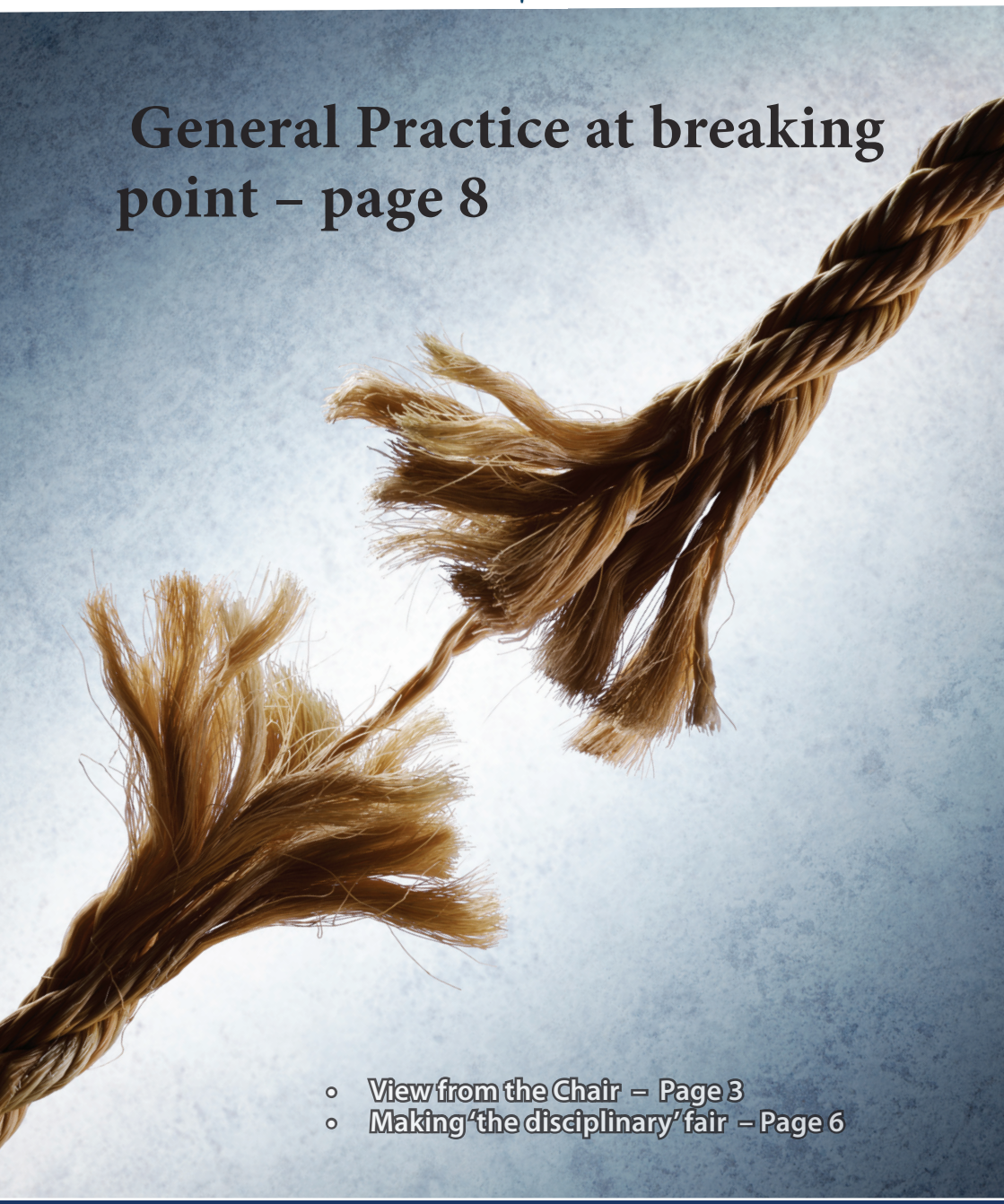
DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

General Practice at breaking point – page 8



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Managing Editor – Alan Taman
healthjournos@gmail.com
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The Fight Continues and is Not Lost

I must apologise to members in Scotland, Wales and Northern Ireland, for what might be seen as a peculiarly English concern, except that the gravitational effect of changes to health services in England do have a strong influence on services in the other nations of the United Kingdom. Even if only as a cautionary tale.

With little fanfare, on 28th April 2022, the Health and Care Bill was enacted on the final day of the last parliamentary session. The latest attempt to find a way to make a market structure work. Integrate the NHS by fragmenting it into 42 Integrated Care Systems (ICSs), each operating largely according to its own rules.

In the end, campaigners were unable to attract the attention of the journalists, the wider public, the trade unions or the professions. It was a stroke of genius to design such 'permissive legislation'. Most of the Act does not stipulate how each ICS should act: it gives them wide freedoms to do their own thing. They will be restricted by the level of funding they receive, but they can make decisions about what treatment they will fund. They can decide the locations where treatment will be provided, and by whom. They will have much greater scope to depart from national terms and conditions for the employees within their area. Because the ICSs are not compelled to do such things, it was very difficult to raise public concern without being branded as alarmist. By making all these things lawful, it also effectively removes the ability to challenge such actions through Judicial Review.

In the end, there was little persistent challenge to "the wrong bill, at the wrong time" from opposition parties: possibly put off by parliamentary arithmetic; possibly because they bought the argument that this legislation would deliver local health services that operated on the basis of collaboration, rather than competition, to provide a less disjointed service to patients.

In the end, despite strong arguments put forward eloquently by a number of members of the House of Lords, the amendments that were made were all voted down in the Commons, leaving the bill largely unaltered. Attempts to ensure that emergency care would be freely available if you became seriously ill, or were injured, outside the boundary of the ICS in which you normally resided, came to nought. Their lordships did not feel strongly enough to die in a ditch over minor matters such as pressing for meaningful workforce planning.

What happens now?

