 2018; this has now been extended with no backdate.

Research

Peer reviewers receive millions from industry

Over half of US physicians who peer reviewed for *JAMA*, the *New England Journal of Medicine*, the *Lancet*, and *The BMJ* received industry payments from 2020 to 2022, mostly for research, a study found. The 1962 peer reviewers in the study received a total of $64.2m (£49.2m), with a median general payment of $7614. The Toronto University authors said additional research and transparency were needed regarding industry payments.

Patient safety

Investigation into former surgeon widens

The investigation into Yaser Jabbar, a former consultant orthopaedic surgeon, has been widened to five London hospitals where the cases of 721 patients are being reviewed. This includes three private hospitals—St John and St Elizabeth, the Portland, and Cromwell—and Chelsea and Westminster Hospital and Great Ormond Street Hospital, where Jabbar worked from 2017 to 2022. The review so far has found his work to have resulted in harm, lifelong injury, and amputation.

Cite this as: *BMJ* 2024;387:q2256

WAITING TIMES

The waiting list for hospital treatment in England is now **7.64** million, after rising by 18 614 patients in August

[NHS England]

SIXTY SECONDS ON . . .

HEADSPIN HOLE

IS THAT A WHAT3WORDS LOCATION?

No, it's a medical condition that breakdancers are at risk of developing if they do too many headspins. Doctors have warned in the journal *BMJ Case Reports* that repetitive headspin manoeuvres may cause a "headspin hole."

HOLE-Y MOLY

The condition, identified by Danish surgeons, appears as a protruding lump on the scalp, often accompanied by hair loss and tenderness. They treated a man in his early 30s who had enjoyed breakdancing for more than 19 years and who practised headspin moves five times a week for around 1.5 hours a time. During each session direct pressure was applied to the top of his head for up to seven minutes.

ENOUGH TO MAKE YOU DIZZY . . .

The man had developed a "cone shaped" head but only sought medical help when the lump on his head grew larger and his scalp began to feel tender. A magnetic resonance image showed a subgaleal mass measuring 33 cm by 3 cm.

QUITE A LUMP

Indeed. Surgeons managed to remove the lump under general anaesthetic but the surrounding skin tissue remained thickened. There were no obvious signs of cancer, which was confirmed on biopsy.

HOW COMMON IS THIS?

The phenomenon is commonly known in the breakdancing community and is sometimes referred to as a "breakdance bulge." It is, however, scarcely documented in the medical literature. A German study surveyed 106 breakdancers and found that 60% experienced overuse injuries to the scalp. Hair loss was seen in 31% of cases, while 24% of those surveyed reported developing painless head bumps.

ANY OTHER BREAKDANCING RISKS?

Sprains, strains, and tendonitis are particularly common. Head and brain injuries, including subdural haematomas, have also been reported. Prolonged breakdancing often leads to "breakdancer overuse syndrome," which includes various conditions, such as carpal tunnel syndrome and swollen and inflamed tendons, as well as hair loss and scalp irritation.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024387:q2229

“PAs must do only doctor delegated work”

Physician associates must only see patients in general practice who have been triaged by a GP and only undertake work delegated to them, and agreed with, their named GP supervisor, says new guidance from the Royal College of General Practice.

The RCGP’s new scope of practice says a PA can take a history, complete a physical examination, and construct a diagnostic and management plan but that this must be shared with the supervisor either simultaneously or at a “hot review” at the end of the session, if the PA is more experienced.

In August the BMA set out a similar scope of practice for PAs working in general practice but went further by stating that the supervisor’s review should take place before the patient left the practice. If a patient contacts the practice a second time with the same unresolved issue, they must be triaged to a GP, the RCGP guidance stipulates.

The document includes a long list of areas of work and patients that are out of scope for PAs, including patients with suspected mental illness, those with complex multimorbidity, and those who are under 16 years old. PAs must also not be given urgent or routine home or care home visits.

The document says that PAs can be the first point of contact for suspected minor or common conditions such as otitis media, urinary track infections, and sore throat. The seven common minor illnesses in the Pharmacy First programme in England “are a good starting point,” it states.

Extra training

With extra training, PAs can carry out other activities such as giving advice on contraception and sexual health, travel vaccinations, and spirometry tests.

All members of staff must wear clearly visible name badges with their role below their name, the RCGP’s guidance says. PAs must introduce themselves fully to the patient, ensuring that the patient understands who they are and that they are not a doctor.

The guidance aims to offer clarity and support to GPs, ensuring safe and effective practice Kamila Hawthorne

The RCGP said its scope of practice guidance was “couched in deliberately narrow terms” because patients’ safety is paramount and the evidence base for the effectiveness and safety of PAs in general practice in the UK is currently limited.

Although it is not within the RCGP’s remit to enforce the guidance, it may be taken into account by NHS Resolution and medical defence organisations in cases of alleged negligence or clinical or professional mistakes, the college said.

In June this year the RCGP called for an immediate freeze on the recruitment of PAs until their regulation and scope of practice guidance was finalised. In September the college decided to oppose PAs working in general practice completely. It has said that its new scope of practice guidance did not change this policy position but was a recognition that many practices already employed PAs.

BMA calls for extra £40 a patient a year to end GP action

We also need a commitment from the government to negotiate a new contract in partnership with us Katie Bramall-Stainer

The BMA is calling on the government to increase the amount of core funding general practices get for each patient, by 11p to 42p a day, as a “significant first step” towards ending GPs’ collective action. This would mean increasing the weighted payment per patient from £112.50 to £152.50 a year.

In August GPs voted in favour of taking collective action over their contractual terms and because of insufficient funding for general practice.

The demand is contained in a document from the BMA’s General Practitioners Committee for England (GPCE) that says many practices are finding it increasingly difficult to stay viable. More than 2000 general practices have closed since 2010, putting pressure on other practices and risking patients’ safety.

It points out that the additional 4% (£312m) investment the new government made to the national practice contract funding baseline for 2024-25 has raised the funding for essential services by only one penny, from 30 p to 31 p per patient a day.

Protect and build services

The GPCE’s “vision document” also calls for a new GP contract for England that would commit the government to a minimum investment standard that protects and builds neighbourhood services. It also proposes a focus on recruiting and retaining new doctors by using incentive schemes and prioritising areas lacking in GPs. It calls for a commitment to deal with the crumbling estate to meet the growing needs of patients in community settings.

