comment

"We can help older patients to make their own treatment decisions" **SCARLETT McNALLY**
"Identifying children needing hospital care can't be done by algorithm" **HELEN SALISBURY**
PLUS Trump and disinformation; future of OB/GYN in the US

TAKING STOCK Rammya Mathew

GPs have to be able to request MRI scans

At a recent clinical meeting, I heard that GPs local to me are about to lose the ability to request magnetic resonance imaging (MRI) scans for patients presenting with musculoskeletal symptoms. We're instead advised to refer our patients to a musculoskeletal clinical assessment and triage service (CATS)—staffed largely by advanced practitioners, who will assess our patients and determine whether imaging is warranted.

The hope is that fewer patients will have unnecessary imaging and that this will reduce the potential harms of overdiagnosis. Radiologists rarely report musculoskeletal MRI scans as entirely normal, and it can be hard to know what to do with abnormal findings. More often than not, patients with abnormal scans are referred to orthopaedic teams, even though there may not necessarily be a surgical target.

At a population level, this is problematic on two fronts. First, MRI scans are expensive and need to be used judiciously. Second, elective orthopaedic services are under tremendous pressure, with some of the longest waiting times in the NHS. So, any effort to reduce waste and streamline referrals makes a lot of sense.

On the flip side, it can be extremely challenging to help patients with chronic pain symptoms effectively in primary care if they haven't had imaging. Many patients strongly believe that, without imaging, a serious diagnosis and/or the need for surgery can't be ruled out. I've had patients consult with CATS and then come back to me saying that "nothing" was done—but what they really mean is that they had no advanced imaging. Without an MRI the patient feels as though there was no intervention by the clinician; they feel unheard and fail to engage in physiotherapy or self-management, and their symptoms continue to deteriorate.

My experience is that many of these patients continue to re-present in primary care, and some even attend the emergency department repeatedly out of sheer desperation. Patients can be bouncing around the system, and this too has a cost—not only a direct cost to the healthcare system but often also a wider economic cost related to worklessness.

The work we do in general practice is seldom black and white: it's about using the evidence, but it's also about working alongside our patients' health beliefs, which are rarely modifiable. GPs may not be specialists in musculoskeletal medicine, but we're the only clinicians who take accountability for the longitudinal care of patients with chronic pain, and ultimately we're experts in the whole person. So, although I agree with the rationalisation of imaging, I also believe it has to be within the gift of GPs to decide what's best for their patients in the wider context of their symptoms.

Rammya Mathew, GP, London
rammya.mathew@nhs.net
X @RammyaMathew

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GPs are the only clinicians who take accountability for the longitudinal care of patients

OPINION Martin McKee and colleagues

Disinformation enabled Trump and is a crisis for all democracies

Fake news has far reaching implications, including for health

Donald Trump did not win the 2020 election, but asserting that he did became a prerequisite for Republicans standing for Congress or the Senate.

Trump did win the 2024 election, and key to that victory was building on the success of the lie. If you control enough of the information ecosystem, truth no longer matters.

Disinformation in politics is nothing new. History is replete with claims that were fabricated to advance political aims. Readers will recall the huge amounts of misinformation (wrong or misleading content that is unknowingly shared) and disinformation (false content that is deliberately spread) during the pandemic, some generated or amplified by politicians. This reduced vaccine uptake, promoted ineffective treatments, and encouraged attacks on health workers.

Modern online information is vulnerable to the human desire to seek content that provokes anger, and organised networks exploit this to spread disinformation. Conspiracy theories and disinformation were deliberately exploited by the Trump campaign in the latest election in a frighteningly powerful ecosystem created by a charismatic populist and media billionaires.

Twitter (now X) already struggled with moderating disinformation, conspiracy theories, and extremist content before Elon Musk's takeover in 2022. But at least it tried. Among Musk's first actions as owner was a drastic reduction in online moderation, accompanied by a relaxation of previous safeguarding rules, greatly facilitated the spread of disinformation and extreme right wing views.

Musk's influence

This was by design: part of Musk's reason for buying Twitter was to influence the social discourse. And influence he did—by using his enormous platform (203 million followers) to endorse Trump, spread deep fakes of Kamala Harris and disinformation about voter fraud, and amplify conspiracy theories about everything from vaccines to misogyny.

Musk's platform is effective: his endorsement of Trump coincided with Republican leaning posts being algorithmically favoured over Democrat leaning posts. A more mundane example: after Musk published three non-evidence based posts on X that favoured one medication over another, sales of the former rose by 18% while the other fell by 11%.

We must create surveillance for infodemics as robust as for epidemics

The playbook involves destabilising online information to radicalise people and build distrust of public figures, science, and mainstream media. These methods are known to work. It also involves putting conspiracy theorists at the heart of government and dismantling agencies that support evidence based policy making. Trump has promised Robert F Kennedy Jr a "big role in the administration." Kennedy is a well known critic of vaccines, has argued that covid is "ethnically targeted," and is opposed to water fluoridation. The Centers for Disease Control and the Food and Drug Administration are in his sights, with Trump indicating he will have free rein.

Democracies rely on voters to make informed choices in a free and fair way. But when a large proportion of the population gets information from unaccountable, unregulated social media platforms how free and fair is the process?