It is now up to all the supporters of ICSs to demonstrate that this massive reorganisation really can deliver the benefits that we have been told will flow: that the sceptics were wrong all along; that it wouldn't open the doors wider still to commercial organisations to plunder the public coffers, or drive the desperate into the arms of the 'independent' health sector, as is already happening (and has increasingly been the case in dental care, particularly since contract changes in 2006).

Attending a webinar organised by the Local Government Association, shortly after the Health and Care Act 2022 passed into law, speakers from the King's Fund, the NHS Confederation and local government all felt that the new structures could be an improvement. They saw potential opportunities in bringing together local authorities with providers of health services, but only if those local authorities act with confidence, to take a leading role in the ICSs and push back against top-down directives from NHS England.

The Act stresses the importance of tackling the social determinants of ill health, rather than simply dealing with the results of disease. Local authorities have extensive experience in working alongside local businesses and crucial services such as education, housing, environmental and public health, and the justice system. They also have their own democratic mandate and are used to listening to their local population. If the professed benefits of population health measures are to become a reality, local authorities must not allow themselves to be cast as minor partners in these new organisations.

The speakers did not underestimate the scale of the Government's agenda, not just in terms of The Act, with the risk of distraction from the challenge of establishing the local Integrated Care Partnerships:

- The Integration White Paper, which stresses the importance of partnership across the health and care services at 'place' level (frequently, but not always, this means corresponds to the boundary of an individual local authority).
- White papers on social care reform, which are mainly concerned with who pays what and the question of data sharing. They do not attempt to fix the widening gaps in access to services, the underfunding of the care services following 12 years of cuts to local authority funding or the inadequate support for people to lead as full and independent a life as possible.
- A Health Disparities White Paper, which is expected.
- An updated version of the Long Term Plan, expected some time soon.

> "There is no way such 'savings' can be made without drastic action that will have serious impact on patients, staff, or most likely, both."

The elephant in the room

The observant among you will have noted a very large gap – the absence of any national workforce strategy, particularly for social care. During the Bill's passage through Parliament, there were repeated cross-party attempts to make amendments that would enforce independent assessments, every 2 or 3 years, of the workforce situation and firm plans to train and recruit sufficient staff over the medium and long-term, but the Government ensured that they were all voted down, using their majority in the Commons, and asserting that this exercise just needed to be carried out once in a parliamentary term, with nothing to prevent that from taking place right at the end of that parliament, when it might be too late to take any remedial action. It's almost as if they want the service to fail!

In the absence of a national strategy, ICSs must take on a greater responsibility for putting in place training programmes to grow their own supply of clinical and support staff. The West Yorkshire ICS serves a population of 2 million people. Surely that offers sufficient scale to plan, build up and retain staff skilled in the range of disciplines required? This Integrated Care Board are establishing a People Committee, which will publish its agenda and minutes, and be open to scrutiny, which could be a source of hope. What would prevent smaller ICSs from collaborating to meet their joint requirements?

The other elephant

In the decade up to 2016/17, the NHS in England was compelled to make 'efficiency savings' also known as 'cuts' of 0.9% per year, on average.

Year on year, these became harder to deliver and were one of the main driving forces leading to the excessive loss of hospital beds, the failure to train sufficient clinical staff, the crumbling buildings, the 'reconfiguration' of services, and the inadequate provision of diagnostic facilities. As ICSs are trying to become established, they are being instructed to make cuts of 4-5% in their first year of operation – and to make serious inroads into the backlog of elective work that was put on hold during the worst of the pandemic, or face further cuts in funding. It's almost as if they want the service to fail ....

There is no way that such 'savings' can be made without drastic action that will have a serious impact on patients, staff, or most likely, both. We can expect the usual playbook, of replacing experienced, fully-trained clinicians with less costly alternatives; holding staff vacancies for longer, while expecting the remaining staff to cover the gaps; providing services on fewer sites, while expecting patients to travel further for treatments that used to be available closer to home.

We can also expect some ICSs to explore fresher options facilitated by their new organisational freedoms: departing from national agreements on pay and conditions; moving clinicians between different hospitals and health centres across the ICS area, to plug staffing gaps; reducing access to treatment by increasingly stringent eligibility criteria, or by ceasing to provide certain treatments entirely. We shouldn't be surprised to see increasing marketing of privately funded options, insurance plans and co-payments in NHS settings, particularly as NHS trusts are permitted to make nearly half their income from paying patients. Many of these actions are already taking place and there is no reason to expect that the trend will reverse.

How will the story end?

I suspect that we will see a huge degree of variation in health and care services in different parts of England, as different ICSs experiment with a variety of approaches to their specific local challenges. Some ICSs might be more heavily influenced by commercial organisations and management consultancies, while others aspire to the model of universal, comprehensive healthcare. Some may attempt to solve their workforce shortages, while others wait for the cavalry to arrive, while cutting the service they provide to patients.

Campaigners now need to switch their attention from Westminster, to their local ICS bodies, and Health and Wellbeing Boards, and use whatever means they can to influence the way in which they develop.

May you live in interesting times!

Colin Hutchinson
Chair, DFNHS
colinh759@gmail.com

Making 'The Disciplinary' Fair

EC members Arun Baksi, Helen Fernandes and Malila Noone, with Whistleblowers UK's Georgina Halford-Hall, are proposing a radical change to the way disciplinary proceedings against doctors are governed in English Trusts, in the hope that fairness can prevail.

'Hospital investigatory proceedings against doctors in England: A case for a change' has a simple pretext: disciplinary proceedings in English trusts against doctors at the moment are all too often unfair, malicious and conducted in a culture of secrecy, bias and retribution.