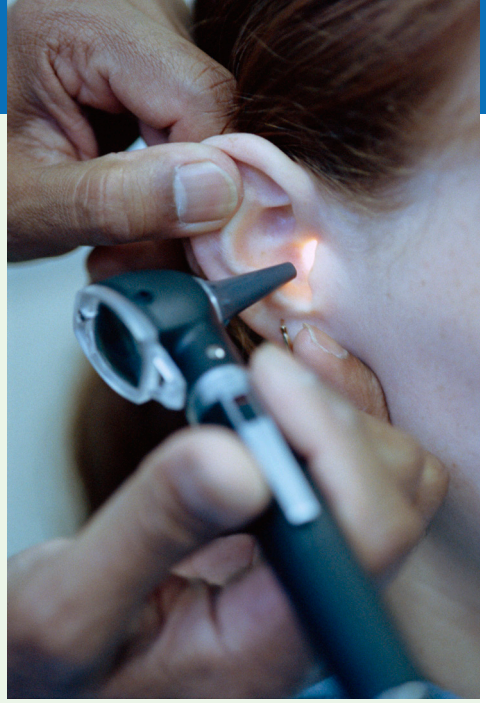
Katie Bramall-Stainer, GPCE chair, said, “An extra 11p per patient per day—that’s £40 a year for each patient—to secure more GPs, more practice nurses, and more appointments would help stabilise our profession and prevent the loss of any more vital local GP surgeries. Doing this would be a significant first step towards us being able to call off collective action.”

She added, “Ultimately, we also need a commitment from the government to negotiate a new contract in partnership with us—one that is fair and supports practices to deliver the care our patients deserve, closer to home in a surgery that is well staffed and safe. The only way that can happen is by working together with us to rebuild general practice in England.”

THIS would mean increasing the weighted payment per patient from £112.50 to £152.50 a year

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;387:q2230



In an email to members the RCGP's president, Kamila Hawthorne, said, "The guidance aims to offer clarity and support to GPs and employers managing these roles, ensuring safe and effective practice where they are in place."

The GMC will begin regulating PAs at the end of this year. However, it has said it will set standards rather than a scope of practice for what they can and cannot do.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;387:q2242

Access to healthcare is much worse for some patients, finds analysis

People from England's most deprived areas are much more likely to say they are waiting for planned care, young black people have longer waits in emergency departments, and women waiting for gynaecological care are now on a vastly increased waiting list, an analysis by the Nuffield Trust and the Health Foundation has found.

The analysis, published by the QualityWatch joint research programme, looked into NHS England waiting times data on emergency care from April 2022 to March 2024, planned care between May 2014 and May 2024, and the latest Office for National Statistics survey asking patients about waits.

The researchers found that black patients were, up to the age of 40, consistently facing longer emergency department waits than other ethnic groups, with black children and young adults up to the age of 19 waiting 21 minutes longer on average than white patients the same age.

Hospital waiting lists for gynaecological care had more than tripled in the past 10 years, from just under 185 000 patients in May 2014 to 597 000 in May 2024. In addition, patient reported figures showed that 21% of people in England's most deprived areas said they had been waiting a year or more for NHS care, nearly double the 12% in the least deprived areas.

Overall, the analysis showed that around a fifth (21%) of people in England were now estimated to be waiting for planned NHS care, equivalent to 9.8 million people.

The analysis suggested possible explanations, such as the large rise in people waiting for care relating to respiratory conditions over the past decade because of covid and the ongoing effects of long covid on related services. The reasons for some disparities are not well understood or easily explained, however, such as the longer A&E waits for young black people.

A Department of Health and Social Care spokesperson said, "This government inherited a broken NHS with waiting lists across the country at record highs, with too many patients facing a postcode lottery and waiting too long to be diagnosed and treated.

"Our 10 year health plan will fundamentally reform the system through three big shifts—from hospital to the community, analogue to digital, and treatment to prevention."

Adrian O'Dowd, London

Cite this as: *BMJ* 2024;387:q2235

LUCY LETBY INQUIRY: Doctor admits to having "a lot of regrets"

A doctor who became close friends with Lucy Letby when they worked together was "misled and maybe manipulated" by the nurse, he told the public inquiry into her crimes.

Named only as Dr U, he was the senior registrar in paediatrics at the Countess of Chester Hospital between September 2015 and September 2016. Letby is serving life in prison after being convicted of murdering seven babies and attempting to murder seven others between June 2015 and June 2016.

Exchange of messages

The Thirlwall inquiry, which is investigating how Letby was able to attack and kill babies for so long, heard that U and Letby exchanged 1355 messages on Facebook Messenger between June and September 2016. U said the nurse was "struggling with her mental health," and he was offering support.

Letby messaged asking for details about the condition of Baby N, who had deteriorated, adding that she "wanted to cry." U replied, "Oh, Lucy, poor little thing. I am sure he has had the best care possible and you will have done everything you could for him." He gave her information about N's condition. Letby was later convicted of attempting to murder him.

U, who is now a consultant, told the inquiry, "I wasn't aware of the full clinical picture, and I provided support by being misled and maybe manipulated, and for that I'm really sorry that things have come to end as they have. I have a lot of regrets about how that period of time took place."

I provided support by being misled and maybe manipulated, and for that I'm really sorry Dr U

The inquiry heard that in December 2016, after the nurse had been transferred to administrative duties, U helped Letby get observational experience in theatre at Alder Hey Hospital.

Earlier, a consultant told the inquiry that doctors raising concerns about Letby were "initially ignored and then later actively bullied and victimised" by senior managers. "I genuinely believed that my job would be at risk if I continued to raise concerns," the consultant said.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2024;387:q2215

COVID INQUIRY: **Ethnic minority doctors felt vulnerable and afraid to raise concerns**

Heather Hallett hears more testimony from doctors and patients about their experiences during the pandemic. **Matthew Limb** and **Jacqui Wise** report

MARK THOMAS

Learning that the first 10 doctors in the UK to die from covid were of ethnic minority origin sent "shockwaves" through this community, a senior consultant psychiatrist told the UK Covid-19 Inquiry on 8 October.

JS Bamrah, a member of the Federation of Ethnic Minority Healthcare Organisations, which was formed during the pandemic, said that covid mortality and morbidity data intensified concerns over longstanding inequalities and the need to mitigate risks.

Voice not being heard

Bamrah said, "It didn't seem as if our voice was being heard, although many of us were trying to shout from the rooftops. We said, 'Look, there's something going on here that shouldn't be happening.'"