The warning signs are clear for democracies around the world. First, governments must

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OPINION Maryl Sackeim

Banning abortion prevents safe care for all pregnant women

In June 2022, the US Supreme Court overturned Roe *v* Wade and revoked the constitutional right to abortion, returning control to individual states. With Donald Trump now the president elect, a federal abortion ban is likely, and even access to in vitro fertilisation and contraception may be at risk.

Many political and moral problems exist with a male dominated court and political party deciding who can make decisions about women's reproductive autonomy. But as a healthcare professional in obstetrics and gynaecology, what concerns me most is the court's limited view of what is at stake here: the ability to keep pregnant women healthy.


TED JACKSON/AP/ALAMY

Abortion is completely banned in 13 states and heavily restricted in others. This removes far more than access to the narrow definition of abortion these lawmakers used: ending an unwanted pregnancy. Banning abortion takes away the ability of healthcare professionals in obstetrics and gynaecology to do their jobs.

Because I live in California, I can provide whatever is the right care for my patient. But I have many colleagues throughout the country who are now prohibited from doing the same. In some states, a patient presenting with an impending miscarriage who is actively haemorrhaging cannot seek treatment until either the fetal heartbeat has stopped or a hospital committee deems her life is at sufficient risk. In other states, if a physician performs an abortion judging a woman's life to be endangered, but a court later disagrees, they could lose their licence and even end up in jail.

US has astounding rates of maternal mortality, and it will get worse

I have seen women presenting with pre-eclampsia so severe their organs are starting to fail. In these circumstances, their babies are usually not yet viable outside the uterus. In such cases, through a dilation and evacuation (D&E) I can save the mother's life by safely ending the pregnancy. At other times, severe infection that may have already killed the baby can also put the mother's life at risk. When this happens, I can empty the uterus quickly and safely by way of D&E. Infections left

regulate social media more rigorously. Brazil's victorious dispute with X shows what is possible, and a battle between the European Commission and Musk is under way. Beyond that, we must grapple with how to hold the world's richest people to account when they directly interfere with politics.

Second, public health agencies must create robust surveillance systems for infodemics just as they have for epidemics. They must monitor the emergence of disinformation and counter it or, ideally, anticipate and counter (pre-bunk) it. And we must accelerate research on "inoculating" people against attempts to radicalise them.

Finally, politicians and the public health community must not be afraid of calling out disinformation. We must also get on the front foot and create counter narratives of a better politics that can support a kinder, more inclusive, and socially just world.

Martin McKee, professor of European public health, London School of Hygiene and Tropical Medicine

Christina Pagel, professor of operational research, University College London

Kent Buse, Global Health 50/50, Cambridge

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untreated put women at risk of sepsis, surgical complications, and death.

In 33 states D&E is heavily restricted and possibly illegal if a court does not agree on the level of danger to a woman's life. In addition, many providers trained in this procedure have left to find jobs in other states, leaving patients unable to find care. About 40% of obstetrics and gynaecology residents now train in states where abortion is either illegal or severely restricted, and they will be unlikely to graduate competent in safely evacuating a uterus. The US already has astounding rates of maternal mortality, which will continue to get worse.

The oversimplification of how we view pregnancy, childbirth, and abortion has led to a disastrous patchwork of access to care. In electing Trump, our job will get harder, and we will watch our patients suffer.

Maryl Sackeim, senior physician, Kaiser Permanente of Northern California

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DISSECTING HEALTH Scarlett McNally

Improving shared decision making

At one of my first meetings as a council member of the Royal College of Surgeons of England, we approved a report called *Access All Ages*. It encouraged less ageist thinking and bias among healthcare staff that might lead to them denying older people surgery.

But sometimes an operation isn't the best option. Among patients who have surgery, 14% express regret and 15% experience complications, which are at least four times as likely if they're frail or physically inactive. The Centre for Perioperative Care has published information on the importance of exercise before surgery, but that alone may not be enough. We need shared decision making, including asking patients what matters to them.

The public should be primed to ask about BRAN—the benefits, risks, and alternatives to surgery and the likely result from doing nothing. A slew of data supports this approach, especially from the Perioperative Care of Older People Undergoing Surgery (POPS) initiative. After discussion with a geriatric medicine team completing a comprehensive assessment and using shared decision making with a POPS approach, 14.8% of patients decided against surgery. Most of these then had their health improved through other means: adjusted medication, lifestyle advice, or other interventions.

Geriatricians and GPs are especially important for continuity of care and treatment planning with older patients. Given this, it's worrying that 10 000 resident doctors who applied to train as GPs, and 120 applicants to geriatric registrar positions, were rejected this year because too few posts were available. Post numbers need to increase from their historically low levels.

Any unit can improve its teamwork. In my trust we increased the productivity of an excellent orthogeriatrician by around 50%, by allocating a doctor's assistant to work with her. Implementing the POPS model is more likely to be successful if clinicians across disciplines share values and can sense what the POPS team describe as the "tension for change." Where shared decision making is co-designed into surgical clinics, 25% of patients decide not to go ahead with surgery.

The concepts of shared decision making, comprehensive geriatric assessment, and POPS can even work in emergency and ward based settings. Emergency laparotomy is the most common major surgery, with an in-hospital mortality of 9.3% and 5.5% of patients having an unplanned return to theatre—yet only 33.2% of relevant patients had geriatrician input that might have reduced complications or interventions.

Older people should make their own decisions about which treatment to undergo. And we should be clearer about giving patients information and coaching them on shared decision making—especially GPs, geriatricians, and surgeons. Less unwarranted surgery and fewer complications would be better for patients and would cut NHS costs, while improving teamwork and reducing the moral injury to staff when things go wrong.