This is happening despite the Maintaining High Professional Standards in the Modern NHS (MHPS) [1] framework for the handling of concerns about doctors and dentists in the NHS in England. Recognising that unfair proceedings have wide implications, MHPS was introduced in 2005 to tackle the blame and suspension culture. Manifestly, a lot is still left to be done. This was despite:'Sir Robert Francis in his 'Freedom to Speak Up' [2] review criticising the use of disciplinary procedures by NHS Trusts saying, 'employers often felt challenged in how to separate safety concerns from disciplinary issues'. Guidance on the appropriateness of disciplinary action in the form of 'A Just Culture Guide', has not improved practice [3]. An imbalance in the workforce in relation to bias in disciplinary action has long been recognised and ambitions to correct this set out [4].Views by external observers suggest that there is a problem interpreting MHPS. Doctors challenge this conclusion and overwhelmingly believe that at the heart of the problem is the common practice and culture of misusing the MHPS disciplinary process.'

The proposal continues:

'It should go without saying that all disciplinary action should follow the principles of natural justice; those are 'Adequate notice, a fair hearing, and the absence of bias.' Further, MHPS states that 'A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action.'

'These principles of natural justice and the requirement for audit are not observed by many, perhaps most Trusts.'

Following FOI requests to all English Trusts, and a notably high level of failures to respond, 'The significant number of incomplete responses, refusals and non-responders suggest that most Trusts, despite the requirement in MHPS, keep no readily available records. It is manifestly clear therefore that Trusts have no mechanism to audit their MHPS activity, MHPS outcomes, and as such there is an absence of accountability and transparency in relation to disciplinary action against doctors and the recording of the decisions.'

The proposed solution

The document proposes that the government establish an Independent and elected Scrutiny Panel with full statutory powers in each Trust. Management would have to seek permission from this Panel before embarking on any formal investigatory process following informal enquiries in all cases.

The changes proposed are designed to identify and stop unfair and malicious proceedings from

the outset. This process would result in an overall reduction of formal investigations, prevent the significant negative effects on doctors and their families and significantly reduce costs and wasted time. The authors believe that the introduction of the Independent Scrutiny Panel will improve trust processes, remove bias and change culture in a positive way.

The more detailed function, make-up and operation of the Scrutiny Panels is then described, including what they term 'panel etiquette' (eg managment should not engage in informal discussion with panel members), who is eligible to stand for election to the panels (7 senior doctors,, 4 senior nurses and 3 non-executive members), and the administrative support that should be made available.

In conclusion

The concluding section of the document draws these points together and ends on a positive note:

'Changes made to the investigation and disciplinary process of doctors have failed to prevent increasing instances of unfair, biased, and malicious proceedings. Natural justice has not prevailed. The proposals made in this paper serve to rebalance the current situation by establishing an independent and elected statutory Scrutiny Panel in each Trust.

'Currently there is absolutely no meaningful process in place to monitor and audit disciplinary proceedings and their outcomes. There is no record or audit of monetary costs.

While doctors have been penalised when found to be guilty Trusts have rarely been subjected to any form of scrutiny or disciplinary action when their actions may have been incorrect or misplaced. This issue requires further consideration.

'This document addresses the situation as it affects doctors in NHS hospitals in England, but it is envisaged that, should the proposals described in it be adopted, the system could be rolled out to primary care, the nursing profession, allied health professionals and other members of staff. It is also our expectation that these proposals would be adopted by all devolved nations.

'In the immediate future scrutiny panels could also be adopted as the local guardians for Freedom to Speak up.

'In summarising our proposals, the first responsibility of every doctor is to do no harm. The overarching objective of the Independent Scrutiny Panel is to protect the public interest which includes ensuring that everyone involved in the trust act in and put the public interest first.

'We welcome and support plans for the introduction of the Office of the Whistleblower currently going through Parliament [5].'

DFNHS has added its voice in support of this move to end the current situation with disciplnary proceedings, which as the authors point out are far too often damaging and unjust, in equal measure.

References

[1] MHPS 205
[2] *Freedom to speak up*
[Available at: https://bit.ly/3wz9Hfj]
[3] NHS England (2020) *A Just Culture Guide.*
[4] *Closing the Ethnicity Gap*
[Available at https://bit.ly/3lB6y1P]
[5] UK Parliament (2021) *Bill for the Office of the Whistleblower 21 June 2021 - Baroness Kramer*
[Available at: https://bit.ly/3PC51wU]

You can dowload the full document from the DFNHS website: https://bit.ly/3sQjn2R

Alan Taman
healthjournos@gmail.com

Primary Care and Public Health Vision for Revitalising Primary Care – A Charter for General Practice

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The crisis in general practice

Currently there is a crisis in general practice as many, whether patient or professional, know all too well. General Practitioners (GPs) are overworked and have become the target of vilification by the populist press intent on misleading the public as to the true causes of the dire state of primary care.

The number of GPs has fallen every year (down almost 1,500) in England since government pledged an increase in 2015. Many routinely work under extreme pressure and well beyond their contracted hours and are frequently subject to abuse from patients and relatives. Increasing numbers are looking to early retirement as a way out and GPs are leaving the profession faster than numbers entering training. The suicide rate for doctors has been estimated at between two and five times that of the general population, and evidence suggests GPs are at greater risk of suicide than most other specialties.

The UK has the lowest numbers of doctors and nurses /1000 people among the Organisation for Economic Cooperation and Development countries and the EU. Recent figures show that annual GP and practice nurse consultations have increased by 16%, now hitting record highs. Evidence also shows that UK GPs see far more patients daily than their counterparts in 10 other high income nations. In a new poll of GPs, only 13% thought their practice was safe for patients all the time with 70% saying threats to patient safety were increasing. The government seems to have no answer except to promise more GPs and then admit its targets will not be met. While being integral to the NHS, ministers are also misleadingly using GP's independent contractor status to deny concerns about privatisation, claiming that the NHS has never been a fully public service and has always relied on the private sector.

