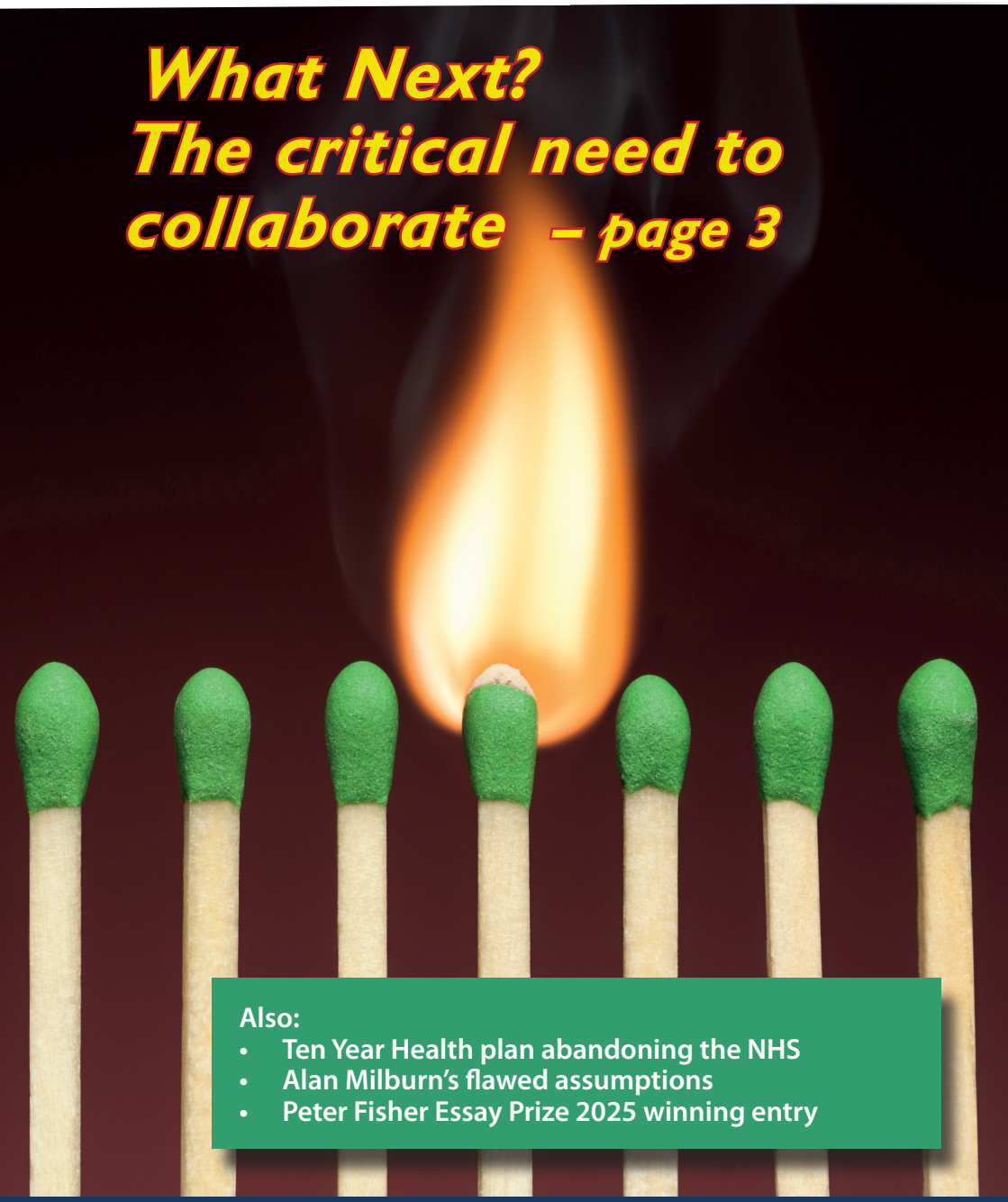
DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

What Next? The critical need to collaborate – page 3



Also:

- Ten Year Health plan abandoning the NHS
- Alan Milburn's flawed assumptions
- Peter Fisher Essay Prize 2025 winning entry

JULY – SEPTEMBER 2025

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A (parting) View From the Chair: What Next?

Remembering Peter Fisher

It is 4 years since the death of Dr Peter Fisher, founder member of the NHS Consultants Association, which in 2015 became *Doctors for the NHS*. After serving as an extremely energetic and effective Chair for many years, he stepped down when he retired from clinical practice, because he felt it important that the Chair should be actively working in the NHS. I shall return to this later. Peter was elected as President for life, and served in that role enthusiastically until he died. The Newsletter of August 2021 contains a more detailed account of Peter's career and contribution to the founding principles of the NHS.

Since 2018, DFNHS has been organising an annual essay competition for doctors in training, encouraging them to explore the wider context of the profession they are entering. This was a project close to Peter Fisher's heart, so it seemed entirely appropriate to associate his name with the competition, by offering the Peter Fisher Essay Prize to the winning entrants.

The importance of experience

It has been my pleasure to have been one of the judges for this competition for a number of years; a pleasure because the essays give an insight into the range of experiences confronting resident doctors in the formative period of their professional lives, which will lay the foundation for the coming decades, and of their impressions of the NHS as a means of delivering healthcare to the nation(s); a pleasure also because of the quality of so many of the essays and the variety of approaches taken by their authors.

The title for this year's essay was 'How can medical education be improved for the benefit of the patient?' Congratulations to Ke Wei Foong, whose winning entry is published in this Newsletter: we hope you agree that it is a mature and thoughtful reflection on how a change in emphasis of values in training might achieve much more than a radical overhaul of the system. We intend to publish other essays that caught our attention over the year, as space allows. It may be unsurprising that doctors with current experience of the education system can have very strong views on the way in which it prepares them for the reality of delivering healthcare. Given the constraints of a 2,000 word limit, the authors were forced to be selective in their chosen themes, rather than offering a critical analysis of the entire range of medical education, and the themes they chose were extremely varied.

There were some recurrent threads that cropped up repeatedly, including a recognition of some of what has been lost with the abandonment of 'the firm' as a basis of apprenticeship training. There was felt to be little opportunity to observe the development of the doctor-patient relationship over a prolonged period of time, rather than a brief episode. There were thoughts on how to improve the educational value of ward rounds and of how lecture-based teaching methods could be improved. The serious impact of rota gaps on the ability to deliver or attend in-person teaching sessions, which were at risk of being seen as a nice-to-have rather than an essential part of clinical training, particularly when the loss of the firm reduces the opportunities for ad hoc teaching. There was felt to be a need for much greater interdisciplinary education, to reflect the reality of such teams in delivering care,

improving communication and mutual respect. It was also suggested that assessment of students and trainees should value and reward caring and empathy alongside knowledge and technical ability. There was also a feeling that the years of education are not providing a sound preparation for the practical realities faced by the new FY1 – a feeling that I suspect many of us can remember.

It was interesting, given all the government's expectations of a digital revolution reshaping the delivery of medicine, how little excitement this seemed to generate amongst the essay writers. One entrant made a strong plea for training in information handling and clinical prioritisation in a system awash with digital noise. Another emphasised the value that could be unlocked by appropriate use of artificial intelligence in reducing the administrative burden of resident doctors, but nobody felt that it would replace the need for highly trained, caring doctors at any time in the foreseeable future.

Maintaining relevance in a changing landscape

The NHS Consultants Association was founded 49 years ago, when it was felt that the BMA was overly supportive of private practice, as opposed to the NHS. That might have changed, but there are still powerful voices promoting the interests of commercial businesses in tapping into the flow of public money allocated to 'health' and plenty of our colleagues who are looking for as much of the action as they can get. There is still a great need for doctors who recognise the value of universal access to comprehensive medical care to use their professional voice to make this a reality.

Unfortunately DFNHS is losing members faster than we are attracting them. This may be inevitable as so many of our members are retired, and many are long-retired. Although we embody a huge amount of experience, and no small measure of wisdom, within our ranks, many of us are increasing that experience from the other side of the counter, as patients, rather than as medics, although there is a lot to learn from being a secret shopper. It is with sadness that we remember Dr Pam Zinkin, retired Consultant Paediatrician of Finsbury Park, who passed away a few weeks ago. Pam had been a member for 24 years, and a member of our Executive Committee from 2012 until her death. She was fearless and tenacious in fighting for her beliefs and convictions and will be very much missed.

We are reaching a point where we need to rise to the challenges that this presents. You might be aware that we have decided against holding our annual conference this year, which was due to have taken place in York on 16th October. Although we have had some fascinating and worthwhile meetings, the number of members attending has steadily decreased to a point where it has become frankly embarrassing to invite high-profile speakers to give their valuable time to address a tiny audience, no matter the quality of that audience. These events have also been absorbing a significant amount of the association's funds. So this year, we will be holding our Annual General Meeting online, via Zoom, but as a standalone event. This is advertised elsewhere in the Newsletter and I hope as many of you as possible will attend, because we will be discussing the future of DFNHS and need the widest possible mandate from our membership.

We have been encouraging members to put their experience and energy at the disposal of other organisations with which we share values. As one of the bodies that founded Keep Our NHS Public in 2006, as a campaigning organisation open to anybody who supports the founding principles of the NHS, we have encouraged our members to strengthen KONP's campaigns and local groups with their understanding and authority, and quite a lot of you have done so. Once again, John Puntis, one of our members who is also Co-Chair of KONP, has made not one, but two contributions to this edition of the Newsletter, emphasising the strong connections between our organisations. In

recent years, formation of the Doctors Association of the UK, (whose Co-Chair is Helen Fernandes, a longstanding member of DFNHS's Executive Committee), and Every Doctor, has provided other options for doctors to raise their voices and attracted many younger (and not so young) doctors, including a number of DFNHS members who continue their membership. Collaboration is the order of the day and is essential in building campaigning strength.

Despite our reducing membership numbers, we still have more than 500 members, with representation in all four nations of the UK and from most disciplines, so we can call on a considerable body of experience. We have a strong impression that one of the main benefits valued by our members is the printed format of the Newsletter, and the quality of the contributions within it, and we will be looking to divert more resources into this and some of the material will also be suitable for enhancing our online presence. We would also hope to encourage more of our members to submit work based on their own experience and ideas. As already mentioned, the Peter Fisher Essay Prize has also been a worthwhile project. Although we had hoped that it might increase awareness of DFNHS amongst resident doctors, and entice more to become members, the impact has been modest, but the quality of entries has been sufficiently high that we have recommended that the competition should continue.