The federation wrote to Public Health England expressing concern at analyses of survival rates showing that people from ethnic minority backgrounds were more likely to get severe covid and that those who were infected were more likely to die than people of white British ethnicity. Bamrah said, "We didn't feel enough was being done to give us the tools by which we could look after patients safely."

He described concerns regarding the availability and suitability of personal protective equipment (PPE) and respirators and pulse oximeters not being standardised according to skin colour. The federation warned health officials and the GMC about cases where staff were told that they would be disciplined if they asked for masks, even though without them they couldn't work safely, Bamrah said.

"We know black and ethnic minority doctors and nurses are more likely to be disciplined or sacked or erased from the register," he said. "Fear was there that we had to keep quiet under these circumstances, but there was every attempt to raise these issues with employers as well as higher up."

Bamrah described how one medical consultant who received such a warning caught covid-19 and became very seriously ill and was away for 18 months without contact from the hospital—"the trust completely shut shop on her." She had since returned to work elsewhere in the NHS, despite having long covid, a condition now affecting many staff who were not getting the support from employers that they should, he said.

Pre-existing inequalities linked to racism

Giving evidence on 10 October, Habib Naqvi, chief executive of the NHS Race and Health Observatory, said that higher rates of covid infection and mortality among ethnic minority healthcare workers than among their white colleagues should be viewed in the context of pre-existing inequalities caused by structural racism.

The Office of National Statistics concluded that a large proportion of the excess mortality risk in ethnic minority groups could be accounted for by factors such as living arrangements, comorbidities, and working in frontline care. But Naqvi added that it was important to look at the "causes of the causes of the inequalities." He asked, "Why is it that ethnic minority staff are more likely to find themselves on the frontline and less likely to find themselves in managerial positions?"

Naqvi added that tackling pre-existing inequalities must be continuous and not reactive or temporary, so that the UK was "not on the back foot" when it came to future pandemics.

Discussing the first rapid review that the Race and Health Observatory carried out into pulse oximetry and the potential for inaccurate readings in patients with darker skins, Naqvi said, "There's a fundamental point here with regards to representation or lack of representation in clinical trials. Where there is a lack of representation we often get products or devices that may not be suitable for the diverse population that we're here to serve."

Distressing experiences in maternity

On 7 October witnesses described upsetting experiences among patients undergoing antenatal and maternity care in hospitals during the early stages of the pandemic, highlighting sometimes inadequate communication and difficulties with how hospitals applied covid restrictions.

In April 2020 Tamsin Mullen gave birth to twin boys prematurely, at 34 weeks, by caesarean section. They spent 31 days in a neonatal intensive care unit before being discharged home.

Mullen said a change in rules in March 2020 meant her husband, who had initially come with her to scanning appointments, had to wait outside. This left him feeling "distressed" and "excluded," while she herself was "very nervous" because of the "high risk" nature of the pregnancy, as she had a pre-eclampsia diagnosis.

After the birth she was taken to a side room where she was on her own for 27 hours. Only one parent at a time could be with newborn babies, even after they had been moved to a single room away from other babies.

Mullen, who was giving evidence on behalf of 13 pregnancy, baby, and parent organisations, said she questioned the

AFTER the birth she was taken to a side room where she was on her own for 27 hours

policy with hospital staff. "The nurses said they didn't understand it either; the matron's hands were tied because the rules came from higher up," she said. "We didn't feel like we were being treated like parents. It was more like we were visitors. We didn't feel like a mother and father to the children the way we should have done."

Hard discussions over DNACPRs

Charlotte Summers, professor of intensive care medicine at Cambridge University, told the inquiry, "One of the most extraordinarily difficult parts of ICU care in the pandemic was that relatives had not seen how the patient had deteriorated."

Giving evidence on 9 October, Summers said discussions about "do not attempt cardiopulmonary resuscitation" (DNACPR) orders often had to take place over Zoom, making them very difficult, because conversations were "remote and disconnected."

Heather Hallett, chair of the inquiry, said it had heard from a large number of bereaved families that they were not consulted about a DNACPR notice on their loved ones' records.

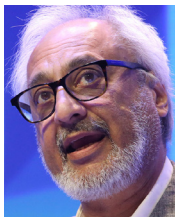
Ganesh Suntharalingam, president of the Intensive Care Society, said that in a critical care situation where the medical staff were used to having such discussions such an occurrence would be very unusual. But he acknowledged that it could happen in different settings where there may be fewer people looking after a larger number of patients.

On 10 October the former president of Resuscitation Council UK, Jonathan Wyllie, told the inquiry he had heard of one NHS trust implementing a blanket do not resuscitate order but had not seen the document itself. He said his charity had then released a very clear public statement that blanket DNACPR orders were not appropriate and should not be implemented.

He added that DNACPR notices should ideally be part of a wider conversation about advance care planning, through use of the ReSPECT form process, which creates personalised recommendations for a person's clinical care and treatment in a future emergency. Training in talking about DNACPR planning should be embedded in medical and nursing training, he added.

Matthew Limb, Jacqui Wise

Cite this as: *BMJ* 2024;387:q2247



Fear was there that we had to keep quiet, but there was every attempt to raise these issues
JS Bamrah

Why is it that ethnic minority staff are more likely to find themselves on the frontline?
Habib Naqvi

A large number of bereaved families were not consulted about a DNACPR notice
Heather Hallett

Benefit and housing requests are overwhelming GPs, royal college warns

The Department for Work and Pensions and housing associations are piling administrative pressure on general practices with paperwork requests that are diverting doctors from care, GPs have told *The BMJ*.

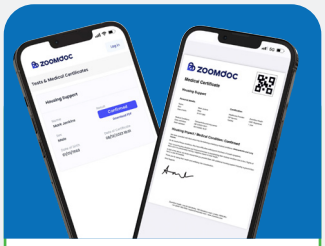
In a poll of 2190 UK doctors by the Royal College of General Practitioners, 648 (30%) said they spent between 11% and 30% of their time on tasks not directly related to patient care, including requests relating to housing applications and benefits. Results of the survey, which analysed GPs' time use between 13 May and 10 June 2024, were shared exclusively with *The BMJ*.

RCGP chair Kamila Hawthorne said that GPs "always take a holistic approach" and consider social factors that might be affecting their patients' health such as housing, disability status, and benefits. "However, with GP time so stretched, it's important this administrative side doesn't impact on the time GPs spend delivering care," she said.