Looking to the future

Those 'on the left' are sometimes accused of looking at the past through rose tinted spectacles, and being preoccupied with defence of the NHS rather than thinking innovatively of a broad strategy designed to bring together health, social and economic justice. This charter from Doctors in Unite (DiU, formerly the Medical Practioners' Union) gives the lie to such assertions and provides a challenging perspective. In fact, rather than calling for a return to the status quo, DiU argues that the starting point must be a radical programme of supported change in primary care if its ultimate demise is to be prevented.

That this is urgently needed can be seen from the facts that current morale, recruitment and retention are at an all time low because of inadequate funding, poor working conditions, erosion of continuity of care, and an inadequate focus on Public Health, health promotion and confronting the social determinants of health. A new national care, support and independent living service is also required, together with funding targeted to where there is greatest need. Hospitals must support primary care in their communities, and closer working with local authorities is also required.

Rooted in communities

General practice must be firmly rooted in its communities, committed to understanding them and the diverse people who live in them, and supporting them in pursuing their own health. Reorganised and reinvigorated services should be based within 'Neighbourhood Health Committees' (NHC) serving a population from 25 – 75k, with practices covering 10k patients and having access to a wide primary care team (not for the purpose of substituting less-trained staff for GPs, but acknowledging the truth that good primary health care depends upon a range of skilled workers in addition to GPs). NHC will have their own Public Health leads, who will be combining general practice/practice nursing with Public Health work.

A first step should be the appointment of Community Development workers, initially to the most deprived neighbourhoods but then progressively expanding coverage. These would be funded to develop local community initiatives. Community Development strengthens social networks; weak social networks are one of the major adverse determinants of health. It facilitates local community organisations to strengthen community spirit, provide mutual help and allow communities collectively to address the determinants of their health and articulate their needs.

Both salaried and independent contractor status for GPs should be maintained, while working towards a system where GPs will positively choose a salaried service option. This recognises that in the current commercialised NHS, independent contractor status has a utility (independence from corporate control) that will no longer apply in the future with a reinstated and fully publicly funded service. Improving working conditions for GPs will include career progression, an agreed finite working day, list sizes of no more than 1200 patients/GP, and an expanded primary care team. The current situation of worst access to services for those most in need must be reversed. Public Health will be comprehensively improved.

Give GPs the tools they need

GPs will have access to high quality, fit for purpose, well maintained IT systems to enable most appropriate use of face-to-face or remote consultations. Digital exclusion will be addressed to prevent a growing area of health inequality. Enhanced IT systems will enable the extensive use of data for clinical care, research and population health analysis whilst requiring specific consent for any commercial use, protecting the confidentiality of individual patient information, and maintaining security of data whilst it is in identifiable form. Patients must be assured of timely, adequate access to the health or care worker most appropriate to their need; triage must facilitate this rather than being a barrier. Continuity of care will be supported and incentivised; the ability to provide continuity of care should be a significant part of how quality is judged.

Reinstatement of a fully public NHS

While these plans are both urgent and eminently affordable, this is not a quick fix, as it would require a re-instatement of the NHS as a public service, and a political party in power that shared the vision of transformational change – this cannot be delivered in a system that relies on commercialisation and fragmentation. A decisive movement away from policies of public sector cuts and preferential investment in the private sector must be abandoned. This would stop the expansion of a two-tier service and give the population of all four nations of the UK the healthcare that they need.

[This article can also be viewed on the Doctors in Unite website: https://bit.ly/3GpXOMf]

John Puntis
john.puntis@yahoo.co.uk

The Peter Fisher Essay 2021: Runners-up

The next two runner-up entries for this year's Prize.

What lessons should we learn from the Covid-19 pandemic?

I'm standing adjacent to the blue screen trying to control the incessant ripples of tremors travelling up my body.

It feels like I'm standing on a washing machine as it does the final fastest spin. I take a deep breath as the sound of the time buzzer is projected from a speaker, and step into the cubicle. It's hard to concentrate on reading the task and I have to triple check the text this time as I think I'm reading something about a parrot that has escaped. My task is to tell my neighbour their beloved pet, which I was looking after while they were on holiday, has broken free, never to be seen again. It was at this station, in one of my medical school interviews, I formally encountered the practice of breaking bad news for the first time.

Having gained a place at medical school, I was immersed in an abundance of seminars and focus groups aimed at improving communication. Initially, I was bemused by the exercise of talking to an actor pretending to be fuming at their waiting time in A&E. However, I found under the pressure I would stumble over my words and babble uncontrollably. At school I had used white lies or humour to wriggle out of trouble – this was no longer an appropriate approach. I quickly learnt to take the sessions more seriously.

Six years later, I found myself on an elderly care ward navigating my first few days as a junior doctor. In our induction to the speciality, we were advised a significant portion of our time would be dedicated to contacting next of kin. I shuddered as I recalled the scenario of 'meeting an angry family member' and a faint feeling of reluctance and dread passed over me. I secretly hoped I wouldn't always be allocated this job as the most junior member of team.

COVID meant, as anyone reading this will know, that no visitors were permitted in hospital. For most patients this was a minor inconvenience that could be remedied with the use of Facetime and social media. Among my patients, who were in their advancing years, there was not such an easy solution as most were unfamiliar with smart phones and the technology designed for them. For those who had mobiles, there was usually trouble with keeping the devices charged as well as in reach. Then there were signal issues of course. The bedside hospital phones were sometimes used but often the audio was too poor for those with hearing impairment. So the ward team became the main channel of communication. In the context of COVID this was a massive undertaking. It was, and still is, frightening not knowing what might happen to loved ones when they disappeared into hospital with the virus. This was especially true for parents and grandparents considering the statistics did not favour the older adult population. This meant families were desperate to gain updates, sometimes asking for news daily. Multiple members of the same family would be keen to hear directly from us and it started to become an overwhelming task.