Despite these strengths, the question remains: how do we make sure that DFNHS remains relevant to the doctors who are working in the NHS of today? There is also the question of how the organisation restores its relevance amongst doctors in Scotland, Wales and Northern Ireland as the health services become increasingly divergent. It is no secret that our influence is in part proportionate to the size of our membership, but it also depends on increasing the number of our members that are actively working in the NHS, so that we are able to speak with greater authority and confidence about the main issues affecting the service.

Decision time

For these reasons, the Executive Committee have decided that we should explore the possibility of developing a more formal association with another organisation with whom we share values and objectives, assuming there are mutual benefits and any such move is supported by the respective membership. Rest assured, any such association would need to be put to an AGM or an Extraordinary General Meeting before it could be ratified. I would expect to report on progress of any discussions at the coming AGM.

I am also aware that there have been very few new members of the Executive Committee (three in the past 10 years), despite repeated appeals for new members. I would like to renew that invitation to become more involved in shaping and taking forward the priorities of your organisation. We could really benefit from new members who are in current employment in the NHS anywhere in the UK. It does not have to be an onerous commitment – meetings are held online and are three or four times a year, with flexible scheduling. Feel free to phone or email myself or any other member of the Executive if you want to find out more about the role.

As I mentioned earlier, our former President, Peter Fisher, felt that it was important for our Chair to be in active employment in the NHS, and stepped down when he retired. I have had the privilege of being Chair of DFNHS since 2017. I retired 10 years ago and, although my position as an Elected Member of Calderdale Council, in West Yorkshire, has given me practical involvement in holding local NHS services to account during that time, I am acutely aware that my clinical experience is disappearing rapidly in the rear-view mirror. As soon as you leave the NHS, the steel shutters come down around the organisation and access to accurate, unfiltered information that you had previously taken for granted about the service, the

quality of care and working conditions, becomes almost impossible. It makes it hard to know whether you are focusing on today's priorities, or fighting yesterday's battles. I have therefore decided to stand down from the Chair at the coming AGM, although I would be happy to continue to serve as a member of the Executive Committee, if elected.

I would be very happy to have a conversation with any member who wishes to consider nomination for the Chair, or is simply curious. I have found it an experience that has taken me outside my comfort zone, but which I have found interesting and worthwhile. Even if the task faced by health campaigners would be familiar to Sisyphus, it is too important to turn away from.

The struggle in front of us

There is no shortage of changes that cry out to be challenged in the light of our experience as doctors, patients and rational humane beings, some of which are highlighted in this Newsletter:

• Since the last Newsletter, the *Ten Year Plan* has been published which seems to largely disregard the findings of the Darzi Review that supposedly analysed the problems facing the NHS. John Puntis gives a detailed analysis of the Plan, although we are still to see publication of the crucial chapter, outlining how the plan is supposed to be delivered. I guess the Treasury has yet to sign this off: so much for mission-led government! The emphasis is on treating patients as consumers, choosing from a marketplace, but this supposes that real and informed choice exists for people in the throes of illness. Don't health services have more in common with gas, electricity and water, than with groceries and clothing? Look how well we have been served by the privatisation of our utilities.

• John Puntis also provides a long view, using the experience of having lived and worked through Milburn's last time in office. It is vital to use the evidence of what went well, and what didn't when we see the re-emergence of policies first rolled out during the noughties, but without the accompanying overall increase in investment in the NHS, when the aim was to bring our spending up to the European average – just the average, remember, so not over-ambitious. There were lessons that should have been learned, but seem to have been forgotten.

• Morris Bernadt reviews the *Leng Review* of professions allied to medicine. This review has revealed the lack of understanding of the value of a comprehensive medical training in laying the foundations for an accurate clinical diagnosis, without which treatment planning becomes unsound. Understanding the way in which the human body functions in both health and disease, coupled with a detailed knowledge of the mechanisms and manifestations of disease, and the effects of medications, cannot be gained from a brief training, but take years of study reinforced by continuing education and experience. Artificial intelligence cannot replace the critical thinking that is required. Although the Government has accepted in full the findings of the review, we have yet to receive a detailed response from the GMC to our enquiry as to how they are going to implement Recommendation 15 on Regulation and accountability.

• Andrea Franks reviews the influential novel from 1937, *The Citadel,* and its relevance today, including the importance of professionalism and high standards in doctors and the profound influence this can have on our patients.

At this time of yet further upheaval in the NHS, and its seventh spasm of system 'reform' I would repeat what I said in the Newsletter from July-Sept 2024, "We have the opportunity to restore the NHS to its former pre-eminence amongst world health systems. We can't afford to blow it!"

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Ten Year Health Plan: how on its journey from 'bricks to clicks' Labour is abandoning the NHS

John Puntis, in the first of two articles, critiques Streeting's '10 Year Plan' – and finds a great deal wanting

The NHS *Ten Year Health Plan* for England (TYP) (1) is less of a blueprint for how to set the NHS back on its feet than 165 pages of fevered imaginings about the transformative potential of technology, artificial intelligence (AI), genomics and care nearer home – 'more a set of ambitions written by committee than a "plan" per se' (2).

We are told that together these will transform patient outcomes, without the need for additional investment. According to Alan Milburn (3) (Streeting's chief health advisor) the health care system will no longer be about 'the NHS', but will embrace the private sector including communication and tech companies, working in a new ecosystem overseen by a much reduced Department of Health and Social Care (DHSC). This will exert control through manipulating financial flows, incentivising particular behaviours and with 'Independent Health Organisations' (IHO, mirroring the Accountable Care Organisation model(4)) playing a key role. The TYP has been characterised as long on 'what' and short on 'how' with the implementation chapter in the draft report (5) failing to appear in the final published version. Here follows a brief summary of some of its key points and weaknesses.

'The NHS is broken – reform or die!'

Against a dramatic backdrop of claims that 'the NHS is broken' and shouts of 'reform or die', the three shifts (hospital to community, analogue to digital and sickness to prevention) take centre stage. However, like Lord Darzi (6) ('the NHS is in a critical condition, but its vital signs are strong'), many reject the idea the NHS is broken (7). The TYP considers that transformational reforms including service improvements and new technology are deliverable within the far from generous £29bn committed in the recent spending review. The fact that this 'record funding' represents a less than average historical annual rise in spending (needed to keep up with inflation and rising demand) is ignored. As Mathew Taylor, Chief Executive of the NHS Confederation pointed out: 'this additional £29bn won't be enough to cover the increasing cost of new treatments, with staff pay likely to account for a large proportion of it ... on its own, this won't guarantee that waiting time targets are met' (8). The Nuffield Trust also commented (9) that 2.8% more is unlikely to be sufficient to enable the NHS to keep up with the routine increases in activity expected of it, let alone implement further government asks (now including the huge demands of the TYP).

Being economical with the truth

The introduction to the TYP states that the following principle is at the heart of who we are: 'every single person, no matter who they are or where they come from, deserves the same quality treatment, free at the point of use'. This deliberately obscures the fact that around 1.2 million migrants are currently required to pay for hospital care (10). Despite Lord Darzi's report warning both of the need for considerable capital

investment to improve productivity and against slashing senior management posts (6), the very opposite is now envisaged. Some 20,000 NHS admin and management posts are to be cut to save about £1.7bn a year, with a redundancy bill probably in the region of £1.3bn. This is in addition to major job losses now being instigated in a drive by trusts to balance the books (11). It seems that Robert Francis's warning over Mid Staffordshire has been forgotten: '... corporate self-interest and cost control [was put] ahead of patients and their safety' (12). The hospital programme promised in Labour's manifesto has been pushed back even further, with the '40 new hospitals' not expected to be delivered until 2046 (13).

A new model of healthcare

The TYP aims to create a new model of healthcare while reassuring the public that this will still be based on NHS founding principles. Omitted from the latter, however, is public provision of services (14). It is claimed that the new model will predict and prevent ill health, substituting a patient-controlled system for today's 'centralised state bureaucracy'. In some unspecified way this will reduce health inequalities, while Artificial Intelligence (AI) and genomic science will 'propel the NHS to global leadership'. Current hospital care, presented as being 'detached from communities', will see cuts in budgets over the next few years to fund increased spending on out of hospital care.

Investment in primary care will aim to train more GPs, with new contracts seeing them work over larger areas and leading new neighbourhood providers. GPs, however, are now feeling threatened and betrayed (15). They see a future where the current partnership model is starved of funds and squeezed out of existence. For NHS GPs, the only options will be to work in large organisations where they have no autonomy and deliver only minimal continuity for their patients – so much for the pledge to 'bring back the family doctor'. The number of people with personal health budgets will double to 1 million by 2030, despite serious concerns over equity and cost effectiveness (16).

A Neighbourhood Health Centre (NHC) will be built in 'every community', each serving a population of around 50,000. Eventually there are to be around 250-300 NHC, covering around a third of the population, and employing a variety of medical, nursing, allied health professional, pharmacy, and care navigation staff, as well as health visitors and social care workers. The lesson from the past failure of Darzi centres (17) seems to have been forgotten or ignored, despite these being abandoned because managers had vastly overestimated the ability of polyclinics to handle the shift in care from hospitals and revolutionise GP care.

> "20,000 admin and management posts are to be cut to save about £1.7 billion a year, with a redundancy bill probably in the region of £1.3 billion."

A new dental contract is anticipated, aimed at improving access to dentistry, while hospital outpatient appointments as well as corridor care are to be ended by 2035. The plan reiterates the commitment to 85 mental health emergency departments for people in crisis, backed by a meagre £120m a year. It is light on urgent and emergency care (18), beyond the use of the NHS app to help patients find alternatives to emergency department attendance.

From analogue to digital, treatment to prevention

'Harnessing the digital revolution' includes expanding the role of the NHS App so that it becomes a 'doctor in your pocket', providing advice, consultations and patient choice. Continuous monitoring of some patients will supposedly

permit clinicians to reach out at the first sign of deterioration. This move to digital technology and from hospitals being the centre of care is summed up as 'from bricks to clicks'. What will happen to 10% of the population (19) who government estimates may never have digital capabilities (and perhaps a further 10% who can't afford digital access?) is not explained. Despite this, the digital NHS is portrayed as a 'force for inclusion'. The unbridled enthusiasm for all things digital contrasts uncomfortably with the acknowledgement in the TYP that 'the relationship people desire is personal not transactional'. The TYP seems to miss that while technological innovation has potential it should be set in the broader context of mitigating AI risks, supporting rather than replacing staff and a prioritising of the social determinants of health (20) as the best way to reduce upstream pressures on the NHS.