Mark Green, a GP in Berkshire, raised the issue in a recent post on X. "This stock phrase seems to be everywhere in the NHS," he wrote. "If you have any problems, go see your GP. Had an operation? See your GP. Social issue? Go see your GP."

Green told *The BMJ* that his clinical capacity was being squeezed by DWP requests to fill in forms for disability benefits. "Often there is very limited information we can supply from patients' notes," he said. "It's clear I'm not the right person to be completing these forms unless it is a patient I know particularly well."

Green said he also receives letter requests from housing associations, "for things like whether the patient needs a walk-in shower or a stairlift or other living aids," that should be dealt with by social services or occupational therapists.



In the RCGP poll 648 (30%) of GPs aid they spent between 11% and 30% of their time on tasks not directly related to patient care, including requests relating to housing applications and benefits

Health related benefits

Recent analysis by the Institute for Fiscal Studies think tank found a sharp rise in the number of working age people in England and Wales receiving health related benefits. The turnover and vacancy rate for occupational therapists is high, with some areas reporting rates as high as 40%. There is also a shortage of social workers, with 18.9% of posts vacant across the UK. NHS England's occupational therapy page instructs patients to request a referral from their GP to access a therapist.

A GP who took early retirement in 2023 because of "unsustainable" workloads at her Medway surgery and who did not want to be identified said patients would book appointments to ask her to write letters to housing associations or private landlords about mould in their homes and about drug dealers trying to recruit children to county line gangs.

"These are not medical issues at all, and other than stating what patients told us and requesting assistance, we cannot do much, and all this takes time away from our job as GPs," she added.

The DWP said it sends requests for further medical evidence to support benefit claims directly to general practices. But it added it was committed to its "red tape challenge," which "will help clamp down on bureaucracy, so GPs are freed up to deliver more appointments."

Sally Howard, London

Cite this as: *BMJ* 2024;387:q2233

THE BIG PICTURE

Wildfires suffocate a continent

As huge tracts of South America are blanketed in smoke, often originating from deliberately laid fires, the residents of Porto Velho in the Brazilian Amazon have barely seen the sun since these toxic plumes were captured in August.

The fires, which are still burning and which have devastated forests across the continent, including in Peru, Bolivia, Ecuador, and Paraguay, are said by experts to be a result of the annual "burning season," in which swathes of rainforest are cleared for development, combined with the worst drought in 40 years, linked to El Niño and the effects of climate change.

A Brazilian think tank, the Igarapé Institute, reported that last month more than 50 000 wildfires raged in the country, while MapBiomas, a fire monitoring site, said about 30 million acres were destroyed there between January and August.

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EVARISTO SA/AFP/GETTY

EDITORIAL

Reverse the benefit cap to tackle poor child health

Labour must act on its commitment to reduce child poverty

Poverty is a disaster for children's health.[1] It causes poor child health outcomes and worsening physical and mental health. It undermines children's learning, social wellbeing, and education. And it risks lower adult productivity and lifelong health.[2]

Rising child poverty, coupled with cuts to services that support children and families under the banner of austerity, have contributed to worrying trends in UK child health over recent years across key outcomes.[1] Life expectancy at birth has stalled: between 2015 and 2020, the life expectancy inequality gap grew from 9.4 to 9.7 years for male children and from 7.4 to 7.9 years for female.[3] Infant mortality rates have increased, with stubborn inequalities between the most and least deprived local authorities.[4] Inequalities in child obesity have widened across all age and sex groups.[5]

Recognising the health damaging effects of child poverty, the government has set up a child poverty task force.[6] To date, the policy debate has focused on the two child benefit cap, which limits financial support for families to their first two children. Families receive no additional support for a third or subsequent child born after 5 April 2017. When fully implemented, the policy will extend to an estimated 1 in 10 families with children, and one in five children.[7]

There is no single fix for child poverty. The two child limit and the benefit cap, which limits the total amount that a family can claim,[10] interact in complicated ways. If the benefit cap remained while the two child limit was lifted, not all families would benefit. Nevertheless, lifting the two child limit is a necessary first step in a broader child poverty strategy. It would lift an estimated 300 000 children out of poverty and reduce the severity of poverty for 700 000 more for an annual cost of £1.7bn,[11] equivalent to around 0.001% of government spending.[12] Easing financial hardship for millions of families would alleviate the conditions that cause poor health and the public health problems that hold back our economy.

Easing financial hardship for millions of families would alleviate the conditions that cause poor health

Over 4.3 million children (30%) are living in relative poverty after housing costs.[13] Almost half of children from ethnic minority groups grow up in poverty.[1 14] Families with more than two children and with disabled family members are disproportionately affected.[13] High levels of child poverty explain why child health is worse in the UK than in comparator countries. The UK has fallen behind other countries in the Organisation for Economic Cooperation and Development, coming in at 27th out of 38 for child health and wellbeing overall, and continues to slip down international rankings on many child health metrics.[15]

The psychological and social burdens of poverty are widespread and long lasting. Poor children suffer the stigma of poverty and higher levels of childhood adversity leading to anxieties, low self-esteem, sadness, and loneliness, which are devastating for lifelong wellbeing.[18 19]

A clear path

We know how to tackle child poverty.[20] It starts with adequate income support for families through the welfare system, which can rapidly reduce child poverty levels and boost children's health.[21] Relative child poverty decreased by around five percentage points during a period of concerted action to "end poverty" between 2000 and 2010. Policy actions included the introduction of child tax credits and increases in child benefit, alongside the establishment of Sure Start (an initiative that provided integrated services such as early childhood education, childcare, health advice, and family support). The strategy was a success. Costing an estimated £20bn, it led to a reduction in inequalities in life expectancy and infant mortality.[22] Unfortunately, these hard won health gains were reversed as austerity measures kicked in after 2010, and child poverty began to rise again. The £20 a week increase in universal credit during the pandemic temporarily lifted children out of poverty but was scrapped in October 2021, as the cost-of-living crisis escalated.[23]

Ambitious social transformation requires that children grow up healthy and achieve their potential. Reducing child poverty is vital for long term productivity. It also contributes to safer communities by tackling the root causes of crime.[24] Promoting fairness and opportunity for all requires poverty reduction to ensure that every child, regardless of their background, can contribute to the UK's future success.[2] The path forward is clear. It has been mapped out in numerous health inequalities reports: we must tackle child poverty by increasing welfare support for children, reinvesting in preventive services that support families, and developing a national strategy to address health inequalities.[2] The government task force should urgently implement the policies we know work—starting with reversal of the two child benefit cap.