Clinical jobs had to be prioritised which almost always meant contacting families came towards the end of the day. This was problematic as we wanted to ensure the window of opportunity the families had to get their update and ask questions was adequate. However, I would find myself looking at my watch and cutting discussions short, knowing

everything also had to be precisely documented before the next family was called. To add to the frenzy, the 2 by 2 m office was invariably packed with other doctors, with whom I was practically touching knees, all trying to do the same thing at the same time. This made it hard to think clearly and at times I found myself once again faltering in my speech and even forgetting words like 'lung' as I tried to break bad news. In these pressured moments I would find myself falling back on the tips I had once thought too obvious to need teaching that I had learnt in those sessions at university.

Something that made communication different during COVID however, was there was a great deal more uncertainty. I felt an expectation to provide all the answers but found I often had to openly declare that I did not have them because we simply had limited knowledge and experience of this new virus. It was challenging not to slip into giving vague and baseless responses and there were often inconsistencies in information given by different staff on the same ward. We recognised this as a team however, and endeavoured to ensure families were communicating with the same doctor each time. In a situation characterized by uncertainty, being consistent was essential.

As time passed and hospital admissions drew on, I began to realise how important it was that we had a structured system in place to ensure that families were being consistently communicated with. Many elements of patient care are tracked with electronic patient record system (eg whether thromboprophylaxis has been prescribed and antibiotic expiry dates). This includes prompts when a task is due and a clear record of when items have been completed and by who. 'Next of kin updates' however, are yet to qualify for their place on the system. Though an entry is made when a discussion has occurred, this can easily get lost in the swathes of other clinical documents and clicking though tens of notes to find one titled 'NOK update' can be time consuming. Without a place to quickly check dates of the last update, days could pass before someone might realise that a phone call was due. It made me wonder if we should set a standard for frequency of communication with families. If those outside hospital knew when updates could be anticipated, anxiety could perhaps be reduced. Clear, honest and timely communication is key for forming a trusting relationships and a good relationship was vital for navigating these uncertain times successfully.

It has not just been doctors that have wrestled with health communication however. Politicians also had to wade through the 'infodemic' and streamline available data to brief the apprehensive public. An article was published in the *Lancet* in February 2020 titled 'fighting panic with information' which highlighted the importance of this responsibility. Despite their efforts to be clear, on many occasions, following a government announcement, the public expressed exasperation over lack of clarity, back-tracking and mixed messages. When listening to Downing Street updates, I found myself wondering what form of communication training politicians undertake and whether they use some of the same tools we are taught to create good relationships and communicate clearly.

In an analysis of health communication, Finset et al. [1] suggested there are many more components to effective health communication than accurate information sharing and that acknowledging emotions is essential. We are taught that being empathetic is vital for building a good relationship with a patient or family member and I noticed that empathetic statements were also being used by politicians. On announcing the return of lock down Boris said 'I completely understand the inconvenience and distress this late change will cause'. For some this might have demonstrated a sense of understanding from the politicians and therefore increased their trust in the policies being made. However, while this is an example of 'acknowledging emotions', it is a form of language we try to avoid in medicine, simply because very rarely can one person 'completely understand' another. This type of phrasing is perhaps what has led some people to feel these statements were

devoid of true sentiment and therefore reduced trust.

When tiers were in place, the country was split by region and each region was communicated with differently and under different lockdown regulations. There was information weekly on which regions would be in a green amber or red system and the changes were frequent. This was a confusing time for the public and for many, the rules were too baffling to follow. Andy Burnham was hailed 'King of the North' for voicing views that the government were handling the pandemic poorly at this time and communication between the government and the public broke down leading to disregard of the system. This is an example of how lack of consistency can break confidence. Similarly, when communication between patients, families and clinicians is occurring independently without collaboration, over time, this can lead to everyone holding different views about how best to proceed. At worst, this can cause completely opposing views which can leads to delays in care. Without being able to gather together at a bedside or in a family room it was tricky to ensure everyone held the same understanding. During COVID, teams politicians and families may have been more vulnerable to splitting as uncertainty made room for subjectivity.

Families were permitted to enter a ward when a next of kin was nearing end of life. This was emotional because we were finally able to put a face to the voice with whom we had formed a relationship over the previous days and weeks. I think it would have been a joyous moment were it not for the circumstances. Meeting the families was when I truly understood the worth of the work we had put in to talking to them. I noticed that even after meeting multiple members of the team (all who were caring for the patient), families would usually defer back to the doctor with whom they had communicated the most which illustrated the trusting bond that had been formed. I realised as I handed over my place at the bedside to the family that in some ways I had at times assumed the role of the brother/daughter/grandchild/partner. I was often asked to pass on love, jokes, well wishes and caring messages and even typed texts to families from patients phones as they dictated.

Being a conduit for these personal interactions gave me all the evidence I needed to truly understand how crucial this connection to the outside world was for the patients and vice versa for the families.

My view of 'next of kin updates' was completely changed over this period of time. I learnt it is a profoundly important responsibility and paramount to providing good care. Oftentimes the conversations were sensitive and when I wasn't delivering good news I understood that this conversation for some families may be one they never forget. As a junior it felt like an incredible privilege to be trusted and relied upon in this way. I learned the importance of preparing for these conversations before initiating them, especially in circumstances where I was uncertain.

More broadly, I observed how good communication and health communication can reassure and lead to effective change. When communication is disorganized or breaks down, confusion, anxiety and poor outcomes result. I found this to be true on a individual and national scale. The lessons I once learnt in medical school continue to be relevant to me today but through COVID I have understood how to apply them.

Reference

[1] Finset, A., Bosworth, H., Butow, P., et al. (2020) Effective health communication – a key factor in fighting the COVID-19 pandemic. *Patient Education and Counseling,* 103(5), pp.873-876.

Sophie Bashall

What lessons should we learn from the Covid-19 pandemic?