In terms of moving towards prevention (21), there is an aspiration to reduce the gap in healthy life expectancy between richest and poorest regions, while increasing it for everyone. Can this be done as suggested by 'harnessing a huge cross-societal energy on prevention'? The tobacco and vapes bill will be welcome, but much more will need to be done in restoring a public health service. There is a lack of ambition here, with the answer to alcohol related illness, for example, being to improve labelling rather than increase tax (22). One can only wonder if those who see corporations as willing partners in improving public health understand much about the commercial determinants of health (23) and the evident conflicts of interest involved. The work of Sir Michael Marmot on the all-important social determinants of health merits a single mention and hardly features in the 'prevention' strategy. Great emphasis is based on genetic testing to provide risk profiles from birth, completely bypassing long-established principles related to risks and benefits of screening for disease.

Brave new world

A new operating model for the NHS will include more devolved power, with a 50% reduction in staff in NHS England (NHSE) and the DHSC. Integrated Care Boards will take on strategic commissioning as support unts are abolished. By 2035 every provider should be a Foundation Trust (FT), with the ability to retain and reinvest surpluses and raise capital. This is despite no discernible benefit of FT status (24) when first rolled out. The best FTs will hold the whole health budget for a defined population as an 'IHO'; over time, this model will become the norm.

> "What will happen to 10% of the population who ... may never have digital capabilities and perhaps a further 10% who can't afford digital access is not explained."

Private sector capacity (25) will continue to be used by the NHS, and private care providers will be encouraged to increase NHS provision in deprived areas. The elective recovery partnership agreement (26) already characterises private sector providers as an important part of NHS systems that should now be involved in planning local services. A new 'patients choice charter' will be introduced, patients given a say on whether the full costs of their care should be released to the provider, and league tables published that rank providers against key quality indicators. It is not clear how uncertainties about remuneration would then be managed by providers trying to plan services. A business case for private finance of NHC (27) is to be developed despite the potential huge costs compared with public financing.

The TYP is thin on workforce planning, but we are told 'because healthcare work will look very different in 10 years' time, by 2035 there will be fewer staff than projected in the 2023 Long-Term Workforce Plan. A 10 year workforce plan

is promised for later this year. AI will become the trusted assistant of every doctor and nurse – saving them time and supporting them in decision making. A new set of staff standards will be developed, and significant contractual changes are expected to provide incentives and rewards for productive and high-quality care. NHS recruitment will no longer be dependent on staff from overseas and agency staffing will be eliminated by the end of this parliament. Reforms to skill mix and training will ensure that more clinical tasks are performed by nurses and allied health professionals.

Transformation without additional investment

A combination of data, AI, genomics, wearables (eg smart watches, activity trackers) and (surgical) robotics are identified as five transformative technologies that will personalise care, improve outcomes, increase productivity and boost economic growth. The TYP states that the era of 'more money, never reform' is gone, glossing over the fact that the NHS has been constantly subject to reform, with seven system-wide and structural reorganisations since 1948. Now, somehow, financial incentives will drive the innovation that will support flow of money from hospital to community. Providers will be rewarded based on how well they improve outcomes for individuals. Poorly evidenced assertions are made: 'More care in the community is cheaper and more effective than care in hospitals.

Digitalisation, as in other industries, will deliver far more productively for far lower cost. Prevention bends the demand curve'. Each of the next 3 years the NHS will be required to make a 2% productivity gain. The majority of providers will be expected to be in surplus by 2030. Trusts will be encouraged to dispose of land assets by being able to keep 100% of receipts.

> "The Plan is presented as putting power into patients' hands, and justified on the spurious basis that no one is arguing the current state of services is acceptable."

Reinvention based on selected founding principles

The NHS will be reinvented in a break from the past. Founding principles of free at the point of use, based on need and not ability to pay, funded from general taxation will be maintained, but 'publicly provided' has been abandoned (as it was by the election manifesto (28)). The new health service will be one that offers 'instant access to advice and appointments; predicts and prevents ill health rather than diagnosing and treating it … today's NHS is broken'.

The TYP is presented as putting power into patients' hands, and justified on the spurious basis that no one is arguing the current state of NHS services is acceptable, while increasing numbers are opting for private care. HealthWatch, the independent voice of patients, is being abolished on the advice of Penny Dash (29), and its functions passed to Integrated Care Boards and local authorities. The inverse care law (30) is acknowledged – 'areas that have the highest need for the NHS have the fewest GPs, the worst performing services, and the longest waits. The most deprived people spend more of their lives in ill health'. The authors, however, appear unaware of Tudor Hart's warning that it 'operates more completely where medical care is most exposed to market forces' or that it will apply with greatest force to those suffering digital exclusion.

Promises, promises

The TYP ends with bold promises:

'By the end of this Parliament the NHS will

be back on its feet and we will have laid the foundations of longer term transformation.

'Within 10 years the NHS will look very different from today. Its model of care will have been transformed into a world-class service where citizens know their risks from birth, where clinical staff and AI work together to provide instant access to help, where patients have a "doctor in their pocket", where neighbourhood health has replaced outpatient care, and where diseases are increasingly prevented before they happen'.

Much of this appears based on hope rather than evidence and represents a huge political risk for a government where a pledge to improve NHS performance was a key factor in being elected to office.

After one year in power, the signs are not good (31) despite Labour doing its best to claim otherwise. When it was elected in July 2024 there were 7.62 million waits for appointments and procedures (6.39 million people). As of June 2025, the numbers were 7.37m and 6.23m respectively. At this rate of reduction, it will take 20 and not 4 years to get down to the 2.32 million waits figure from 2010. Labour has delivered 4.6 million more appointments from July 2024 – May 2025, however the 3.6m more in the first 8 months was notably smaller (32) than the number delivered by the Conservative government in its last year over the same time period. The extra appointments are noted to have had only a modest impact on waiting lists. NHSE has admitted that the service is not on course to meet elective care targets for 2025/6 (33). In addition, the TYP does little to tackle the current priorities of waiting lists, GP access, workforce retention, huge delays in A&E, patient flow through hospitals, or the community services needed to help people leave them.

TYP – much more work needed

If the TYP was a business case being submitted to investors, it would be sent back with a request for much more detail to justify the claims being made. Any serious plan should be based on a systematic review of all relevant evidence and subject to expert peer review rather than being written by those with a background in accountancy (34) whose main concern is reducing costs of healthcare in the name of 'sustainability'. Reforms would be trialled and tested before any decision about general implementation, and many questions would need answers: what are the year-by-year objectives?; where are the named organisations responsible?; where is the IT roll-out roadmap?; what happens if population needs change over the next 10 years?; where are the funding allocations by year and service?; who builds the neighbourhood hubs?; what's the time-line?; what happens to hospitals in the meantime?; when do we start training the workforce to staff NHC?, etc.

Conclusion

The TYP appears to be a description of where government and advisors would like healthcare to be in 10 years' time rather than a plan for how to get there. In many ways it is a mapping out of a huge experiment with shaky underpinning evidence, while recycling failed policies from 20 years ago including independent NHS Foundation Trusts, relying on non-existent spare capacity in the private sector, and private finance to build infrastructure. It argues that cutting numbers of senior managers and staff will make the NHS more efficient. Private sector interests are promoted throughout, while the historic evidence that better funding made the NHS model of care the best (35) among developed countries is ignored.

What is really needed is a plan to restore the NHS as a publicly provided service based on all its founding principles, informed by learning the lessons of the past so as not to repeat old mistakes. Funding should be in line with need and prevention be centred on addressing the social determinants of health. Dealing with the crises in acute care and staffing would be a priority together with investment in infrastructure and

rebuilding community and social care services. Like other long-term plans foisted on the NHS, it seems unlikely that many of the promises in the TYP will have come to fruition by 2035. We might well ask 'where will Labour be then'?

References

1. UK Government (2025) *Fit for the Future: the 10 year health plan for England*
[Available at https://tinyurl.com/2wh2f2eh]
2. Oliver, D. (2025) 'The NHS 10 year plan—more a set of ambitions than a plan' *BMJ* 2025;390:r1398
[Available at https://tinyurl.com/m8k763dc]
3. Dixon, J. (2025) 'Alan Milburn on the 10 year health plan' Health Foundation
[Available at https://tinyurl.com/2s3pxwzn]
4. Keep Our NHS Public (2025) 'ACOs: a taboo term is back on the agenda' KONP
[Available at https://tinyurl.com/3d57dkxh]
5. Dunton, J. (2025) 'NHS 10-year health plan 'published without delivery strategy' *Civil Service World,* 3 July
[Available at https://tinyurl.com/3edvuwn3]
6. Darzi, Lord (2024) 'Independent investigation of the National health Service in England' DHSC
[Available at https://tinyurl.com/4xrbeudx]
7. Health Foundation (2024) 'The NHS is weakened, not broken', press release, 11 September
[Available at https://tinyurl.com/bdhycxj9]
8. Brown, S. (2025) 'NHS prioritised in spending review, but leaders remain concerned' FHMA, 11 June [Available at https://tinyurl.com/44uvrv78]
9. Gainsbury, S. (2025) 'Spending review leaves a greater need for clarity on healthcare priorities', *BMJ* 2025;389:r1223
[Available at https://tinyurl.com/s5mr2s9n]
10. Walsh, P.W. and Sumption, M. (2020) 'Recent estimates of the UK's unauthorised resident population' Migration Observatory, 11 September
[Available at https://tinyurl.com/yuntctt2]
11. Campbell, D. (2025) 'Hospitals in England could shed 100,000 jobs in response to cost-cutting orders' *Guardian*, 8 April
[Available at https://tinyurl.com/4y8w6n9b]
12. Francis, R. (2013) 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive summary' HMSO, 6 February
[Available at https://tinyurl.com/mr3ejzf2]
13. Tidman, Z. (2025) ' ''40 new hospitals'' will not be delivered until 2046' *HSJ*, 13 August
[Available at https://tinyurl.com/mtxucncs]
14. Mercer, A. (2018) '3 challenges to the NHS on its 70th birthday' Socialist Health Association, 16 May [Available at https://tinyurl.com/2v2y6hah]
15. Salisbury, H. (2025) 'What the 10 year plan means for GPs' *BMJ* 2025;390:r1408
[Available at https://tinyurl.com/3zndx9px]
16. Scott-Samuel, A. (2015) 'Personal Health Budgets in England: Mood Music or Death Knell for the National Health Service?' *International Journal of Social Determinants of Health and Health Services*, 45(1)
[Available at https://tinyurl.com/w9vv7u86]
17. Wikipedia (2025) 'Polyclinics in England'
[Available at https://tinyurl.com/6257ahpe]
18. Dropkin, G. (2025) 'Ten Year Health Plan: Urgent and Emergency Care' 17 July
[Available at https://tinyurl.com/3nm3b523]
19. HM Government (2014) 'Government Digital Inclusion Survey' 4 December
[Available at https://tinyurl.com/2u7xcupu]
20. Sheldon, T. (2025) 'From genome to exposome: universal newborn genetic screening is the wrong focus if we want to improve population health' *BMJ* 2025;389:r1349
[Available at https://tinyurl.com/yccrnzk2]
21. Dropkin, G. (2025) 'Ten Year Health Plan for Prevention —Turn away from Social Determinants and embrace Tech' 17 July
[Available at https://tinyurl.com/mrz7men5]
22. Gilmore, I. (2023) 'Commending Public Health Scotland's evaluation of minimum unit pricing' *Lancet* 402 (10404), 771
[Available at https://tinyurl.com/4uub3696]
23. Ralston, R., et al. (2023) 'Reconceptualising the commercial determinants of health: bringing institutions in' *BMJ Global Health* 2023;8:e013698
[Available at https://tinyurl.com/2vxrtrhv]
24. Lister, J. (2025) 'Ten Year Plan – a tour of the