Scarlett McNally, professor, Eastbourne
scarlettmcnally@cantab.net
X @scarlettmcnally

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Less unwarranted surgery and fewer complications would be better for patients and cut NHS costs

PRIMARY COLOUR Helen Salisbury

Children's medicine by numbers

"Do you remember the child you saw two days ago?" All doctors dread what might come next: we fear something bad because we missed a clinical sign or made a poor judgment. This kind of worry keeps us all alert.

Hospitals have developed scoring systems to help medical and nursing staff gauge how sick a child is, and the Royal College of Paediatrics and Child Health has suggested these be rolled out in the community.

However, research recently published in the *British Journal of General Practice* found these scores weren't useful in primary care. They lacked both sensitivity, meaning that they missed a significant proportion of children who needed hospital care, and specificity, advising escalation for many who could safely be looked after at home.

These findings are not a surprise. Early warning systems used on a ward were developed for a different baseline population, where the children have already been judged to be significantly unwell. Most of the children we see in the community, fortunately, are not.

The hospital systems also incorporate data not routinely collected by GPs: for instance, while we take account of pulse, temperature, and respiratory rate, we rarely measure blood pressure in children. Instead, we use other information to decide how sick a child is. Changes in drinking, eating, and play are key: the toddler with an alarmingly high temperature who is investigating my cupboards is unlikely to be significantly unwell, whereas the 18 month old who sits quietly on her father's lap and doesn't protest when I examine her ears is far more concerning.

In a traditional GP setting, we have the advantage of prior knowledge of families and how they respond to their children's illnesses. It can take a lot to make an experienced mother bring in her feverish child, and I'd pay particular attention to her worry and be wary of being too quick to reassure.

Assessing acutely unwell children, and accurately picking out those few who need hospital care, can't be done by algorithm. It's a skill built over time, with baseline knowledge supplemented by repeated experience. And it's yet another reason why acute and urgent care should remain an integral part of general practice rather than being separated into same day access hubs, staffed mostly by non-doctors. Seeing a succession of snotty toddlers may not be everyone's idea of a fun day, but if GPs don't practise this skill they may lose it or never even acquire it.

Medicine by numbers, delegated to less trained staff, is not an option. This study confirms it would result in overburdened paediatric emergency departments and an increased likelihood of children at risk of deterioration slipping through the algorithm.

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

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A succession of snotty toddlers may not be everyone's idea of a fun day

LATEST PODCAST

How do we cope when a family member is unwell?

Medical school is tough for students, with high workloads, exam pressure, and uncertainty around placement rotations. So what happens when, added to this, a family member or loved one becomes unwell? This episode of the Sharp Scratch podcast explores what it's like and the pressures students face when supporting family.

One of the panel describes their experience:

"There's a layer of emotional and mental pressure that comes when a loved one is unwell. I've been the person who, when a family member gets test results or a report from a scan, they'll say, 'There are all these long words in here. What is this?' and you have to go through, breaking it down. And while it is useful to have that knowledge, it also comes with responsibility, because not only are you explaining what's going on, but you're expected to have input on what we do about it because you're seen as the person who understands."

Guest Hilary Williams, a consultant medical oncologist, explains how you can navigate the role of relative, while also having medical knowledge:

"Number one is you can't fix it. It's going to be tough. And I think just recognising that is probably quite helpful. As doctors we have a real tendency to try and fix things and I am the worst at this—I want to go and cure everyone. But perhaps one thing I've learnt is that there are a lot of things you can't fix. The second thing is that if stepping back and perhaps acknowledging it isn't getting you there, then absolutely talk to someone. It might just be a 20 minute chat with your supervisor or calling a charity support line."

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

ANALYSIS

How outsourcing has contributed to England's social care crisis

Benjamin Goodair and colleagues argue that growth of private provision in adult social care in England has resulted in worse care and should be rolled back

Adult social care in England is in crisis. Chronically underfunded services are struggling to accommodate unmet need, and inequalities are widening. The number of people applying and being rejected for care provision is rising year on year, and unmet need is twice as high in the most economically deprived areas compared with the least deprived.[1,2] Meanwhile, 9 in 10 adult social service directors in England did not believe there was adequate funding or workforce to meet care needs of older and disabled people in their area.[3] These deficiencies have seen the social care sector brought "to its knees."[4]

Care for older people and people with physical and mental disabilities is facing record demand but performing worse than any time in recent history. One contributor to this is the outsourcing of care provision to the private sector. Although competition from private sector provision was championed as a solution to achieve cheaper and better quality care, evidence from the past few decades in the UK and elsewhere challenges this view.[5-7] In England, in particular, adult social care now faces a reality where reform is needed but the capacity for change is constrained by a model of care where most providers are run by for-profit companies.

24 out of every 25 care residents are in private sector accommodation

KEY MESSAGES

- The provision of adult social care services in England has almost been entirely outsourced to the private sector
- The share of publicly provided adult social care has fallen by 56% since 2001
- The increasing outsourcing of care provision has coincided with a care crisis and worse quality of care
- Removing the profit motive would help improve quality and reduce inequities

Commercialisation of care

Social care in England, sometimes referred to as community, residential, or personalised care, constitutes services that support people with activities of daily living and maintaining independence. In England, care services are largely divided between healthcare and social care, with local government responsible for organising and funding social care and the NHS a distinct service directly funded by central government.