> **"Obey my commands at all times. Protect yourselves at all times. Now touch gloves and let's have a good clean fight."**

Fans of the *Rocky* films and boxing in general will recognise these sentences as the instructions referees give to fighters at the start of a bout. Media reports often characterise the pandemic as a fight and, at the time of writing, in the UK at least: we are reaching the final rounds of an epic battle between virus and vaccine.

The question this essay seeks to answer is: "What lessons should we learn from the COVID-19 Pandemic?" As the poser of this question is 'Doctors for the NHS', it seems reasonable to assume that the 'we' referred to are doctors as opposed to society as a whole.

My answer to this question is derived from the referee's instructions I have cited above.

Obey my commands at all times. In my experience doctors are used to issuing commands: requesting scans and bloods, prescribing drugs and handing down lifestyle advice to patients. We are less good at taking orders: I have lost count of the times I've tutted and rolled my eyes at being requested to remove my watch by a ward nurse (although I always do so when asked) in order to be 'bare below the elbow'. Our nursing colleagues are, again I can only speak from my own experience as a relatively junior doctor, considerably better at adhering to rules and regulations than we are. We give ourselves license to bend – and sometimes even break – the rules if we feel that doing so is in the best interests of our patients.

We might order a 'therapeutic X-Ray' that we know is not really clinically indicated but will make our patient feel that something is 'being done' for them. Ordering a scan may get that patient off our back so we can move on to someone more acutely unwell and in need of our help but is it really the right thing to do? Perhaps the pandemic should push us back down the path of complying more consistently with the edicts and guidelines that exist to protect both us and our patients? The slogan was: "Stay Home. Protect the NHS. Save lives." We are the NHS and we know better than anyone how finite our healthcare resources will always be: we should use them more sparingly.

Protect yourselves at all times. The obvious point here dates back to the shortage of PPE equipment at the beginning of the pandemic last year. We were being asked to re-use masks and I will never forget a BBC story from 31/03/2020 entitled: Coronavirus: Paramedic protective kit 'only fit for making sandwiches' [1]. Supplies of PPE have subsequently stabilised, and you now can't walk 10 steps without seeing surgical masks strewn on pavements.

In my own Trust, I have seen the pandemic and the ensuing 'surge rotas' and 'special measures' lay waste to the health (physical & mental) and morale of my colleagues. We were urged – ordered even [2] – to be 'flexible' because of the extraordinary nature of the pandemic and most of us have more than answered that call but have we protected ourselves? Thousands of us have caught Covid or had to isolate – more than once – because a colleague or household member has tested positive. The devastating toll this crisis has taken on us and the trauma we have undergone as a profession will only become apparent once the dust has settled. There are 700 anaesthetists – the very doctors we relied on most to protect the airways of the most severely ill Covid patients – who are now jobless [3]. To say nothing of the development opportunities missed, clinical experience lost, and training disrupted for junior doctors at all levels in every specialty.

I was very happy, as a BMA member, to learn that I now have 24/7 access to face-to-face counselling for the next 6 months via the Covid-19 Healthcare Support Appeal. [4] However, this generous offer turns out to be a one-off session capped at no more than six sessions in total following triage: six

times is not the same as protecting ourselves at all times! Clap for carers was wonderfully inspiring for the first couple of weeks but we need ongoing support financially, physically and mentally if we are to really learn the lessons of Covid.

Now touch gloves… I will avoid making the same cheap point about PPE again but remark instead on the enormous deficit the lack of physical contact (necessitated by the pandemic) has had – and continues to have – on both our interactions with each other and our clinical encounters with patients. Will we ever be able to shake hands again? Or hug a distressed colleague coming off a brutal night shift? Or lightly tap the shoulder or elbow of a fellow clinician to either get their attention or bid them hello or goodbye? Much is made in fiction, superstition and the history of medicine of the 'healing hands' [5] of physicians and lightness or deftness of touch are virtues we prize highly in our surgeons above all. Has the pandemic put paid to the concept of 'therapeutic touch' in perpetuity?

> "Without wishing to stray too far into the bungling of Boris Johnson ... I think it is fair to say that there has been nothing 'clean' about our fight against this disease. "

Virtual appointments are clearly here to stay, and the pandemic has been of enormous assistance – particularly in general practice – in making such consultations palatable to patients.

There is little point in wasting half a morning trekking into your GP's surgery only to sit, arms folded and fuming, in a packed waiting room because s/he is running behind only then to be advised that what Google had convinced you was end-stage colorectal cancer is actually an anal fissure when a carefully positioned (in this particular hypothetical example it would need to be very carefully placed!) smartphone camera and a few minutes on Zoom would have provided all the reassurance with none of the inconvenience.

However, I can recall being told endlessly during 'comm skills' sessions at medical school that 90% of communication is non-verbal and the nuances of expression and body language are lost when both doctor and patient are confined to a two-dimensional square on a computer screen. It is an unpopular motto in an age where we must concentrate on sustainability rather than consumerism but, when it comes to face-to-face versus online appointments, I think we must adopt an "as well as, not instead of" attitude in the wake of the pandemic.

…and let's have a good clean fight. Without wishing to stray too far into bashing the bungling of Boris Jonson and the hapless halfwits in his cabinet for their (mis)management of the pandemic I think it is fair to say that there has been nothing 'clean' about our fight against this disease. We panicked when we saw what was happening in Italy – patients piling up in the corridors – and emptied our hospitals thereby seeding the care homes with Covid-19 and causing tens of thousands of unnecessary deaths. We failed to appreciate that the Italian system – whereby you pay for your treatment yourself – does not practice triage in the way that we do and is in the habit of admitting anyone who presents to hospital on an 'admit first, ask questions later' model. I have already touched on the fiasco of PPE procural so I will here remark instead on the lunacy of the 'Eat Out to Help Out' scheme, which all but guaranteed the second lockdown in November 2020.