dead ends' *The Lowdown*, 8 July
[Available at https://tinyurl.com/mth7mrcx]
25. Dropkin, G. (2025) 'Ten Year Health Plan for Privatisation — but it could come sooner...' 17 July
[Available at https://tinyurl.com/47zr82sbl]
26. NHS England (2025) 'Elective recovery: a partnership agreement between the NHS and the independent sector' 6 January
[Available at https://tinyurl.com/bdzenns6]
27. NHS Support Federation (2025) 'Private finance to power NHS move into community – other options?' 1 August
[Available at https://tinyurl.com/4ycat8r8]
28. Labour Party (2025) 'Health and Social Care: our plan to transform the health service'
[Available at https://tinyurl.com/yk2dvf86]
29. DHSC (2025) 'Review of patient safety across the health and care landscape' 7 July
[Available at https://tinyurl.com/4sxsbdsr]
30. Tudor Hart, J. (1971) 'The inverse care law' *Lancet* 297, 405-12
[Available at https://tinyurl.com/yc5xmf8f]
31. Lister, J. (2025) 'What difference has Labour made so far?' *The Lowdown*, 28 April
[Available at https://tinyurl.com/4wdwvdwb]
32. Full Fact (2025) 'New data reveals rise in NHS appointments hailed by government is smaller than last year's increase' 23 May
[Available at https://tinyurl.com/3j5usrdx]

33. Mathers, M. (2025) 'NHSE admits service not on course to hit 2025-26 waiting list targets' 14 August [Available at https://tinyurl.com/33kr3653]
34. Wells, L. (2025) 'Streeting appoints advisor to shape 10-year plan' *Healthcare Management*, 5 February
[Available at https://tinyurl.com/yckdmf9a]
35. 99% Organisation (2025) *The Rational Policy-maker's Guide to Rebuilding the NHS*
[Available at https://tinyurl.com/3rhvvz3m]

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Flawed assumptions, Alan Milburn and the 'Ten Year Health Plan for England'

John Puntis on the 'voice in Streeting's ear'

Alan Milburn argues that the NHS can't have more money than it has currently been allocated because this would take funding from other public services and from defence.

This view is reflected in the *Ten Year Health Plan* for England (TYP(1)): it is technological developments that will make the NHS more efficient and allow current resources to be used more effectively. In terms of national resources, we must accept that there is a 'pie' of limited size. This means that what is in fact an inadequate slice for the NHS should be regarded as generous given the prevailing economic conditions (2), while to increase the size of the slice would inevitably involve cuts elsewhere. The Treasury contends that to fund public services properly, we just need a bigger pie and this can be achieved by economic growth (3). Hence, an effective healthcare system is not seen, as it was in 1948, as a necessary prerequisite for growth, but rather as something that must wait to be a beneficiary of future growth before it can materialise.

The TYP considers that transformational reforms are deliverable within the far from generous provisions of the recent spending review: 'an extra £29 billion in investment will fund the reforms, service improvements and new technology required'. It even sees prevention of illness rather than investment in staff and infrastructure as an answer to the negative effect on the economy of rising numbers of those unable to work (4) through ill health. The fact that this £29bn 'record funding' represents a less than average historical annual rise in budget (needed to keep up with inflation and increasing demand) is ignored. As Mathew Taylor, Chief Executive of the NHS Confederation pointed out: 'this additional £29bn won't be enough to cover the increasing cost of new treatments, with staff pay likely to account for a large proportion of it ... on its own, this won't guarantee that waiting time targets are met' (5). The Nuffield Trust also commented (6) that 2.8% is unlikely to be sufficient to enable the NHS to keep up with the routine increases in activity expected of it, let alone implement further government asks as in the TYP.

Despite evidence showing that for every £1 spent on the NHS, £4 is generated for the economy (7), arbitrary fiscal rules act as a barrier (8) to economic decisions that would actually improve people's lives. 'Pie theory' (as Richard Murphy (9) has pointed out) ignores the fact that when economic growth in past years has produced a larger pie, this has disproportionately benefited the rich, increasing rather than reducing inequalities. Crucial questions of 'who is in charge of the oven?' (eg the effects of government policies, corporate lobbying, etc) and any issues of wealth redistribution are avoided. Tellingly, US academics puzzling over previous drives by Labour to partner the NHS with the private sector concluded this offered no more than 'a covert means to redistribute wealth and income in favour of the affluent and powerful' (10).

Woefully inadequate assessment of costs and benefits in the TYP

The TYP is full of techno-optimism but short on realism (11) and on detailed analysis of costs and benefits; many have been challenging some of the assumptions on which it is based. For example, there is little evidence to suggest that good community care is really cheaper than

hospital care. Thea Stein spent nearly a decade leading a community healthcare trust and, writing in the *Financial Times* (12), strongly contested the view that moving care closer to home would save the NHS money. This is partly because community services identify unmet need (13), and hospitals benefit from economies of scale. In addition, she warned that 'if care is moved to a more efficient local or home-based setting, it can take many years to cash in any savings: closing wards or hospital beds cannot happen overnight'. Note also, that we already have almost the lowest number of beds/1000 population among OECD countries.

Sheldon and Wright (14) argue strongly against a reliance on newborn genome sequencing (genetic testing) as a sure-fire way to improve population health and reduce NHS demand. They point out how easy it is for politicians to be seduced by technological fixes, and ask for the evidence that this will 'transform the NHS over the coming decade, from a service which diagnoses and treats ill health to one that predicts and prevents it'. They ask too about the negative consequences and costs, emphasising: 'it is the harms in particular that should concern us. Population genetic screening with its inherent false positives, false negatives, and unpredictable clinical consequences of mutations has the potential to generate a lifetime of anxiety for parents and their children. We run the risk of turning future generations into patients from the moment they are born, with overdiagnosis and overtreatment, as well as profound implications for how these data will be used by third parties such as life insurance companies'. Far better that politicians focus on tackling systemic societal inequalities that drive ill health and are amenable to government interventions. There is no evidence in Labour's TYP that these complex issues have been thought through, while they open up the possibility of profit driven companies enjoying a bonanza from marketing personal care in the form of targeted lifestyle, dietary advice and medication.

Artificial Intelligence (AI) represents a multitude of technologies and is clearly not at this point a panacea (15) for the ills of the NHS. Some even regard the claim that AI will transform NHS productivity as no more than snake oil – not only a false hope but potentially a bottomless money pit. Hope in AI is driven by marketing and not evidence (16). To imagine AI could transform the model of healthcare in the short term seems highly unlikely. Big tech (Microsoft, Google, AWS, Apple, Oracle), already at the heart of the NHS, remain crucial to the TYP. The negative consequences of the dominance of these companies (global theft of personal data and science knowledge from public institutions; harm to the environment and to human rights; direct destruction of human life through use by the military and for surveillance) are ignored. Far from aspiring to be a leader in technology, the UK government seems all too happy to hand over data, infrastructure and public services to US tech giants, with an AI strategy based on techno-utopian assumptions (17).

Repeating the mistakes of the past

Alan Milburn was Secretary of State for Health from October 1999 to June 2003 before immersing himself in the world of private healthcare companies. When first appointed, he lost no time in declaring that the 1948 model of healthcare was not suited to today's needs and set about measures to entrench and institutionalise a market system (18) within healthcare, advocating strongly for private finance deals. Now described as Streeting's chief health advisor, he was appointed lead non-executive member on the DHSC Board in November 2024. He is credited by Wes Streeting as having previously helped deliver the shortest waiting times and highest patient satisfaction in the history of the NHS. Milburn has long been arguing for abolition of NHS England and is now keen to highlight failings in the NHS as an existential crisis, describing it as 'a million times worse' than when he was in office and very much 'in the last chance saloon' (19).

A Labour spokesman (18) commenting on Milburn's recent return to the DHSC stated that 'Alan brings the insight and the knowledge of what

made the biggest difference last time Labour was in office… It was the reforms on transparency, choice, and use of the private sector that delivered the goods on cutting waiting lists and making the NHS sustainable for the long term'. This view has been strongly contested in an analysis by the 99% Organisation (4) which argues cogently that increased investment was by far the most important element in improved NHS performance under New Labour while various reforms had only marginal impact. This is a message the current government does not want to hear and studiously ignores. As with a planned return of private finance (20) to build health infrastructure, there seems to be a dogged unwillingness to learn from mistakes of the past.

Milburn speaks to the Health Foundation

Milburn is the most prominent among a number of former advisors (21) who played a key role in formulating health policy under Tony Blair and are now back in positions of influence. His recent interview with the Health Foundation (22) makes the current direction of travel even more clear than in the TYP. He argues that the centralised operating model for the NHS is wrong, that the NHS can't have more money and that it is wrong to focus on acute care rather than prevention. The new 'care model fundamentally should be about empowering the individual patient, citizen, to take greater control of their health'. He acknowledges that in the next 3 years Labour must deliver on GP and A&E access and waiting times. Over the following 7 years there will then be long-term change through use of genomics (genetic tests), digitalisation and workforce transformation.

Social determinants of health are dismissed as being outside the remit of the NHS: 'the wider social determinants of ill health, poor housing, poor jobs, poor people, and all of that, and frankly, that broadly is outside the remit of the National Health Service', while genetic testing is talked up as enabling a move from a 'diagnosis and treat' model to a 'predict and prevent model'. According to Milburn, the combination of big data and genomic science will facilitate medical interventions both at individual and population health levels and be the focus of the neighbourhood health service. The danger of telling many individuals that they are 'at risk' and thereby fuelling demand for services is acknowledged but apparently can be controlled by applying financial flows that incentivise behaviour deemed appropriate by the centre. A key role here will be played by Integrated Health Organisations.