In England, healthcare is provided largely universally, whereas social care is means tested. A growing proportion of people do not qualify for state funded services and have to pay out of pocket because the threshold at which people have to pay for their own care has not been increased since 2010.[9]

The commercial interest in providing social care services has risen rapidly since the 1980s. Outsourcing—whereby the state pays private providers to deliver public service—was enabled by government legislation, in particular the decision to make social security grants available to residents in private care homes. Notably, this funding was not available for residents in public care homes and led to a boom in private (both third sector and for-profit) residential care.[10,11] This rise in private, but primarily for-profit, provision in the 1980s was accompanied by new regulation in the sector to avoid exploitation and low standards of quality.[12]

Outsourcing has continued to rise since the 1980s, and private provision of social care has steadily taken over. As a result, the public social care provision has all but disappeared and almost all services are provided by the private sector (box 1, figure). Extrapolation from the reported hours of care delivered by each sector suggests that 24 out of every 25 care residents are in private sector (for-profit and third sector) accommodation.[13]

Why do services get outsourced?

Public services can be considered different degrees of "public" according to whether the government is in control of funding, provision, or regulation.[15] Outsourcing refers to public services being delivered by privately owned organisations, including for-profit or non-profit third sector providers. Two theoretical arguments are commonly used to support outsourcing of public services. The first is aligned with the values of enhanced care provision whereby private providers, through adding a supplementary service, can offer different specialisms, capacities, and capital investment to the existing public service.[16,17] Core to this argument are assumptions about the behaviour of profit motivated providers. Profit motives in the private sector are assumed to make such providers more responsive to consumer needs, more willing to expand into new "markets," and attempt innovation in how they deliver care.

The second argument rests on a more persistent ideological position about the value of competition, whereby the market is seen as the optimal provider of social goods. The argument is that the best service

Box 1 | Decline of public social care provision in England

Published data that track a total of £194bn expenditure on services and a combined 279 million weeks of residential care provision from 2001 to 2023document how publicly provided social care has eroded and almost disappeared[13]:

- The average share of public services in local authority expenditure has declined from 40% to under 10%. In 2023 most local authorities spent nothing on public sector residential and home care services
- Data on residents in public provision corroborate the steep and radical decline in public service provision, decreasing from 27% in 2001 to 4% in 2023
- Although austerity measures saw large spending cuts to social care services after 2010, public expenditure had already substantially dropped by £300m between 2006 and 2010
- Most services are now run by for-profit providers with around 12% of care homes run by third sector organisations
- Social care services are now increasingly provided in the home, as housing support and community care. These too have been largely outsourced

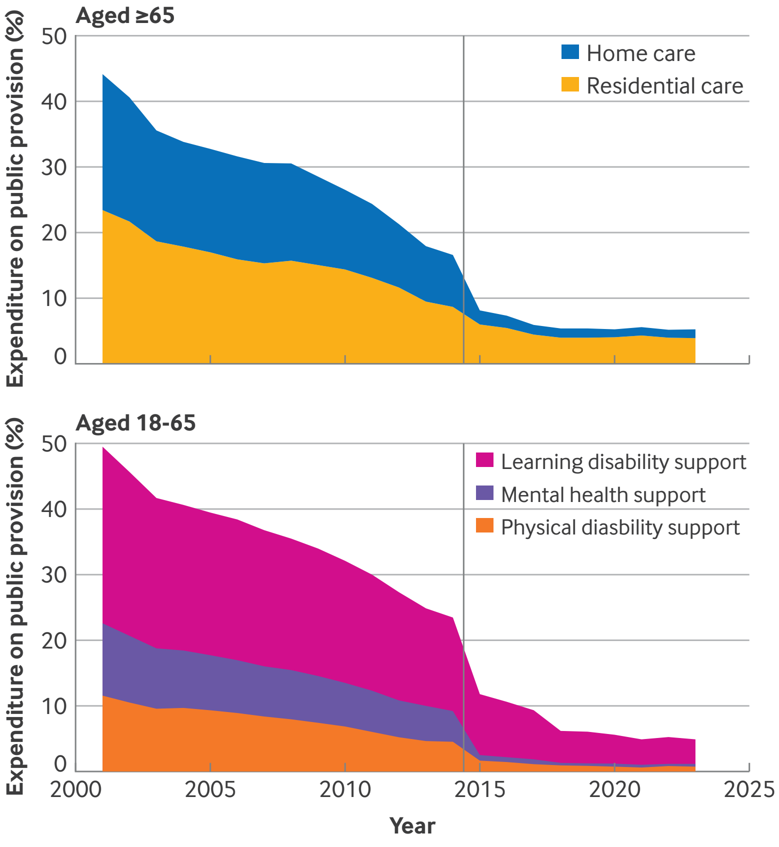
is achieved when service users become empowered consumers and service providers become competing vendors—and that such competition improves quality, reduces prices, and tailors services to residents' needs.[18] The best markets are considered to have a diverse and varied selection of providers, as this enables optimal competition and more service options for consumers. Following this argument, the main intention of allowing commercial provision is to build a mixed and diverse market of providers.[19]

In England, and elsewhere (box 2), both arguments have been used to motivate reform. The 1990s social care reforms under Margaret Thatcher's government were widely justified by the idea that competition in a private market provides the most efficient services.[23] This narrative has been pervasive. In the 2010s, legislation, white papers, and official policy documents aimed to create varied and mixed markets, and advocated for markets to provide "innovation, investment and continuous improvement" to service "efficient consumers."[24] Legislation in line with these aims paved the way effectively to eliminate publicly provided adult social care in England, based on the assumption that quality and value for money are protected, if not improved, in the process.