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EDITORIAL

Children's right to oral health

A focus on rights can help improve dental care globally

Oral diseases are a leading contributor to the overall burden of non-communicable diseases, reflecting a global crisis in oral health. Around two billion adults and children have untreated carious lesions in their permanent teeth, while 514 million children have untreated carious lesions in their primary teeth.[1]

Dental caries is largely preventable,[2] and although population level (upstream) policies can help reduce prevalence, an inappropriate focus on individual oral care remains.[3 4] This individualised approach overburdens health systems, as exemplified by the oral health crisis in the UK.[5]

Dental professionals have called for reform of the oral health system with a clear emphasis on preventive, population level policies.[3-7] The right to oral health, particularly every child's right to oral health, creates an imperative for policy makers to design and implement such policies.

The World Health Organization's global strategy and action plan on oral health 2023-2030 recognises oral health as a fundamental right."[8] The vision of this strategy centres on universal coverage by 2030—meaning access to quality health services that respond to people's needs and that they can use "without suffering financial hardship."[8] Additionally, the WHO strategy recognises the need for "upstream interventions . . . to strengthen the prevention of oral diseases and reduce oral health inequalities."[8]

Upstream policies are particularly important in preventing the most common oral disease, dental caries, as it is driven primarily by sugar consumption and the associated commercial and social determinants.[2] A clear focus on children is also critical,[9] as childhood caries has serious consequences for oral health in later life, largely because of the persistence of childhood sociobehavioural factors such as dietary patterns.[10 11] This requires a broader approach to children's oral health based on children's rights stipulated in the UN Convention on the Rights of the Child, which is legally binding on virtually all states.[9 12]

Better oral health is associated with better general health during childhood and in later life

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Rights based approach

The right to health[12 13]—which includes oral health—is defined broadly by the UN and others.[14-16] It goes beyond universal health coverage and includes "facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health."[16]

It additionally covers "a right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants of health."[14]

An approach to oral health based on children's rights tackles the root causes of oral disease with preventive policies such as those targeting the availability and accessibility of dietary sugars and oral hygiene.[15] It also emphasises a life course approach, including (preventive) measures targeting children,[14] given the intergenerational and intragenerational effects of poor oral health in childhood.[10 11] Finally, in response to disadvantaged groups being affected disproportionately,[6] a focus on child rights offers a framework to inform the development and implementation of more equitable policies.[14]

WHO's recognition of the right to oral health is a welcome first step towards better oral health for all children globally. But a rights based approach to implementing the WHO strategy in national settings[9] would provide important additional benefits for all relevant actors—including policy makers, clinicians, and patients—and should be prioritised. A rights based framework would help target limited health budgets more efficiently, as studies suggest that preventive population level policies are associated with substantial cost savings for health systems, including the NHS.[17] It would also benefit clinicians by reducing the treatment burden on overstretched services such as emergency departments.[17 18]

Policies that uphold every child's right to oral health benefit patients directly but also have a broader societal impact. Better oral health is associated with better general health during childhood and in later life. Moreover, as poor oral health in childhood is associated with missed school days and poorer educational outcomes,[2 19] effective policy making in this area can help reduce educational inequality.

Finally, a rights based approach to reform of oral health systems would contribute to the fulfilment of other related rights such as the rights to (general) health, education, and rights related to children's development and wellbeing throughout the lifespan. This approach should underpin all national and international efforts to improve the oral health of children.

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VACCINATION

How covid, influenza, and other seasonal vaccine programmes are changing

Chris Baraniuk reports on what we can expect this coming winter and beyond after a summer wave of covid and a rise in other respiratory illnesses

As summer faded this September, staff at a general practice in Hampshire, England, activated a computer program—as they do every year. It will scour patients' medical records and send those who are eligible for a seasonal flu or covid-19 vaccine a text message, inviting them to make an appointment.

"We're bracing ourselves for it, as ever," says Neil Bhatia, one of the GP partners. By July, the doses have already been ordered, and drug companies are shipping boxes of vaccines around the country. Every winter, hospitals fill up with older people with flu, says Bhatia, describing the purpose of the autumn vaccine drive. "It's desperately important."

The World Health Organization (WHO) has announced its recommendations for the southern hemisphere 2025 flu season vaccines, roughly a year in advance of when they'll be administered.

But the concept of winter or "seasonal" vaccine programmes is changing. The arrival of covid vaccines in 2021 brought the possibility that these medicines could become part of a recurring drive to immunise people on a large scale every autumn, as has been the case with flu vaccines in many countries for decades (the first UK seasonal flu jab for over 65s was introduced in 2000). This year, the UK and US will also offer vaccines against respiratory syncytial virus (RSV). And with H5N1 influenza causing concern, vaccines against it might become part of seasonal immunisation one day.

Changing landscape

The world has changed since covid-19 emerged, says Ann Lindstrand, unit head of the essential programme on immunisation at WHO. The SARS-CoV-2 virus that caused millions of deaths and flung the world into chaos remains slippery: new variants keep emerging, and outbreaks in many countries this summer have made headlines. In the US state of Arizona, a 37% spike in cases in July prompted a unplanned vaccine programme.

An annual vaccine for rhinoviruses and coronaviruses would be a boon
Neil Bhatia

The appetite for covid vaccination in Africa is very low right now
Ann Lindstrand

Lindstrand expects that the situation will stabilise into a seasonal pattern like influenza. In a blog, Erik Topol, a cardiologist and professor at the Scripps Research Institute in the US, says that we already "have two major waves each year and, for high risk individuals, semi-annual (every 6 months) shots will be needed for protection." Christina Pagel, professor of operational research at UCL, London, told Yahoo News that it was already more like an "all-year-round" virus.

Decisions over how and when to administer flu, covid-19, or RSV vaccines vary across WHO regions. And, officially, WHO does not yet have a recommendation for seasonal covid-19 vaccination. Even flu jabs are not deemed essential. "It's not a strong level of recommendation," notes Lindstrand. Countries must weigh up the substantial cost of such programmes and whether immunising against flu and covid-19 is a priority.

"I was recently in a regional meeting in Africa, and the appetite for covid vaccination at this point in time is very low," says Lindstrand. African countries might be more interested in malaria or human papillomavirus programmes, she says.

New and returning patterns

Covid lockdowns greatly affected the annual pattern of disease incidence for infections such as flu and RSV, but those patterns have largely returned, meaning that winter vaccination programmes can help keep people out of hospital—especially in parts of the world that experience harsh winters. In the past five years, data have shown the significant disease burden of RSV, according to Lindstrand, which is partly why a vaccine against it is now offered in some countries.