Meanwhile, abolition of NHS England is consistent with the operating model government says it wants to see, which is 'more delegated, more devolved and more diverse, and has to be smaller'. Milburn insists that we must stop seeing the health care system as being about a single institution (the NHS) and see it rather as an ecosystem involving telecommunication and technology companies, private sector providers and (lastly) the public sector. The job of the centre is to convene and manage that ecosystem. 'Change is not pain free. Nobody but nobody that I hear, anywhere across the system, is saying that it is currently sustainable'. Milburn is clearly listening to the wrong people. He should take heed of Lord Darzi's review – 'It is not a question of whether we can afford the NHS. Rather, we cannot afford not to have the NHS'. To put it another way 'If the NHS is allowed to fail, the economy will fail (4) with it – the UK economy cannot afford not to fund the NHS properly'. Darzi's views that reform and further austerity were not the right prescription (23) for an ailing NHS seem to have fallen on deaf ears.

References

1. UK Government (2025) *Fit for the Future: the 10 year health plan for England*
[Available at https://tinyurl.com/2wh2f2eh]
2. NHS Support Federation (2025) 'Explainer: NHS funding after the spending review', *The Lowdown*, 16 June
[Available at https://tinyurl.com/yc4pt9tp]
3. HM Treasury (2025) 'Chancellor Rachel Reeves

is taking immediate action to fix the foundations of our economy' 8 July
[Available at https://tinyurl.com/2uzp5hmb]
4. 99% Organisation (2025) *The Rational Policy-maker's Guide to Rebuilding the NHS*
[Available at https://tinyurl.com/3rhvvz3m]
5. Brown, S. (2025) 'NHS prioritised in spending review, but leaders remain concerned', HFMA, 11 June [Available at https://tinyurl.com/44uvrv78]
6. Gainsbury, S. (2025) 'Spending review leaves a greater need for clarity on healthcare priorities', *BMJ*, 2025;389:r1223
[Available at https://doi.org/10.1136/bmj.r1223]
7. NHS Confederation (2023) 'The influence of NHS spending on economic growth', July
[Available at https://tinyurl.com/mteu7wn2]
8. Keep Our NHS Public (2024) 'Funding the NHS: a plain English guide to money and affordability', 2 April [Available at https://tinyurl.com/ytcphcs2]
9. Murphy, R. (2025) 'Pie theory', Funding the Future, 6 August
[Available at https://tinyurl.com/mrxfyczr]
10. Woolhandler, S. and Himmelstein, D.U. (2007) 'Competition in a publicly funded healthcare system', *BMJ* 2007;335:1126
[Available at https://tinyurl.com/ycx8a2tt]
11. Gerhold, M. (2025) 'We need to move from 'techno optimism' to 'techno realism', *Digitalhealth*, 15 July [Available at: https://tinyurl.com/6j38npmc]
12. Stein, T. (2025) *Financial Times*
[Available at https://tinyurl.com/fn6v9x9e (Paywall)]
13. Reed, S. and Stein, T. (2024) 'Bringing care closer to home: three questions that need answering', Nuffield Trust, 3 December
[Available at https://tinyurl.com/m2th8n85]
14. Sheldon, T. and Wright, J. (2025) 'From genome to exposome: universal newborn genetic screening is the wrong focus if we want to improve population health', *BMJ* 2025;389:r1349
[Available at https://tinyurl.com/ha5t7knf]
15. Strain, W.D., et al. (2025) 'NHS 10 year plan: Can using AI offer a solution to the NHS' problems?', *BMJ* 2025;390:r1407
[Available at https://tinyurl.com/mrfj23f6]
16. Black, S. (2025) 'The mythbuster: Now even Nobel Prize winners are leading us astray on AI', *Health Service Journal*, 28 July
[Available at https://tinyurl.com/2zd4nz9m]
17. Guardian (2025)'The Guardian view on Britain's AI strategy: the risk is that it is dependency dressed up in digital hype', *Guardian*, 18 August
[Available at https://tinyurl.com/4j6u3jna]
18. Dropkin, G. (2025) 'Alan Milburn and the Labour agenda for the NHS', Keep Our NHS Public [Available at https://tinyurl.com/4u8awxmb]
19. Ferguson, D. (2024) 'NHS in 'last-chance saloon', says former health secretary Alan Milburn', *Guardian*, 9 November
[Available at https://tinyurl.com/mvz6sddt]
20. Stewart, H. (2025) 'Past mistakes must be avoided': anxiety as Labour eyes public-private funding for NHS', *Guardian*, 20 August
[Available at https://tinyurl.com/4hvkud87]
21. Lister, J. (2024) 'Wes Streeting turns to the 'usual suspects': why no involvement of trade unions and patients?', *The Lowdown*, 21 July
[Available at https://tinyurl.com/338n6yua]
22. Milburn, A. (2025) 'Alan Milburn on the 10-Year Health Plan', Health Foundation, 5 August
[Available at https://tinyurl.com/ps57ptk8]
23. Keep Our NHS Public (2024) 'Darzi Report: will Government write the wrong prescription?', Keep Our NHS Public', 12 September
[Available at https://tinyurl.com/un36fbev]

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Annual General Meeting 2025: Thursday 16 October, online

This year's AGM will be held on Thursday 16 October, starting at 11 am.

This will be held online this year, to allow more members to attend virtually.

To register, please go to:

https://tinyurl.com/2vc23k69

An agenda will be sent to your e mail before the event. *There is no charge for joining the online meeting.*

There are several important questions to consider, in addition to the usual 'business' items of annual reports and Executive Committee elections/re-elections.

Perhaps most importantly, at the last EC meeting held earlier this month it was decided to report to AGM on a proposal to increase the degree of co-working and collaboration with other similar campaign groups, such as Doctors' Association UK and EveryDoctor Uk, as well as of course Keep Our NHS Public. This could include formal affiliation, though the agreement of the other organisation or organisations would need to be obtained.

DFNHS has a unique 'voice' on its own, which members align with and support. It remains important to echo and support the views of other groups over chosen issues, with our unique identity. Membership remains over 500. That is a respectable size, for a peer group with campaigning interests. We can and will continue to make a difference. Closer co-working and affiliations will yield better results for both organisations.

There is also the benefit in switching to closer and more focused co-working, which will raise the group's profile, thereby increasing the chances of more new members joining.

Please join us online for what promises to be a productive and encouraging AGM.

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The Peter Fisher Essay Prize 2025 Winning Essay

This year's Essay Prize drew over 40 entries, again another record. The essay question was 'How can medical education be improved for the benefit of the patient?' There was an impressive range of interpretations and styles. The winning entry, by Dr Ke Wei Foong, is published in this issue. Runners-up will be published in the next issue. You can also read the essays on the website: https://tinyurl.com/2vj92tdn/

Introduction

'To cure sometimes, relieve often, and comfort always' (1) as a statement of the aims of medicine is a useful one to consider. It speaks to the practice of medicine as a beneficent act, and reminds us that the fundamental role of the doctor, notwithstanding the possibility of a cure, is one of psychological and emotional companionship and healing.

In his moving exposition titled 'Caregiving as moral experience', anthropologist and psychiatrist Arthur Kleinman describes how being present, 'being there, existentially, even when nothing practical can be done and hope itself is eclipsed', is central to the giving of care (2).

It can be daunting to consider that medical education today has to enable the doctors of tomorrow to fulfil these roles, especially in a climate where austerity frequently trumps aspiration. Fortunately, education here is not an end-point but a process extending from undergraduate to postgraduate supervision, and arguably continues long after a specialist completes their formal training.

As technology continues to burgeon and bring an overwhelming plethora of options to patients and doctors, we need to refocus the attention of medical education on the centrality of the doctor-patient relationship. This involves helping doctors to discover the therapeutic benefit of the relationship itself, understanding communication training as more than a one-way process of information-giving, and, by developing doctors with a deep understanding of the powers and pitfalls of their roles, addressing the 'privilege gap' (3,4) that encumbers the profession. None of this has to preclude medicine's pursuit of scientific breakthroughs. Instead, patients benefit from having doctors they can trust to guide them in an increasingly confusing moral and technological landscape.

The therapeutic doctor-patient relationship

Most complaints raised by patients relate not to a doctor's technical capability, but to communication and attitudes (5). High-profile legal cases like the Montgomery ruling (6) highlight the centrality of the doctor-patient interaction, no less significant than the primary medical intervention offered. Unfortunately, doctors' and patients' perceptions of the quality of healthcare interactions are frequently mismatched (7). While doctors are inclined to measure success through objective outcomes like cure and absence of complications, patients point out the shortfall in terms of how much they felt cared for (8). Indeed, the concept of care is what we need to reacquaint with. The term is ubiquitous – care assistants, Integrated Care Boards, Care Quality Commission, care plans, care navigators, among others – but what does it

mean for those learning to care?

One area of medicine where the intervention intended to benefit the patient is inseparable from the relationship between patient and clinician is psychotherapy. We can take a leaf from the books of psychotherapy for the benefit of medical education as a whole. Traditionally regarded as on the peripheries of medicine and even psychiatry, psychotherapeutic approaches are increasingly recognised as beneficial to all doctor-patient interactions. The Royal College of Psychiatrists set out in its 'Cradle to Grave' education strategy the case for psychotherapeutically informed training for all students and doctors, regardless of eventual specialisation (9).

A psychotherapeutically informed doctor treats with ample respect the therapeutic nature of the doctor-patient relationship. They recognise that they can bring something to a patient who is suffering even when there are no pharmacological or operative solutions left to offer. At a time when doctors face a crisis of moral distress and injury (10), it is difficult to overstate the potentially transformative impact of realising that there is always something you can do. Interestingly, guidelines on various treatment-resistant conditions, from seizures (11), to angina (12), and other forms of chronic pain (13) all recommend a shared exploration of the psycho-social factors that are important to the individual. This is not to say it is 'all in their minds', but instead speaks to the value of a doctor who 'acknowledges the personhood of the sufferer and affirm[s] their condition and struggle' (2).

"At a time when doctors face a crisis of moral distress and injury, it is difficult to overstate the potentially transformative impact of realising that there is always something you can do."

Doctors need to be taught this, just as they have to be shown how to operate or prescribe. An unintended consequence of the European Working Time Directive has been the erosion of apprenticeship structures in the form of the 'firm' as well as reduced continuity of care (14). The modular nature of medical school curricula also means that students rarely develop, or even witness, longitudinal relationships between patients and their trusted clinicians. It might be necessary to sacrifice exposure to the full breadth of specialties and prioritise longer placements to underscore the therapeutic value of a committed doctor-patient relationship.