As far as we know, severe acute respiratory syndrome coronavirus 2 came into being in late 2019 in a wet market in Wuhan in China. It was therefore unlikely to have been present in London in 1865 when the 9th Marquess of Queensbury [6] drafted the code of rules on which modern boxing is based. My point here being that Covid

does not fight fair: it does what viruses do. It mutates and changes. Just when you think you've got it on the ropes (as we all did in summer 2020) it comes back at you with a series of low blows, kidney punches and sneaky digs when the referee's back is turned.

So far our 'jabs' are keeping the variants at bay and the UK government's gamble of going all in on the vaccination programme appears to be paying off. However, we are deep into the championship rounds now and there is no certainty that we will be saved by the bell…We, as doctors, need to take our opponent seriously and ensure we do not stint on our preparations for a fourth wave this winter.

The question posed was: what lessons should we learn? What lessons we will learn – if any – is quite a different matter and I will conclude my essay with this advice to myself and my fellow NHS doctors from a certain poet who hailed from Stratford-Upon-Avon:

> **"Once more unto the breach, dear friends, once more" [7]**

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David Trennery

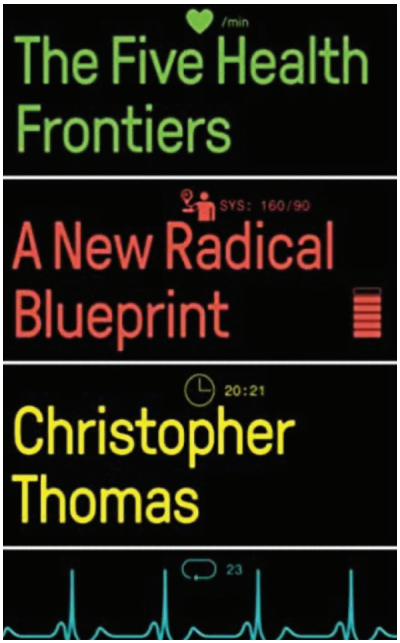
Book Reviews

The Five Health Frontiers. A New Radical Blueprint
(£13.99, Amazon, paperback; Also Kindle and hardback)
Christopher Thomas. Pluto Press, London, 2022, 240 pp.

This book provides a helpful and eminently readable overview of 'health' and how a government with a 'health justice agenda' might effect meaningful change.

'The left' (a troublingly amorphous concept that casts the Royal Colleges in the role of key institutions of the 'health labour movement') is castigated for being romantic and defensive rather than innovative and visionary, placing a narrow focus on health services rather than the more important social determinants of health. Some arguments appear overstated for rhetorical reasons, for example: "We believe in 1948 as an ultimate victory for the left on the health agenda". This disregards justified and longstanding criticism of the NHS by progressives that it was a 'sickness' service rather than a 'health' service, and that some elements such as mental health were never given the investment they warranted. The author also acknowledges that Bevan's plan did not include a universal public health service.

In any case, few would now look at the current state of the NHS with its record waiting lists, staffing crisis, relatively poor outcomes and increasing penetration by the private sector, and not reflect that the 'ultimate victory' may yet prove to have been only a temporary respite. The Just Treatment 'NHS New Deal' is singled out as an exemplar of a myopic fixation on the NHS (exacerbated by covid), and yet a glance at this organisation's website shows it also has an international focus including vaccine equity and challenging the profiteering by big pharma. There is no mention of last year's People's Covid Inquiry which critically examined the government's response to the covid pandemic, but also explored health inequalities and in fact opened with internationally renowned



Michael Marmot as an expert witness.

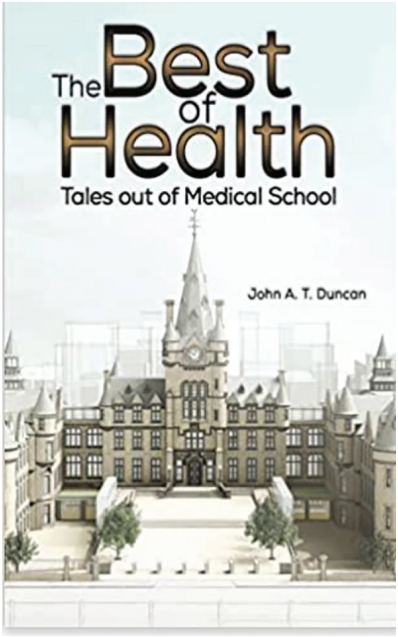
The book is divided into sections on the NHS, social justice, economic issues, social care, sustainability, and finally, a new deal for public health. Work on health inequalities by pioneers such as Marmot, Kate Pickett and Richard Wilkinson is duly acknowledged. The section on social care is rightly critical of the limitations of Labour's National Care Service ("the NCS does not sufficiently change the nature of care, the power relationships that define it, or the level to which institutionalised and paternalistic care dominates provision") and advocates a much broader approach, similar to the campaign for a National Care Support and Independent Living Service (NaCSILS).

There are a couple of minor if surprising errors. It is stated that "Since 2010, about 10,000 hospital beds have been closed in England", whereas according to King's Fund data around twice this number were lost. Of less importance is the attribution of the Black Death to a virus rather than the bacterium *Yersinia pestis*.

The author makes a cogent plea that health improvement and health justice require looking beyond health services to a public health system as a whole. This is perhaps the key message overall for health campaigners. The issue of affordability is dealt with well, although there is little on reformation of the tax system as a way to finance public services. While the author distances himself from the suggestion that the book is really a polemic with a somnolent Labour Party in need of "a far more compelling vision", statements such as "the leftist strategy in health has therefore become defined by maintaining the status quo", leaves little doubt as to exactly where the barbs are aimed. If we agree that it is conditions of social injustice that make us sick, the questions remain as to whether democratic socialism is up for seriously challenging the dominance of those businesses and corporations who profit from our ill health, and what might be revealed about the balance of power in the course of such a struggle. Even more reason to rally the troops around defending and rebuilding the NHS perhaps, while setting this in the context of a much broader vision of public health as outlined in this book.