Experience contradicts assumptions

Research does not support the assumption that outsourcing of social care services improves quality.[5,6] Quality in social care requires ensuring the safety and wellbeing of care recipients. Observational studies have found that for-profit and private equity owned care homes deliver worse quality care than third sector or publicly owned homes.[5-25] The outcomes are clear, but how do we know the comparisons are fair and that it is for-profit ownership causing this difference? It is not easy to make causal claims from observational studies, but the range and consistency of studies are compelling. First, quality differences are observed when private companies take over public services, suggesting that the same locations run by for-profit companies do worse.[26] Second, these quality differences are observed in many countries and in different services, such as healthcare.[6-28] For example, studies of covid-19 outbreaks and care home deaths in England, Canada, and the US found that, on average, more residents died after outbreaks which occurred in for-profit care homes than those in public and third sector homes.[29] This suggests that there is nothing unique to the context of adult social care services in England. And finally, the quality difference is observed in many different measures of quality, such as lower staffing rates or forced closures of care homes (an action of last resort when residents' safety is at risk) suggesting that the for-profit gap is robust to different measures of quality.[30,31] Combined, there is prevailing evidence that the outsourcing of social care has not benefited residents, and with people's safety at risk, there is sufficient cause for advocating changes to policy and regulation.[32]

Inequality has also been worsened as adult social care has turned to



Local authority expenditure on public social care services in England, 2001-2023. Data collection processes changed in 2015 and spending before and after 2015 is not directly comparable.[14] Spending on public services fell by 37.8% in 2001-14 and 29.2% in 2015-23. Taken together, we estimate a decline of 56% in 2000- 23

Box 2 | Public ownership of social care in Europe

Between the mid-2000s and the mid-2010s, the share of care homes owned by private provision increased in almost every European country with available data:

- In Ireland, expenditure on for-profit home care grew from €3m in 2006 to €176m in 2019[20]
- 2015 legislative reforms in the Netherlands saw a large increase in for-profit nursing homes—doubling from 2015 to 2017 alone[21]
- The share of privately owned nursing homes increased in both Norway and Sweden between 2005 and 2014[22]
- The proportion of private care homes rose to 35% in Slovakia, over 55% in Romania, and by 15% points in Croatia[7]
- One notable exception, Cyprus, saw a growth in public care homes and a decline in private care homes between 2003 and 2014[7]

market based and more self-funded provision. Providers in England are increasingly focused on attracting affluent, self-funded, social care users, who pay higher fees than the rates set for state funded residents.[34] This has led to services becoming less accessible in the most deprived areas.[3] The end of public provision has meant that providers focus their commercial interests where the profit potential is highest. As a result, socioeconomically deprived people are now facing a double burden of service deprivation, while those in the richest parts of the country are more likely to have access to the care they need.

Selective expansion of care provision has probably created issues of sufficiency: the number of care homes is falling, and the rate of unmet needs is increasing.[2] Sufficiency and expansion of care capacity now relies on the private sector, but the financial incentives for providing social care are no longer linked to local levels of need.[35]

One reason for the failure of privatisation is that when quality is hard to measure, as it is in the care sector, market based provision is likely to incentivise cost cutting over quality improvements.[36,37] Commercial organisations are often most responsive to financial stimuli, especially as their survival in a market relies on profitability. Enforcing quality standards among private providers requires regulatory, contractual, or structural conditions that are difficult to implement. For-profit providers are therefore likely to maximise profits through cost reduction at the cost of quality, if regulatory and market structures allow them to.

The regulatory framework in England has proved ineffective at preventing the profit maximising behaviours that affect quality. This is partly because the primary role of the industry regulator (the CQC) is to measure the quality of services, and its enforcement powers apply to individual care homes performing below the regulation threshold rather than the underlying provider. It does not have any regulatory powers that can prevent the quality of care homes becoming worse on average, as long as homes are not performing below the enforcement threshold. More importantly, the CQC's regulatory role has much less emphasis on statutory powers over provider chains and finances.[38,39] For example, even though the CQC has the powers to monitor the finances of social care providers, it merely operates an "early warning" system to local authorities once companies are at risk of failing.[40] This light touch regulation means that profit seeking remains largely unchecked, allowing companies to cut costs and quality in pursuit of financial gain.