Communication is not purely information-giving

Another crucial element in harnessing the therapeutic relationship is communication. Admittedly, the teaching of communication skills in medical school should begin with a framework for a competent consultation. Models such as the Calgary-Cambridge (15) propose an approach that allows doctors to achieve the two-fold aims of assessment through information gathering followed by delivery of a management plan.

What should set a medical encounter apart from a consultation for a kitchen makeover or with a mortgage adviser, is in fact, the element of 'building a relationship' (15) that is conspicuously sidelined as the icing on the cake – a 'good-to-have' add-on perhaps. The expectations patients and regulators have of clinical communicators, however, far exceed the demands placed on salespeople. A salesperson can give a convincing explanation of the benefits of their service, and if we're lucky, an honest account of its costs. They are unlikely, however, to apprise you of all the options available to you, and even less likely to recommend that you buy nothing at all.

When clinical pressures abound, doctors may feel forced to choose between telling and listening, the former nearly always taking precedence. The listening could, we would like to believe, be done by a myriad of other healthcare professionals, or

indeed a sympathetic and available layperson, such as a volunteer or a family member. It is hopefully not only arrogance that drives this, but reticence towards the more uncomfortable aspects of our conversations with patients.

But the experienced among us would confirm that clinical communication cannot be a linear flow of information. It is, instead, to use a rather tired analogy, a dance between partners. The holy grail of 'shared decision making' (16) is more complex than negotiating a business deal. Doctors are reminded that the information we give and how it is given should be tailored to the individual patient. We must be clear and compassionate, ascertain how our words land, and indeed, respond appropriately to their response (17). All this and more has to feature more explicitly in medical education, for we cannot expect students to master this intricate *pas de deux* any more than we would expect them to dance without prior instruction.

Information-giving is still important, but different in an age where information is eminently accessible. Many online and printed resources can convey information more comprehensively and effectively than the verbal explanations possible within the constraints of the ward or clinic. What these resources cannot replace is addressing patients' emotional need for comfort, companionship, courage, or a good cry. These needs exist not least because patients as individuals bring with them a lifetime of experiences and aspirations which are often irrevocably altered by the news we deliver.

Medical education should identify such patient-centred communication as a necessity, not a luxury. It is disappointing how in many self-scored, domain-driven application processes, from university to specialty recruitment, doctors do not accrue points for being an excellent communicator or a consistent advocate for their patients. Such attributes are difficult to measure, but that is not a reason to forsake them. In fact, we have managed, somewhat strenuously, to quantify other equally nebulous qualities like leadership and 'achievements outside medicine'. It is, therefore, probably a lack of will, rather than a lack of way.

Self-awareness as a way to seeing the other

Throughout history and geography, patients do not look like the doctors who treat them (3,4). The socio-economic pre-requisites for completing conventional medical education continue to select disproportionately from privileged segments of society. Conversely, as described extensively by epidemiological studies (18) and Julian Tudor Hart's 'inverse care law' (19), ill health is disproportionately a predicament of the poor and marginalised.

The latter term can be interpreted in its widest sense, encompassing geographic, ethnic, religious, class- specific, and inter-generational disparities, to name a few. Even if we surmount the barriers such populations face in accessing healthcare, there remains a pivotal challenge – how do we train doctors capable of identifying with them?

Formal initiatives promoting equality, diversity, and inclusion and access to medical education (20) are commendable. However, since it is impossible for every doctor to match every patient in background and identity, diversifying recruitment is only part of the answer. Developing the ability to connect requires doctors to continually work at an honest and detailed understanding of the prejudices they bring to their roles. Through this, we begin to see beyond the 'us' and the 'other' (21).

This process of identification can occur despite how different we are to our patients. Indeed, medical education should include training on recognising our unconscious biases (22) and

understanding its impact on quality of care. Many of us consider ourselves immune to overt forms of discrimination like racism and sexism.This is not true (23), but even if it is, there are other insidious ways in which we might treat someone unfairly. What assumptions do we make about a nonagenarian, a woman with short hair, a family with many children, or a man with a much younger spouse? Such prejudices become even more potent when they involve behaviours that society openly regards as vices – think drugs, alcohol, casual sex, or alas, even unemployment. The temptation for doctors to assume moral superiority is unignorable, fueling the risk of erroneous clinical judgement.

With the demise of the firm as a natural incubator for mentorship, there is greater need than ever for provision of meaningful clinical supervision and wider platforms, such as Balint Groups and Schwartz Rounds (24), to develop the reflective and socially cognizant doctors of tomorrow. Named supervisors for every resident doctor and mandatory regular meetings are positive steps. However, like many other worthwhile endeavours, the challenge lies in ensuring this is not relegated to another perfunctory exercise.

Conclusions

The late Harvard anthropologist and physician Paul Farmer, who ostensibly had a lot not in common with the people he served, once wrote: 'If access to healthcare is considered a human right, who is considered human enough to have that right?' (25). In taking the weighty concept of human rights and recentring the focus on our definition of humanity, Farmer challenges us to reflect on what truly underscores the relationship between the healer and the beneficiary. In other words, if disease brings a patient to the doctor, what brings a doctor to a patient? It is, gratifyingly, a recognition of our shared humanity, which medical professionals passionately defend as their source of meaning and purpose (2,) despite the economic and logistical troubles that define healthcare systems today.

The students and doctors of tomorrow can identify this enduring moral imperative within the heart of their hearts. It is the role of those in medical education to enable them to apply it in practice. We must continue to expect rigorous knowledge and technical competence, but more so, we should begin to reward individuals who employ the power of the doctor-patient relationship to the benefit of the patient. We must not allow ourselves the usual refrains of lack of time, money, or administrative possibility. The changes proposed require no groundbreaking invention, but a purposeful reimagination of our relationships with our patients. The patient – singular and individual – and not the disease, the relative, the regulator, the government, or the bottom line, is our goal. For that, the doctor – singular but powerful – must be taught that they can and should, despite the noise, reach across and meet the patient, human to another formidable human.

This essay is dedicated to Dr Lise Paklet and Dr Abigail Manjunath, who, in addition to the indelible marks they have left on me as a patient, inspire me every day to become the doctors that they are.

References

1. The origin of this saying is unclear, but is most commonly attributed to Edward Trudeau or William Osler.
2. Kleinman, A. (2012) 'Caregiving as moral experience' *Lancet*. 2012; 380 (9853): 1550-1551.
3. Nahvi, F.A. (2013) 'The privilege gap in medicine'. *Acad Med* 2013; 88(7): 907.
4. Gordon, A. (2019) 'Medical students: privilege faced with poverty'. *Br J Gen Pract* 2019; 69(687): 502.
5. Abdelrahman, W. and Abdelmageed, A. (2017) 'Understanding patient complaints'. *BMJ* 2017; 356: j452.
6. Montgomery v Lanarkshire Health Board [2015] UKSC 11
7. Valentine, K.D. and Scherer, L.D. (2022) 'Interpersonal (mis)perceptions and (mis)

predictions in patient-clinician interactions' *Curr Opinion Psychol* 2022; 43: 244-248.
8. Roos, A.K.Ø., et al. (2023) 'The importance of being taken care of – Patients' experience with the quality of healthcare in a Norwegian hospital'. *Nurs Rep* 2023; 13(4): 1742-1750.
9. Royal College of Psychiatrists (2017) 'Learning from the cradle to the grave: the psychotherapeutic development of doctors from beginning to end of a career in medicine and psychiatry'
[Available at https://tinyurl.com/4jt7yjct].
10. British Medical Association (BMA) (2021) 'Moral distress and moral injury – recognising and tackling it for UK doctors'
[Available at https://tinyurl.com/mu9puuzr].
11. Tidy C. (2024) 'Non-epileptic seizures'. [Available at https://bit.ly/4685j9]
12. National Institute for Health and Care Excellence (NICE) (2016) 'Stable angina: management' [Available at https://bit.ly/42sR8J9]
13. National Institute for Health and Care Excellence (NICE) (2021) 'Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain' [Available at https://bit.ly/48gqKpF]
14. Black, J. and Jones, R. (2010) 'The European Working Time Directive: less means less' *Br J Gen Pract*; 60(574): 321-322.
15. Kurtz, S.M. and Silverman, J.D. (1996) 'The Calgary-Cambridge Referenced Observation Guides: an aid to defining the curriculum and organizing the teaching in communication training programmes' *Med Educ* 30(2): 83-89.
16. National Institute for Health and Care Excellence (NICE) (2021) 'Shared decision making' [Available at https://bit.ly/4ncds2m]
17. General Medical Council (GMC) (2024) 'Good medical practice'
[Available at https://bit.ly/3JYoeun].
18. Hiam L., et al. (2024) 'NHS and the whole of society must act on social determinants of health for a healthier future' *BMJ* 2024; 385: e079389
19. Hart J.T. (1971)'The inverse care law' *Lancet*. 1971; 1(7696):, 405-412.
20. Sutton Trust (2025) 'Unequal treatment? Access to medicine for socio-economically disadvantaged students' [Available at: https://tinyurl.com/3fadapfs]
21. Akbulut, N. and Razum, O. (2022) 'Why Othering should be considered in research on health inequalities: Theoretical perspectives and research needs' *SSM Popul Health*; 20: 101286.
22. Oxtoby, K. (2020) 'How unconscious bias can discriminate against patients and affect their care' *BMJ*; 371: m4360.
23. Chapman, E.N., et al. (2013) 'Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities' *J Gen Intern Med*; 28(11): 1504-1510.
24. The Point of Care Foundation (2025) 'About Schwartz Rounds' [Available at https://tinyurl.com/y5xysvna]
25. Partners in Health. 5 quotes from Paul Farmer that inspire us (2025) [Available at https://tinyurl.com/322jnr6p]

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A few comments in appreciation of the Leng Review

EC member Morris Bernadt gives a summary of the Review, published in July. (https://bit.ly/40YP1ME)

The purpose of the review was to evaluate the safety and effectiveness of what were called Physician Associates (PAs) and Anaesthesia Associates (AAs).

Information elicited

The data set was huge. It included:

- A literature review.
- Communications with colleagues in Germany, Switzerland, Netherlands and Canada which have PAs and AAs.
- Meetings with 20 stakeholder groups including the Royal Colleges, BMA, UNISON, the United Medical Associate Professionals (the PA and AA union) and the Patients Association.
- Meetings with PAs and AAs, resident doctors and consultants.
- Local level audit data and national data sets.
- Webinars.
- Patient focus groups and meetings with individuals affected.
- 100-plus written submissions from PAs and AAs.
- 600-plus submissions from the public following an invitation to comment, including a response from DFNHS.