John Puntis
john.puntis@yahoo.co.uk

The Best of Health. Tales out of Medical School
(£8.19, Amazon, paperback. Also Kindle)
John A.T Duncan. Austin Macauley, London, 2022, 236 pp.



***The Best of Health* is an engaging and entertaining memoir. John Duncan, now in his eighties, describes his medical training as an undergraduate, pre-registration house officer and then trainee anaesthetist at the Edinburgh Royal Infirmary in the sixties.**

He started as a mature student with a technical rather than science background having managed a family owned pottery in Stoke before deciding to study medicine at the age of 24. He was fortunate to have been offered a place at ERI – the only teaching hospital which seemed to be keen to offer places to mature students with unconventional backgrounds.

Before the NHS was created in 1948, the ERI was the largest charity hospital in Europe. It had an established reputation for being dedicated to clinical excellence and continued to flourish in the post-war NHS. John recalls his years at the ERI with affection. There are also vivid descriptions of

the mainly Victorian architecture of the ERI buildings and of the city which dazzled him when he first moved there all those years ago. They are brought to life for those unfamiliar with the city.

The more amusing and dramatic highlights of his years as undergraduate and trainee are entertainingly told. Some are bizarre – like the great sleep experiment and the debacle of the cutting edge surgical resuscitation hamper. Some are hair-raising. Untrained juniors are no longer called on to administer a general anaesthetic!

These diversions carry the reader along but no one is left in any doubt that those years were also gruelling and stressful. It was a hard slog with 30% failing to complete the course.

The financial strain experienced by the medical student and junior doctor is also clearly evident. This, coupled with working in less than ideal conditions in a peripheral hospital as a houseman ,nearly drove him to abandon medicine altogether. Fortunately his next pre-registration job was at ERI where junior doctors were cherished. Conditions have worsened for present-day medical students. Although bursaries are available, they find it difficult to make ends meet especially during their clinical years and they also wind up with a hefty debt due to the introduction of tuition fees (in all countries except Scotland). Junior doctors continue to be poorly paid and their working conditions are not ideal. Unremitting work in inadequately staffed units is leading to burnout with many abandoning their medical careers in the NHS.

John feels he was lucky to have undergone his early clinical training in the seemingly different world of the post-war early NHS. He describes it as the Golden Age of the Health Service compared with the 'politically engineered desolation' of the current NHS. It was a time of high morale among clinical staff when the gap between health needs and clinical provision seemed to be closing. A supportive government with an enthusiasm for advancing technology resulted in a surge of 'special units': coronary care, renal dialysis, neonatal care, and intensive care. His interest in the political workings of the establishment did however reveal the conflict which existed then as now between management and clinicians.

John was observant and sensitive to the social issues of the time. The precept that medicine is more than money runs through the book. He acknowledges the close working relationship with, and the fundamental role played by the nursing 'Sisters' and the teamwork across all levels which helped maintain high clinical standards. He identifies several clinical teachers to whom he is particularly grateful. Valuable life lessons were learned including the importance of absolute honesty. He also vividly recalls the introductory lecture given to medical freshers. The lecturer, who had experienced pre-NHS medicine, championed the idealism of the NHS where patients were treated according to their needs and not according to their means. 'Hold tight to your ideals and cherish them through the long years of study and the work ahead' he urged. This counsel clearly stayed with John.

John Duncan has been a long-standing member of NHSCA (now DFNHS). He was active on the executive council for many years. This book reinforces our commitment to restoring the ethos of the NHS of John Duncan's youth.

Malila Noone
malilanoone@gmail.com

EXECUTIVE COMMITTEE : Elected at AGM 2021

Contact information is provided so that members can if they wish contact a Committee member in their area or working in the same specialty.

Mrs Anna Athow
General Surgery, London
0207 739 1908
07715028216
annaathow@btinternet.com

Dr Arun Baksi
General Medicine/Diabetes,
Isle of Wight
01983 883 853
07786 374886
baksi@baksi.demon.co.uk

Dr Morris Bernadt
General Adult Psychiatry,
London
020 8670 7305
07510 317 039
mbernadt@hotmail.com

Dr Chris Birt
Public Health
07768 267863
christopher.birt75@gmail.com

Dr Matthew Dunnigan
General Medicine,
Glasgow
0141 339 6479
matthewdunnigan@aol.com

Miss Helen Fernandes
Neurosurgery, Cambridge
haatchy1966@gmail.com

Dr Andrea Franks
Dermatology, Chester
0151 728 7303 (H)
Roger.Franks@btinternet.com

Dr Alison Hallett
Trainee, Leeds
alisonelizabeth@live.co.uk

Mr Colin Hutchinson(Chair)
Ophthalmology, Halifax
07963 323082.
colinh759@gmail.com

Dr D.A. Lee
Paediatrics, Whitehaven
01946 820268
Lee535877@aol.com

Dr Malila Noone
(Secretary)
Microbiology, Darlington
01325 483453
malilanoone@gmail.com

Dr Maureen O'Leary
Psychiatry, Sheffield
jm.czauderna185@btinternet.com

Dr Hans Pieper
General Practice, Ayr
hansandphil@icloud.com

Dr Peter Trewby (Treasurer)
General Medicine/
Gastroenterology
Richmond, North Yorkshire
01748 824468
trewbyp@gmail.com

Dr Eric Watts
Haematology,
Brentwood, Essex
01277 211128
eric.watts4@btinternet.com

Dr C.P.White
Paediatric Neurology,
Swansea (Morriston Hospital)
CPWhite@phonecoop.coop

Dr David Zigmond
General Practice/Psychiatry,
London
0208 340 8952
davidzigmond@icloud.com

Dr Pam Zinkin
Paediatrics, London
02076091005
pamzinkin@gmail.com

Communications Manager
(paid staff, non-voting)
Mr Alan Taman
07870 757309
healthjournos@gmail.com

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