Inequality has been worsened as adult social care has turned to market based and more self-funded provision

Reducing the profit motive

So how can we ensure that England's ageing population and population with disabilities can access safe, equitable, and effective care? A partial solution is to control, restrict, or remove the profit motive in social care services, which would both improve the quality of provision and reduce inequalities across the system. This can be achieved in three ways. First, restricting the profit motive could be achieved by imposing additional regulation on social care providers. Examples of such measures include profit caps, limiting the payment of shareholder dividends, and restricting offshore and private equity investment and ownership. The downside of such measures is that they can be circumvented; evidence from the US shows nursing home companies using complex accounting techniques to hide profits between multiple companies owned by the same parent company or individual.[41]

A second option is attempting to align financial incentives with care quality through performance related payments. This approach faces multiple challenges. Quality is difficult to measure, and using the wrong metrics can lead to providers prioritising the targets at the expense of genuine quality, as observed in the NHS.[42] Moreover, even with satisfactory quality measures, enforcement is difficult, and there is a risk of misreporting of self-reported data.[43]

A third option is changing the ownership of social care providers, bringing services back into public ownership or restricting all private ownership to third sector (non-profit) models. Because of the scale and embeddedness of for-profit provision in adult social care, a complete restructuring may not be feasible in the short term. Instead, incrementally commissioning local, small, ethical, and third sector provision while building up publicly owned capacity could be the first step in taking back control and moving towards a care system less driven by the profit motive.[44]

Insufficient quality care can cause severe harm and distress for people who need it. Outcomes can range from people not receiving proper psychological support to preventable suffering, abuse, and death. Urgent steps to reduce the profit motive and reverse the outsourcing of services are essential to protect the growing population in need of care.

Benjamin Goodair, postdoctoral researcher
benjamin.goodair@bsg.ox.ac.uk

Adrienne McManus, doctoral researcher

Anders Bach-Mortensen, associate professor in social care and policy, University of Oxford, Oxford, UK

Michelle Degli Esposti, research assistant professor, University of Michigan, USA

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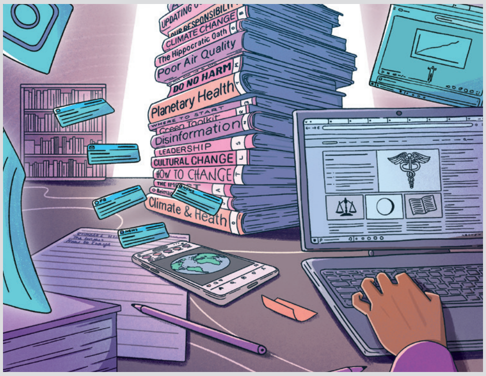

ROWENA SHEEHAN

LETTER OF THE WEEK

Time to talk to patients about climate change

The spread of misinformation and disinformation about climate change and health is of great concern to society (Opinion, 12 October). The healthcare community must engage in climate change education with at least as strong a resolve as it has with other major public health challenges (such as smoking cessation). Piatek and colleagues propose a range of actions, from education and advocacy in the community up to higher level stakeholders. Education should also be emphasised at the patient-clinician encounter. There is no escape—it is time to talk to patients about climate change.

Healthcare providers can help patients achieve health and climate co-benefits by recommending, for example, plant based diets and active transportation. But even with these simple options, a substantial portion of healthcare providers still feel unprepared, uncomfortable, or simply lack the time to engage in climate and health action. We need to incentivise innovative communication strategies for discussing climate change during clinical consultations.

This patient-clinician communication gap is starting to be tackled by healthcare professionals. The World Organization of Family Doctors, for example, has promoted the One Minute for the Planet framework, which educates patients about climate related health topics in brief, focused conversations, creating the opportunity to explain the co-benefits for healthier lifestyles and the climate. Incorporating discussions into healthcare practices worldwide could be a major step towards combating misinformation and disinformation while simultaneously promoting the health of patients and the environment.

Enrique Falce, family doctor and professor, Santa Maria do Herval, Brazil

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HEAT STRESS

Coordinated action to tackle heat stress

As global temperatures rise, heat stress is becoming a critical concern (News Analysis, 12 October). Heat stress is more than just discomfort: it can lead to immediate adverse health outcomes as well as chronic, debilitating diseases.

Many health professionals lack sufficient training on the effects of climate change, including heat stress. Medical curriculums must incorporate environmental health education, focusing on how high temperatures affect the body, especially for vulnerable groups like outdoor workers, older people, and those with pre-existing health problems.

Public health initiatives should inform people about hydration, recognising symptoms, and understanding when to seek medical help. And governments must adopt policies that ensure safe working conditions, particularly for outdoor and manual labourers. Employers should support workers' wellbeing by providing cooling areas, hydration stations, and rest periods during extreme heat.

Tackling heat stress through education, health interventions, and preventive measures is essential to mitigate its effects and safeguard the health of millions.

Giovanni Ghirga, paediatrician, Civitavecchia, Italy

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APPLYING COLD SENSATION IN REGIONAL ANAESTHESIA

Simple and cost effective solution

Nichols and colleagues describe the use of reusable devices for applying cold sensation when assessing regional anaesthesia (Sustainable Practice, 15 June). The financial and environmental costs associated with disposable cold sprays are concerning. But the proposed solution of a reusable cold metal stick, which necessitates additional equipment cleaning, seems to overcomplicate what is otherwise a simple procedure.

I think a simpler method is being overlooked. In our hospital, we fill paper pill pots with water and freeze them. This solution is elegant and environmentally friendly, offering an ideal alternative without the need for elaborate devices or extensive cleaning protocols.

Paper pill pots, costing less than 1p each, generate less environmental waste than metal-plastic sticks and can provide a similar number of uses without the need for cleaning or the upfront costs of equipment, apart from a freezer, which is probably already part of the theatre suite.

Callum H Weller, core anaesthetic trainee, Gateshead

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BAN ON JUNK FOOD TV ADVERTS

Social media is the problem

Iacobucci reports that public health leaders and campaigners welcome the government's announcement that it will ban advertisements for junk food on television before 9 pm (This Week, 21 September).