Since 1 September, adults aged 75 or older and pregnant women were eligible for an RSV jab in the UK. This won't be a vaccine that people receive annually—one jab is all most people will ever need—but the rollout will roughly coincide with the annual flu and covid-19 vaccine programme. Those jabs, in contrast, are offered year after year due to waning immunity and changes in the specific viruses that are circulating.

The exact types of flu targeted by the vaccine are chosen each spring, depending on which strains are expected to be dominant in the coming winter period. Flu jabs used this year will be trivalent, targeting three strains of the virus—B/ Yamagata has not circulated since March 2020 and has been dropped.

Some experts are concerned about the UK's approach to covid vaccination. Official advice not to offer boosters to unpaid carers or household contacts of immunosuppressed people has been criticised by Sheena Cruickshank, professor in biomedical sciences at Manchester University, writing in the research news website the Conversation. She also called the decision to use vaccine doses left over from autumn 2023 in this year's drive "enormously frustrating," saying that covid has evolved and that these doses could be noticeably less effective.

In the US this year, covid-19 and flu vaccines will be available at healthcare

facilities from the autumn. Everyone aged 6 months or older (with some rare exceptions) is eligible to receive these jabs, according to the US Centers for Disease Control and Prevention. Some people received an RSV vaccine in the US last year, but those who didn't and who are eligible for it will be able to receive one this year.

Pharmacies are an important resource in vaccine rollouts in many European countries and the US, "because of the accessibility of pharmacies—longer hours, weekend hours, potentially no appointment [required]," says Mary Hayney, professor of pharmacy at the University of Wisconsin. "We can prevent a lot more hospital admissions with these additional vaccines," she adds.

The European Centre for Disease Prevention and Control recommends that vulnerable and at-risk people get a flu or covid-19 jab this autumn. The advice currently remains the same as last year on that front. "Depending on the epidemiological situation, updated advice might be issued in upcoming months, also for RSV," a spokesperson says.

One country approaching the end of its winter vaccination programme is South Africa, in the southern hemisphere. Health authorities there have emphasised the importance of people coming forward for flu jabs, specifically.

New vaccine tech

Cell based flu jabs—grown in the laboratory in cell cultures rather than the traditional way, in chicken eggs—will be available in Australia for the first time this year. Such vaccines should have fewer mutations than those grown in eggs, potentially making them more effective. Cell based flu vaccines have previously been offered in the UK and US.

Japan usually offers annual flu jabs, but in 2024 its free covid-19 vaccination programme will end, and the government will cover perhaps only part of the cost of vaccinating people aged 65 and over as well as those who are particularly at risk of severe disease. South Korea intends to secure more than seven million doses of covid-19 vaccine, to be given to high risk groups this autumn and winter.

Currently, no countries are planning to include an H5N1 jab as part of widespread seasonal vaccination rollouts, but Japan will reportedly begin stockpiling these vaccines ahead of any potential pandemic. Earlier this year, Finland became the first country in the world to offer pre-emptive H5N1 jabs to human poultry workers.

The accessibility of pharmacies—longer hours, potentially no appointment--makes them important for rollouts
Mary Hayney

For high risk individuals, semi-annual shots will be needed Erik Topol

Covid is already acting like an all year round virus
Christina Pagel

New vaccine strategies

Covid and flu immunisations are generally given as separate injections—often at the same time, with the patient usually receiving one jab in each arm. This practice of co-administration was found to be safe in a study published in 2023.

"We were quite happy that we saw there is no problem with reactogenicity compared to a single covid vaccination," says coauthor Manuel Krone of the University Hospital of Würzburg. He notes that, although covid-19 has evolved since most people received their jabs in 2021 and 2022, research he and his colleagues are undertaking suggest these people still have good immune responses against the viruses. That seems to be thanks to both vaccines and previous infections, he notes. This work is yet to be published.

mRNA makes 2-in-1

Two-in-one or combined covid and flu vaccinations are in development. Moderna is testing an mRNA version, as is Pfizer and BioNTech. "What a great idea," says Hayney. Lindstrand agrees, though Bhatia points out a minority of people might resist vaccination altogether if only a combined jab is available and the person in question is uncomfortable with receiving one of the two doses on offer.

One advantage of mRNA vaccines is that they can be produced very quickly. As seasonal vaccinations become more numerous, the rate of production matters. "What would take weeks to months with conventional technology, with mRNA can be done in two hours," explains Zoltán Kis at Sheffield University, who studies vaccine manufacturing technology. There are still challenges in that the mRNA molecule is fragile, he adds, and it can be more expensive to make as it requires purified raw materials.

Vaccines tend to be produced in batches, says Kis, which helps regulators link any problems to their production. But continuous production could vastly speed up manufacturing. By recording the exact time the vaccine was made, and quantifying the raw materials that went into it, continuous production could meet regulatory requirements, he argues. Equipment used in the process would, then, almost never be idle. "What we see is that continuous [production] normally is around six to eightfold as productive," says Kis. This approach might help manufacturers rapidly roll out jabs in future pandemics while maintaining seasonal capacity as well, he adds.

In the coming years, other diseases might be targeted by seasonal programmes. Hayney says human metapneumovirus, another respiratory infection, is one example. It causes cold-like symptoms and can lead to hospital admissions for some people.

An annual vaccine for the "common cold"—targeting various rhinoviruses and coronaviruses behind these often mild infections—would be a boon, says Bhatia. "My goodness, that would save vast hours of consultation time in general practice."

Reflecting on the rise of various vaccines in the 2020s and looking ahead to the coming winter, Bhatia acknowledges that annual programmes have changed drastically in just a few years. "There was a time when there wasn't much but now there is," he says. "That's science for you. It's great."