Who else to collate all this into a coherent, cogent, balanced, top-quality, well-written review than the former CEO of NICE, professor Gillian Leng? She had a small (unspecified) team to assist her.

Key points

There are now over 3,500 FTEs (full-time equivalent roles) for PAs. In both primary and secondary care the review recommends they work in health promotion, disease prevention, vaccinations and audit. Before starting work in primary care, they should have 2 years of experience in secondary care.

Critically, they should not see undifferentiated patients in either primary or secondary care. They could see triaged adult patients with minor ailments (in line with the advice provided by the RCEM and RCGP), administer injections (but not steroids), and explain care plans to patients. In secondary care they must be supervised by an experienced doctor. In both primary and secondary care the doctor supervisor must have time allocated for supervision.

AAs: for AAs, there are over 160. They work in a more supervised setting.

To prevent patients confusing PAs and AAs, their designation will be physician assistants and physician assistants in anaesthesia. Following publication of the Review on 16 July, NHS England contacted all provider units to immediately institute a change of name: to Physician Assistant for PAs and Physician Assistants in Anaesthesia for AAs.

Leng also suggested uniforms and name badges to distinguish them from doctors and other members of the team.

PAs and AAs must have opportunity to further their careers and, if appropriate, be called advanced PAs and AAs.

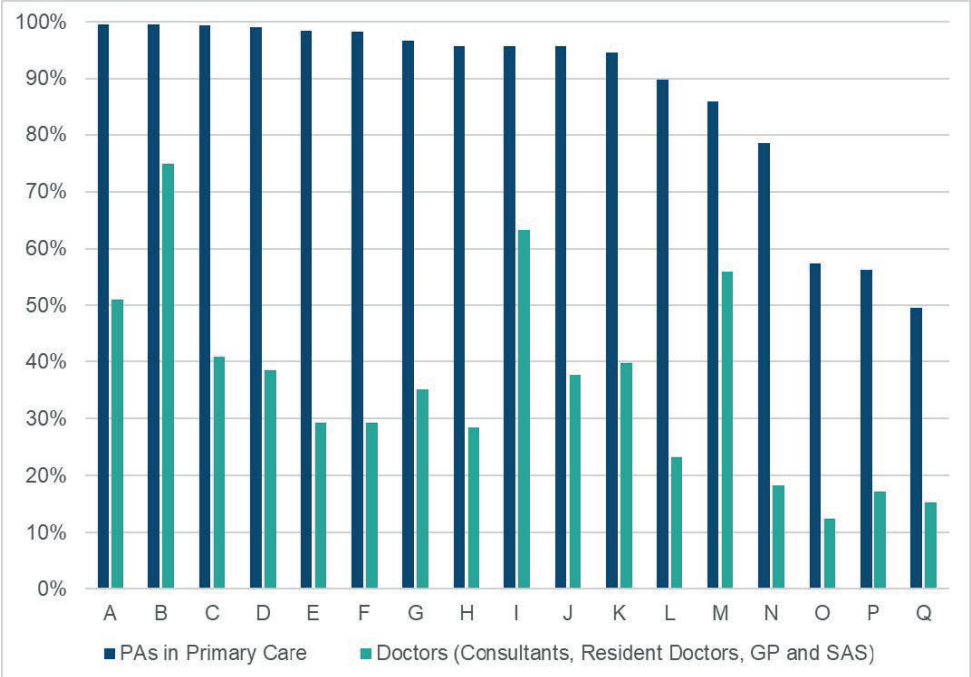

Figure 1 Appropriateness of potential physician associate activities in secondary care given by respondents in the survey. Reproduced from the Leng Review (Fig 11, p.58).

Medical leadership

Throughout the review there is emphasis on doctors making decisions about the education, training, management and work implementation of PAs and AAs. Their training will be within the remit of the Royal Colleges which will advise PA and AA training establishments.

The role of the GMC

The GMC should institute separate lists for medical practitioners on the one hand and PAs and AAs on the other. The GMC must clearly differentiate between the two professions.

Perceptions of PAs in primary and secondary care

I was particularly struck by the difference between PAs' and doctors' perception of PAs' work. The doctors were consultants, resident doctors, GPS and SAS doctors. See Figures 1 and 2, and Tables 1 and 2.

There were 17 parameters examined in both primary and secondary care. For example, in primary care:

- 98% of PAs though it appropriate for them to make a diagnosis (see column E, Fig.1), whereas the doctor's perception was 29%.
- 50% of PAS thought it appropriate to prescribe medications whereas the

Activity	Key to Fig 1	PAs in primary care (%)	Doctors in secondary care (%)*
Take medical histories from patients	A	100	51
Provide health promotion and disease prevention advice to patients	B	100	75
Perform physical examinations on patients	C	99	41
Provide clinical assessments on patients	D	99	38
Diagnose illnesses	E	98	29
Develop management plans	F	98	29
Manage care for patients with long-term chronic conditions	G	97	35
Review test results	H	96	28
Support innovation, audit and research	I	96	63
Interpret, monitor and respond to clinical readings and patients' parameters	J	96	38
Provide contraceptive services	K	95	40
Perform diagnostic and therapeutic procedures	L	90	23
Deliver immunisations	M	86	56
Teach, supervise and assess other team members	N	79	18
Deliver antenatal care	O	57	12
Order ionising radiation	P	56	17
Prescribe medications	Q	50	15

*Table 1 Potential physician associate activities in primary care given to respondents in the survey. *Consultants, resident doctors, GP and SAS that have worked with PAs within the last 5 years. Reproduced from the Leng Review (Table 10, p.58),*

doctors' view was 15% (column Q).

- Performing diagnostic and therapeutic procedures (column L), 90% versus 23% respectively.
- Delivering antenatal care (column O), 57% vs 12%.
- Ordering ionising radiation (column P), 56% vs 17%.

The disparities were greater in secondary care:

- Performing physical examinations on patients (column B, Fig.2): 99% versus 29%.
- Providing clinical assessments on patients (column C) 99% vs 24%.
- Taking medical histories from patients (column E) 98% vs 37%.

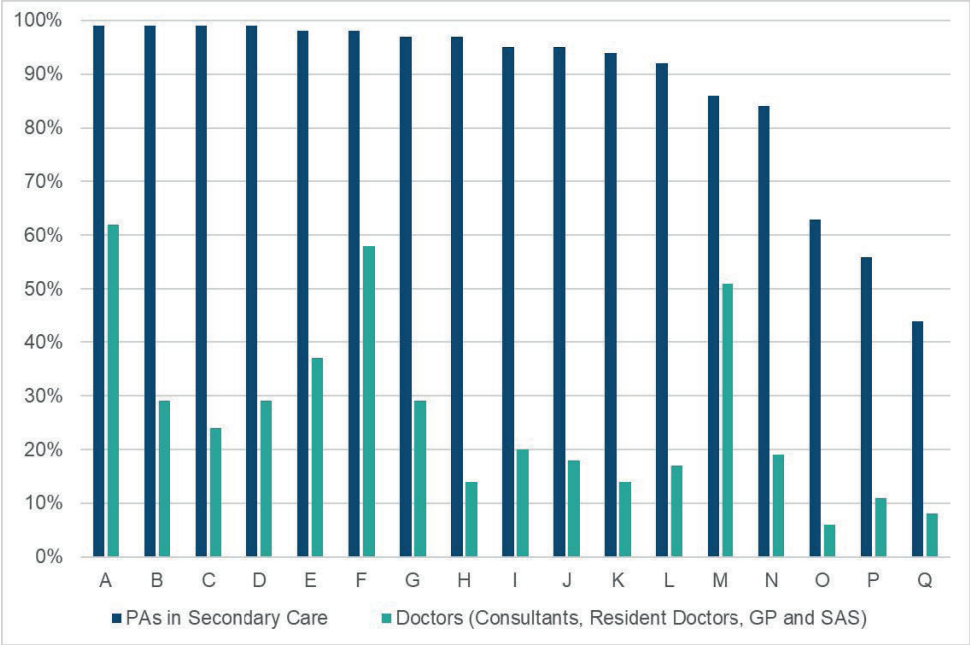

Figure 2 Appropriateness of potential physician associate activities in secondary care given by respondents in the survey. Reproduced from the Leng Review (Fig 12, p.61).

- Interpret, monitor and respond to clinical readings and patients' parameters (column G) 97% vs 29%.
- Diagnose illness (column K) 94% vs 14%.

Leng wrote that PAs "performed significantly weaker [than newly qualified doctors] in the diagnostic domains. This was particularly true in complex care settings with evidence suggesting that PAs were under-equipped to manage undifferentiated multimorbidity" (p.68). And "The generalist nature of the PA role without further training can potentially lead to risks to patient safety or hinder service delivery" (p.69).

For AAs, 12 very different parameters were examined with similar large disparities between the perceptions of AA's and anaesthetists with regard to AAs' activities (see Figure 3 and Table 3, page 29).

Template job descriptions

Template job descriptions for PAs in primary and secondary care, and for AAs, are given in Appendix 5. These include overview of the roles, accountability, principal duties and responsibilities, and person specification.

Resident doctors

The review points out the many difficulties facing newly qualified resident doctors and those in speciality training. The needs of doctors in training and those in permanent staff roles must

Activity	Key to Fig 2	PAs in secondary care (%)	Doctors in secondary care (%)*
Provide health promotion and disease prevention advice to patients	A	99	62
Perform physical examinations on patients	B	99	29
Provide clinical assessments on patients	C	99	24
Review test results	D	99	29
Take medical histories from patients	E	98	37
Support innovation, audit and research	F	98	58
Interpret, monitor and respond to clinical readings and patients' parameters	G	97	29
Develop management plans	H	97	14
Manage care for patients with long-term chronic conditions	I	95	20
Perform diagnostic and therapeutic procedures	J	95	18
Diagnose illnesses	K	94	14
Teach, supervise and assess other team members	L	92	17
Deliver immunisations	M	86	51
Provide contraceptive services	N	84	19
Deliver antenatal care	O	63	6
Order ionising radiation	P	56	11
Prescribe medications	Q	44	8

*Table 2 Potential physician associate activities in secondary care given to respondents in the survey. *Consultants, resident doctors, GP and SAS that have worked with PAs within the last 5 years. Reproduced from the Leng Review (Table 12, p.62).*

not be adversely affected by the employment of PAs and AAs. The review mentions that newly qualified doctors are paid less than PAs and talks of salary adjustments.

Cost and cost effectiveness

The review points out that the available evidence base was insufficient to address these.