But the problem is less about TV than social media. The average time that UK children aged 4-15 years spend watching broadcast TV decreased from 242 min a day in 2010 to 38 min in 2023. By contrast, the average time spent on social media platforms has skyrocketed. In the US, it ranged from 4.1 hours a day for 13 year olds to 5.8 hours a day for 17 year olds.

Ofcom, the regulator for the communications services, has never shown that it has adequate resources for monitoring adverts or the ability to impose dissuasive sanctions.

The ban will come into force on 1 October 2025, but the House of Lords Food, Diet, and Obesity Committee said that it "does not go far enough."

Alain Braillon, retired senior consultant, Amiens

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OBITUARIES

Alexander Cresswell Thurlow

Consultant anaesthetist (b 1940; q London 1964; FFARCS), died from spontaneous upper gastrointestinal haemorrhage on 23 May 2024

Alexander was born in Egypt to a Greek mother and an English father, who was killed in a bombing raid over Libya in 1940. He and his mother travelled to England in 1946, and Alexander grew up in Sussex. He attended Brighton Grammar School and then studied at St Mary's Hospital Medical School. After qualifying and house jobs he progressed to anaesthetic training. During his consultant career at St George's he pioneered research into safety in dental anaesthesia and performed studies into the efficacy of space blankets in recovery. In his retirement he enjoyed travel and he loved restaurants and the theatre. His wife, Joanna, died in 2009 and he is survived by his partner, two daughters, and four grandchildren.

Sue Thurlow

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Kenneth David Hudson

GP (b 1938; q London 1962; MRCGP), died from complications following fractured neck of femur on 6 April 2024

Ken undertook GP training in Ipswich after junior hospital appointments, and became a partner in Woodbridge. He was then appointed to Teignmouth in 1973, where he remained a single handed family doctor for the rest of his career. He was medical officer at Teignmouth Hospital and port, radiotherapy clinical assistant at Torbay Hospital, and medical officer at Marks and Spencer. He also undertook research into hypertension and obesity. After retirement Ken was a Maritime and Coastguard Agency examiner and Medical Practitioners Tribunal Service member. He had many interests, particularly history and boats. He leaves his wife, Vivienne; three children by his first marriage; eight grandchildren; and six step grandchildren.

Jonathan Hudson, Michael Dillon

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Chuda Bahadur Karki

Consultant psychiatrist (b 1948; q Allahabad 1972; FRCPsych), died from heart failure on 28 August 2024

Chuda was born in Bhojpur, India, in the foothills of the Himalayas. There was no local school so his grandfather sent him to Kathmandu in Nepal when he was 8. He initially studied botany before graduating from MLN Medical College, Allahabad, India in 1972. He then came to the UK in 1979, working in Scotland before training in England. He initially wanted to be a paediatrician but realised that as an overseas doctor it would be difficult to get into his chosen specialty, so he pursued psychiatry. He eventually became medical director of New Possibilities NHS Trust in Essex. Chuda also joined medical camps in Sierra Leone, Russia, India, and Nepal. He was a passionate gardener and traveller. Chuda is survived by his wife, Anju, and two sons.

Akash Karki, Indrajit Tiwari

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Annie Sara Mathew

Psychiatrist (b 1958; q Thiruvananthapuram 1984; MRCP, MRCPsych), died from respiratory failure on 9 November 2023

Annie (known as Joyce) was born in Nellikala, in Kerala, India. She completed a bachelor of science and then studied medicine at the Government Medical College, Thiruvananthapuram. Here she met Mathew, a fellow medical student, whom she married in 1983. In 1987, the couple moved to Oman to run a private health clinic. After 10 years they emigrated to Ireland. Annie found her calling in psychiatry and the family moved to Scotland, where she worked at the Woodlands Mental Health Resource Centre in Kirkintilloch and then at the Parkview Resource Centre in Shettleston. Annie was diagnosed with frontotemporal dementia at the age of 63. Outside medicine, her passions were singing and feeding those around her. She was also a devout Christian. Annie is survived by Mathew, and her two children, Alice and Rojy.

Alice Mathew, Syba Sunny

Cite this as: *BMJ* 2024;387:q2370

David Norman Phear

Consultant physician (b 1925; q Cambridge 1949; FRCP, FRACP), died of old age on 27 April 2024

David was born in Grantchester, Cambridge, and went to Winchester College. In 1943 he went to Caius College, Cambridge, and completed his clinical studies at the Middlesex Hospital in London. He worked as a senior registrar in London, where he met Margaret Woods, an anaesthetist, who soon became his wife. The family lived in Australia, where David's interest in endocrinology, particularly diabetes, began. David returned to England to take up a consultant post at Queen Elizabeth II Hospital in Welwyn Garden City and at St Albans City Hospital. He was an expert diagnostician, showing great empathy to all his patients. Margaret died at the age of 44 and David later married Rita, a consultant obstetrician and gynaecologist. In his retirement David set up two therapy gardens. He leaves his children, Phillipa and Alan; three grandchildren; and three great grandchildren.