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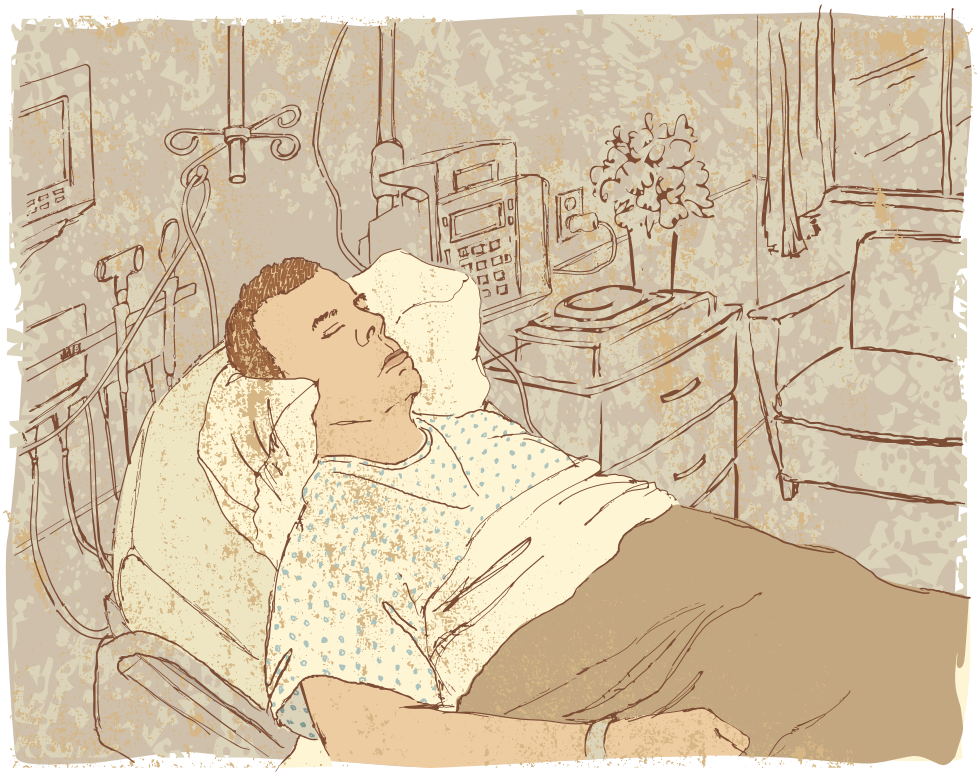
HEALTHCARE FOR DOCTORS

What's it like to be a patient as a doctor?

Being the person needing care can feel alien to many medics and can bring unique challenges. **Jo Best** reports



The notion of a sick doctor is conceptually, in some ways, a contradiction in terms
Robert Klitzman

For many doctors who start their medical careers as young, fit, healthy people, it can feel as though there's an abyss between them and their patients. Doctors are the well; patients are the unwell. For most doctors, however, there will come a moment of crossing the Rubicon, from being a medical professional to being a patient.

But the nature of doctors' work can make them reluctant patients—medical knowledge can predispose doctors to self-treat, for example—while long hours make it hard for them to attend medical appointments, and understaffing of health services can put pressure on doctors not to call in sick.

Contradiction in terms

"Doctors often delay seeking treatment. They will try to diagnose themselves, and they treat themselves," says Robert Klitzman, psychiatrist and author of *When Doctors Become Patients*. As doctors progress through their careers there's a change in their attitude towards seeking healthcare, he tells *The BMJ*. Whereas, anecdotally, medical students often attribute their own minor symptoms to the serious diseases they've learnt about, Klitzman notes that more experienced doctors tend to downplay the severity of their symptoms and under-diagnose conditions in themselves.

Research also suggests that a sense of embarrassment can act as a barrier to doctors seeking healthcare. While they may experience the same embarrassment around symptoms as any other patient, their job can add other layers of discomfiture. They may have concerns that the treating doctor will think that they're over-reacting or that they'll be shown up if their own diagnosis of their symptoms is wrong. Doctors may worry that they're imposing on a fellow medic's time—or that there's simply something inherently embarrassing about being a doctor who becomes a patient.

Klitzman explains, "Some doctors say they wear a magic white coat when they go to work: even though they may not be feeling great they have to be there for the patients. As physicians we're trained to think that illness is over there, and we're over here. The notion of a sick doctor is conceptually, in some ways, a contradiction in terms."

The same mental scaffolding that doctors use to keep themselves strong in the face of the difficulties of their job can also pose a challenge

A REGULATOR'S VIEW

The General Medical Council's *Good Medical Practice* sets out a doctor's professional obligations—including taking care of their own health. The guidance advises doctors, "Take care of your own health and wellbeing needs, recognising and taking appropriate action if you may not be fit to work."

Good Medical Practice also advises against doctor-patients being treated by close colleagues. It says, "You should avoid seeking medical care from a family member or anyone you work closely with. If you are registered with a general practitioner this should be someone outside your family and your workplace."

when they have to face up to the possibility of being unwell. Clare Gerada, former president of the Royal College of General Practitioners and founder of the Practitioner Health programme, tells *The BMJ*, "Part of the identity of the doctor is not accepting vulnerability, working when you're tired, going without sleep and without food. But it's also about patients being on the other side of the consulting room and the idea that 'I can't possibly get ill.'

"That actually protects us from the vicissitudes of medicine, which are pretty tough. You develop psychological defences so that you don't break down if you have to see a baby that's dead or have to break bad news. But the flip side of this is the denial of vulnerability, which makes it very difficult to take on the patient role."

Doctors who become patients are forced to reimagine their role in medical settings—going from running wards to being a fixture on them, subject to the same indignities and frustrations as any other patient. Anisha Patel, a GP who had stage III bowel cancer diagnosed at age 39, describes the hardest part of her experience as being the loss of control that came with becoming a patient.

"Being a doctor is definitely a double edged sword when you're a patient," she tells *The BMJ*. "In health settings, as a doctor, you're trying to be in control of the situation, but when you're a patient, you haven't got that control anymore. You're very much in the hands of other people, and you're helpless. Although people think that as a doctor you know what's coming next, you just don't—you can't prepare yourself for what it's like to actually go through it."

Care from colleagues

Being a doctor comes not only with medical knowledge but also with access to other physicians and resources that most non-doctors would envy. Doctors, for example, can more easily call on specialist colleagues for a quick discussion of their symptoms. However, such

corridor consultations can be risky. Gerada says, "You often see this in hospital practice—a doctor popping in on a cardiologist to say, 'Oh, by the way, I've got chest pain.' But it means that those doctors aren't put onto the computer record, so they don't get a follow-up, they're not having the proper investigations, and so they're ending up with worse care rather than better."

Hospital doctors who need a secondary care follow-up can face the dilemma of whether to be seen in their own workplace or elsewhere. Research suggests that doctors who choose to be treated in their own hospital are afforded "VIP status"—tests are expedited, clinic appointment waiting times are cut—as colleagues try to get a fellow doctor to be seen as quickly as possible. But at the same time there can be concerns about confidentiality: information about their condition can be spread to other colleagues, whether involved in their care or not.

Liz O'Riordan, a breast surgeon, says that she wanted to be treated in her local hospital for her breast cancer but it came at the cost of a friendship. "I wanted to stay local because it meant I didn't have to travel and my husband could come to my clinic appointments," says O'Riordan, who had the condition diagnosed in 2015. "I'd worked in the hospital, I trusted the team, but I had to agree to stop being friends with my consultant. I lost a close friend so that she could treat me. It's hard treating people you know well, because there are emotions at stake."

The denial of vulnerability makes it very difficult to take on the patient role
Clare Gerada

You can't prepare yourself for what it's like to actually go through it
Anisha Patel

Treating a doctor-patient

During her work as a breast surgeon O'Riordan saw and treated many of her fellow healthcare professionals. She says, "With treating staff, especially when they're doctors, you assume they know things, and you don't give them your usual patter.

"What I learnt to do over the years was to say, 'Right, I know you have some medical knowledge, but I'm going to treat you like any other patient—otherwise I'll forget things, I'll make mistakes, and you've not had this before.'

"I learnt to say, 'I don't want to patronise you, but I'm going to treat you like I normally would, and then if you want extra information, we can do that at the end.' That was my way of making sure that they got the right care, because they were a patient when they were in that room, not a doctor or a nurse."

While doctors caring for other doctors will aim to treat them just like any other patient, Graham Easton, honorary professor of communication skills at Queen Mary University of London and a former GP, says that such consultations can be uniquely uncomfortable both for the treating clinician and for their patient.

Easton suggests that one way to help overcome that unease is to recognise the exceptional nature of doctor-to-doctor consultations. "I think a good approach is to articulate the challenges up front: acknowledge that the patient who's coming in is a doctor," he says. "Do the normal things you'd do for any patient, but almost do them in an enhanced way—for example, exploring the patient's agenda early on, which I think becomes especially important here."

Doctors are likely to have considered their diagnosis before arranging an appointment and may already have particular investigations or management in mind. If the treating doctor and the doctor-patient's ideas of how to progress don't match up, it can create friction.

Easton says, "If there's an awkward moment I'd say something like, 'I know you came in thinking this or hoping for that, and I'm obviously very keen, as far as possible, to give you what you want. However, it's a bit tricky at the moment because, having assessed you and gone through the history, I think we need to go down a different route.'

"You need to spell out your rationale in an evidence based way and acknowledge that it's different from what they've asked for, in a calm and assertive way. Don't be manipulated and pushed into doing anything you wouldn't normally do."

There's a temptation for doctors treating fellow doctors to assume that they already have the knowledge to completely understand their diagnosis. Rather than walk the patient through the physiology, investigations, management, and prognosis—as they would a non-doctor patient—doctors treating other doctors may inadvertently breeze through a consultation with, "I know that you know this already."

Many doctor-patients often do know it already—but the consensus is they still need the same information as any other patient, the same time to process any bad news, and the same chances to ask questions.

Patel found that her medical background led her medical team to assume that she'd want to be more involved in treatment decisions than another patient might. "What we're meant to do for patients is to gather ideas and talk about all the options available, but I was almost given too much choice—and that made it more scary," she recalls.

My consultant stayed in the anteroom and held my hand until I went under Liz O'Riordan

"I really wanted someone else to make that decision for me because the surgeons, the oncologists, they're the experts.

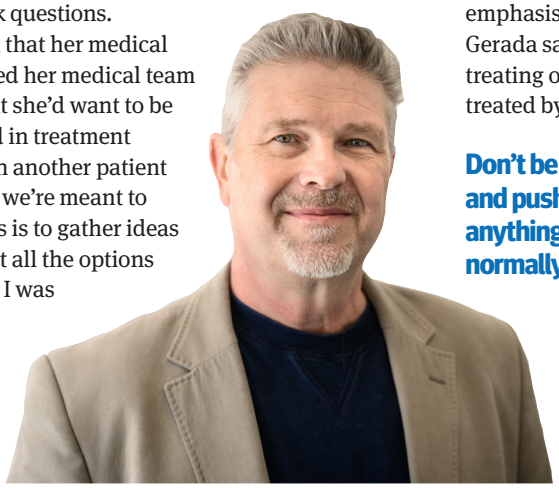
"I wanted to say, 'You choose what's best for me, I have every faith in you. I trust you to make that right decision.' I wanted to be cared for as a patient. Being a doctor was irrelevant to me: as soon as I went on sick leave it was by the by."

From her time as a patient, Patel now individualises how she communicates with other medics. "What I've learnt from this is to ask a health professional how they'd prefer to be spoken to," she says.

For doctors, learning how to communicate with other doctors is a skill they learn on the job. Typically, treating doctor-patients is a job led by the more senior clinicians as a courtesy to their fellow professional, meaning their younger colleagues may not have a chance to observe or partake in consultations with doctor-patients later in their careers.

While modern medical schools emphasise communication skills, Gerada says that how to approach treating other doctors—and being treated by them—is rarely covered.

Don't be manipulated and pushed into doing anything you wouldn't normally do Graham Easton



"I think it has to be part of the curriculum, and it has to be part of the training of doctors," she says. "It's a skill."

Doctors who have spent time on the other side of the doctor-patient divide can find that it leaves subtle imprints on their practice. Medics with first person experience of the difficulties of being a patient often develop a greater practical understanding of what their own patients are going through and what they may be thinking.

Seeing the patient perspective

Patel describes gaining new insights into patients who are rude or angry in consultations—for example, that rudeness can be a symptom of fear. She tells *The BMJ*, "When I was irritable at home, it was because I felt so ill or because there was that worry about uncertainty. Now I can have those conversations with patients: 'I can see that you're really angry, and I'm sure that losing control of this aspect of your life has made you feel like this.' Then suddenly you'll get cathartic tears from them."

O'Riordan recounts how her own experience of having surgery affected how she approached operating on her patients. She recalls that before her own surgery she was terrified of having an anaesthetic, and she remembers her consultant's support during the process.

"My consultant stayed in the anteroom and held my hand until I went under," she says. "I thought, 'I can't remember whether she does this for everybody or just for me, because I'm normally in the coffee room waiting to be called through.'

"When I went back to work for a year between my first two diagnoses I stayed with patients while they went to sleep, and the ODP [operating department practitioner] gave me a talking to, saying, 'What are you doing—that's my job.' And I said, 'No, I'm the one in charge, and I want the patient to know that I've got their back.'"

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