Phillipa Knowles, Mike Kirby

Cite this as: *BMJ* 2024;387:q2360

Gillian Lesley Rees

GP (b 1963; q Birmingham 1986; DRCOG, FP), died from motor neuron disease on 12 September 2024

Gillian (also known as Gillian Gee) was born in Canberra, Australia, but spent most of her childhood in Formby near Liverpool. She studied medicine at Birmingham and after house jobs she worked as a GP trainee in Birmingham. She became a GP principal at Stoke Health Centre in 1998 and senior partner in 2002. In 2018 Gillian and her colleagues took over a neighbouring practice. Honeywall Medical Practice prided itself on its small size and ability to offer continuity of care. Gillian was diagnosed with bulbar onset motor neuron disease in 2023 and it quickly took away her ability to speak, swallow, and walk. Until then, Gillian had been skilled at art and crafts. She loved golf and raised funds for charities. Gillian is survived by her parents, Jean and Alan; her husband, Martin; her daughters, Sammy, Sarah, and Jenny; and a granddaughter, Phoebe.

Martin Gee

Cite this as: *BMJ* 2024;387:q2371

Veronica Moss

Physician, Christian, and early pioneer of the care of patients with AIDS in the face of stigma and suspicion

Veronica Ann Moss (b 1943; q London 1970; FRCP), died of lung cancer on 18 July 2024

When the Mildmay Mission Hospital in east London began accepting patients with HIV/AIDS in the 1980s little was known about the disease. Diagnosis was a certain death sentence and there was no treatment, only symptom relief.

However, Veronica Moss, the Christian hospital's medical director, said she felt a calling and soon developed vast expertise in treating the disease, whose complications included bacterial pneumonia, Kaposi's sarcoma, and stomach problems.

The disease was dubbed the "gay plague" by the tabloid press and there was little understanding of how it was spread. Medical staff wore full protective clothing when treating patients and ambulance staff often refused to transport them.

Moss, the daughter of missionaries, told the *Church Times* in 2007 that the first few years were tough.

"We received opposition from all quarters. People hurled stones and bottles at our windows, and at the patients as well, and gave us constant verbal abuse," she said.

Suspicions raised

Some of the hospital's supporters were horrified that it had taken on this cohort of patients and some gay people were suspicious of the charity's motives.

Moss worked hard to understand the disease and how best to relieve patients' symptoms. She and her team spent a month in San Francisco, the epicentre of the AIDS epidemic in the US, to learn from its palliative care programme.

The expertise she developed was crucial for her work in Uganda in her later years, said Ruth Sims, director of nursing at Mildmay at the time and who became a lifelong friend of Moss's.

"We managed to keep some of the young children alive with good symptom control until antiretroviral drugs came along. Some of those patients are now married with their own children," she said.

The hospital soon won recognition for its work and received visits from high profile supporters—Diana, Princess of Wales, was a frequent visitor.

Veronica Moss: "People hurled stones and bottles at our windows"

Moss was the eldest of four girls born to Clement and Ingegerd Moss, Christian missionaries in India. Veronica's first home was in a village in what is today Madhya Pradesh, where Clement was a Lutheran minister and also ran a dispensary. Ingegerd was Swedish and at the age of 6 Veronica was sent to India's only Swedish boarding school in the south of the country—a journey that was 1000 miles and three days away by train. Clement later trained to be a doctor and founded a hospital for the poor in Padhar.

At 17 Moss was sent to a boarding school in north Wales to complete her A levels. Landing in London in January 1961 was a shock. She had never felt so cold and was horrified to find ice on the inside of her bedroom window. The 60s fashions were also an eye opener.

Moss studied medicine at the University of London, doing house jobs around the city, including at the Mildmay, after qualification. She then returned to India, where she worked with her father. She set up community health projects and returned to the country throughout her life. She came back to the UK, where she wrestled with what path to follow while studying at a theological college and doing GP locum work.

"I felt very unsure of what God wanted for my life," she wrote.

That calling eventually came, she said, in the shape of the Mildmay Mission Hospital, which also gave her the opportunity to go abroad. Increasing numbers of patients with HIV at the Mildmay were from African backgrounds and with other members of staff she raised money to visit Kenya, Uganda, and Zimbabwe to learn how better to care for patients. Moss returned to Africa to teach and, on the invitation of the Ugandan government, helped set up a Mildmay centre in the country, becoming its first medical director.

Strong faith

The Mildmay Centre for Aids Treatment and Care in Uganda was opened in 1998 by Princess Anne. Emmanuel Luyirika, former country director of Mildmay International, said Moss constantly looked for grants so that patients would not be forced to pay for medicines. She also arranged transport and food parcels for patients.

In the early 2000s life saving antiretroviral drugs were becoming available and Moss got a grant that would provide them for 15 children—at the time the clinic had several thousand on its books. She could not make the agonising choice so put names in a hat.

When US president George W Bush made a flying visit to Uganda Moss was granted a brief audience with him. She took the hospital's children's choir to sing to him and secured some US government funding. When Bush set up the President's Emergency Plan for Aids Relief, Mildmay was the first place in Africa to receive a grant.

Training was a huge part of Moss's focus and Julia Downing, a UK nurse who worked at the Mildmay with her, said the plan was always to "do themselves out of a job" by sharing their skills and knowledge with local staff.

Moss became chief executive of Mildmay International and a ward in Uganda was named in her honour.

Moss was a gentle, compassionate, and quietly determined woman. Her faith was the cornerstone of her life and she would start every day with prayers.

She returned to the UK in 2002 becoming chief executive of Mildmay International, training doctors around the world. She retired in 2008, living in Southend, Essex, near Ruth Sims and her family.

She leaves two sisters, Ulla and Solveig, many nephews and nieces, her best friend Ruth, and Ruth's children and grandchildren.

Anne Gulland , *The BMJ*

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