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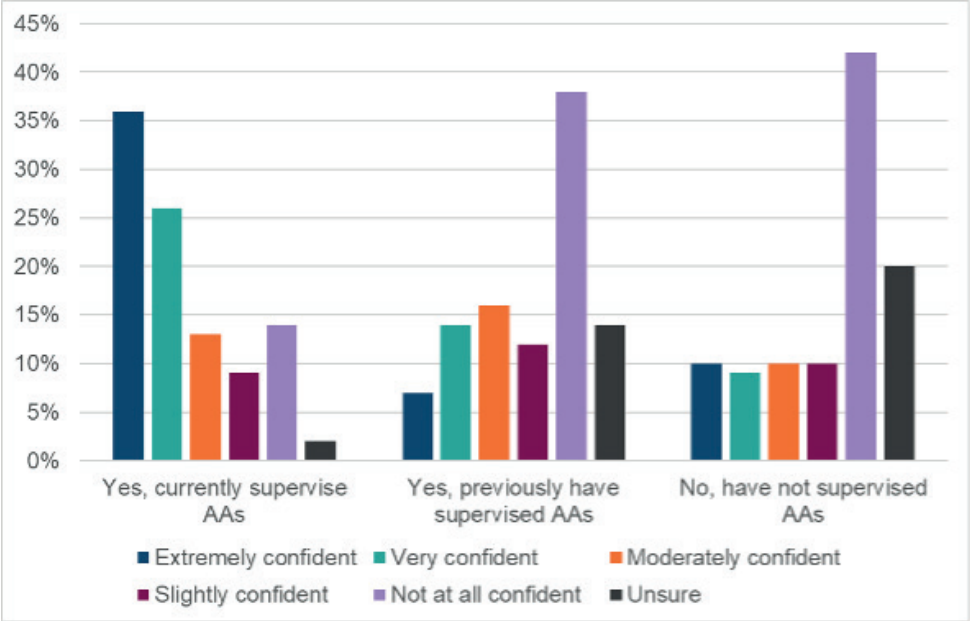


Figure 3 How confident do you feel that anaesthesia associates deployed in your service receive enough supervision and support? (Respondents had worked with AAs within the last 5 years.)
Reproduced from the Leng Review (Fig.14, p.66)

AA supervision status	Currently supervise (%)	Previously supervised (%)	Have not supervised (%)
Extremely confident	36	7	10
Very confident	26	14	9
Moderately confident	13	16	10
Slightly confident	9	12	10
Not at all confident	14	38	42
Unsure	2	14	20

Table 3 How confident do you feel that anaesthesia associates deployed in your service receive enough supervision and support? (Respondents had worked with AAs within the last 5 years.)
Reproduced from the Leng Review (Table 14, p.66)

Book Reviews

The Citadel

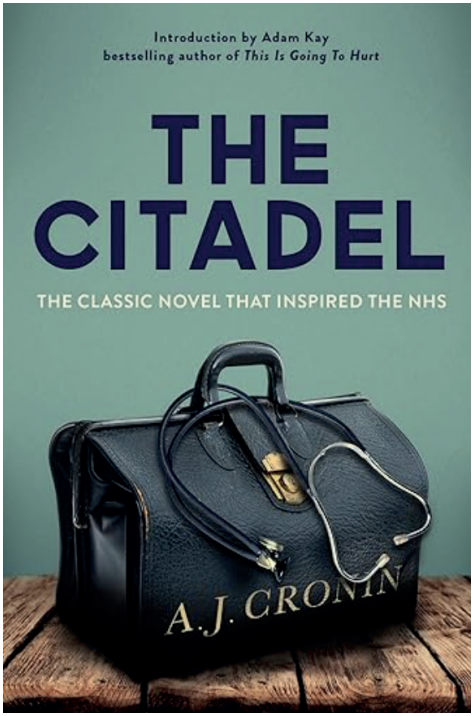
(£4.99, fiction, Bello, available via Amazon as Kindle and as hardback and paperback, used)
A. J. Cronin, 392pp.

Did A J Cronin's semi-autobiographical 1937 novel help to promote the formation of the NHS or even influence the 1945 election?

We will never know, though both claims have been made. What we do know, however, is that *The Citadel* was thought in a UK survey at the time to be 'the most influential book after the Bible'. A film the following year won an Academy Award and the novel even sold well behind the Iron Curtain as it was felt to have exposed the defects of medicine under a capitalist system. Some of the medical establishment wanted the book to be banned as it was considered to be 'professional treachery' to expose the deficiencies of doctors, but it showed the need for postgraduate medical education, for the use of science and for professional co-operation without the profit motive, although it has been said that Cronin himself did not think the Government should be involved in healthcare.

Although the novel is not strictly autobiographical, the career of Andrew Manson in *The Citadel* draws very much on Cronin's own medical experience.

Archibald Joseph Cronin (1896-1981) qualified in Glasgow in 1919 and was awarded the DPH and MRCP, and later an MD. He worked as a GP, first in Garelochhead and then in the south Wales mining town of Tredegar where he was employed by the Cottage Hospital which had been established by benevolent societies and philanthropists. The local MP, Aneurin Bevan, was a member of the management board and became Chairman. The Tredegar Medical Aid Society covered 95% of the town's population and provided free medical care in return for a small weekly contribution (this had been 1d/week in 1909 [*equivalent to £0.65 per week now*]). Staff were well treated with good



wages and conditions, and could also do some private work if they wished. This was the model Bevan used for the NHS.

In 1924 Cronin was appointed Medical Inspector of Mines and researched lung disease associated with coal dust inhalation. He subsequently moved to London where he undertook private general practice in Harley Street and then in Notting Hill as well as acting as medical officer for a department store. As a result of a duodenal ulcer he was advised to take 6 months' rest, during which he wrote his first book, *Hatter's Castle*. Although he never returned to active medical practice, he used his social observations and

clinical experience extensively in his novels, and created other well-known characters such as Dr Finlay. Cronin was a fierce critic of instances of incompetence, corruption and greed which he had encountered. He wrote " I have written all I feel about the medical profession, its injustices, its hide-bound stubbornness .... The horrors and inequities described in the story I have personally witnessed. This is not an attack on individuals but against a system".

The Citadel is the story of Andrew Manson, a newly qualified and idealistic young Scottish doctor who is starting his very first job as an assistant to a GP in Drineffy, a mining village in the Welsh valleys. A gifted student, he would have preferred a hospital post, but housemen at the time earned little or nothing and he was committed to repaying a loan he had needed to complete his studies. He had been warned about "questionable ways of practice" in these remote valleys, and soon discovers that there had been a high turnover of assistants. The GP, Dr Page, had suffered a serious stroke some while earlier and would never return to work, so Andrew is entirely on his own but approaches his work enthusiastically.

When his first patient is found to have typhoid, Andrew discovers the complete lack of local facilities. There is no hospital, so no means of isolation, and the District Medical Officer is totally unhelpful. Philip Denny, an able but unconventional local doctor, tells him that the problem is a leaking sewer which the Council has never dealt with. In frustration, the normally law-abiding Andrew joins Denny in blowing up the sewer. Their involvement is fortunately never discovered and a flood of sewage round a councillor's new house results in a rapid repair. Both he and Denny are frequently shocked by other practitioners' incompetence and failure to take any steps to keep up to date, just relying on "an acquired capacity for bluffing their patients". There are other memorable patients in Drineffy including a successfully resuscitated infant and a miner with myxoedema madness who another colleague had wished to certify for the asylum. A measles outbreak introduces Andrew to Christine, an intelligent and spirited schoolteacher, and a move to the town of Aberlaw (fictitious, but closely modelled on Tredegar) allows them to marry.

The facilities in Aberlaw are far better than in Drineffy. The hospital has a chief physician and surgeon, and Andrew is one of four assistants. All the workers pay a little each week, and all the treatment they need is then free. Andrew's principled stance makes him some influential enemies when he refuses to give "off work" certificates to malingerers, and his earnings go down every time someone moves to a colleague's list. Once again, he is unimpressed by his medical colleagues, one of whom 'has not opened a book in 20 years'. There is no real co-operation between them as they are competing for patients, and he muses that "if every doctor were to eliminate the question of gain, the system would be purer".

"There is no real cooperation between them as they are competing for patients, and he muses that 'if every doctor were to eliminate the question of gain, the system would be purer'."

Encouraged by Owen, the dedicated secretary of the Aberlaw Medical Aid Society, Andrew continues a longstanding interest in chest conditions by researching miners' lung disease and is awarded his MD. He also takes MRCP and to his delight he passes, but on arriving home is immediately called to an emergency. A miner, trapped by the forearm by a roof fall, needs an immediate amputation in difficult and very dangerous conditions. Fortunately this is successful and helps Andrew's reputation but there are still local frustrations and he and Christine leave for

London although she would have preferred a country practice.

Christine becomes increasingly unhappy as Andrew is seduced by materialism and concentrates on making money from fashionable patients – many of them just hypochondriacs. We see the widespread medical corruption and incompetence, unnecessary treatments and useless remedies, all of which he had previously despised. He is finally brought to his senses by the death of a friend through incompetent surgery and asks himself "Where in the name of God am I going?".

A crisis arises when the favourite daughter of an Aberlaw friend develops TB. She is not improving in the Victoria Chest Hospital so he arranges treatment in a sanitorium run by an American scientist who has had excellent results in the US. The young woman is cured, but an enemy reports him to the GMC for associating with a non-doctor to treat a patient. Fully expecting to be removed from the Register, Andrew makes a passionate speech in his own defence. All the frustrations of his career come out, for instance the unscientific nature of so much medical practice and the vital contribution of non-medical scientists to improve care. He speaks of the inadequacies of training and the need for postgraduate education, of quacks and bogus remedies, of the need to collaborate and specialise and of the ill-effects of commercialism.

As well as the NHS itself, Cronin must have welcomed compulsory preregistration posts which started in 1953 and mandatory GP training in 1973, as well as the increasingly scientific nature of medicine. How would he feel about the marketisation of the NHS or the current pressures to replace doctors with staff who have had far less training, Physician Assistants, ACPs and others? Somehow I do not think he would have approved.

Many members will have read this novel in the past, perhaps when considering a medical career, but it is an account of conditions at the time. It shows how much medical practice has evolved and improved since it was written, perhaps influenced by Cronin's writing. Are we now threatened by a possible return to some of those pre-NHS practices, against which he railed, under political influence?

The Citadel is well worth reading, or re-reading.

PS. Andrew Manson was not stuck off.

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You Don't Have to be Mad to Work Here. A psychiatrist's life
(£7.97, Jonathan Cape Publishing, available via Amazon; paperback, hardback and Kindle)
Benji Waterhouse, 2024,316pp.

This account by a psychiatrist in training follows on from the book by the obstetrics and gynaecology registrar Adam Kay, *This is going to hurt* (1).

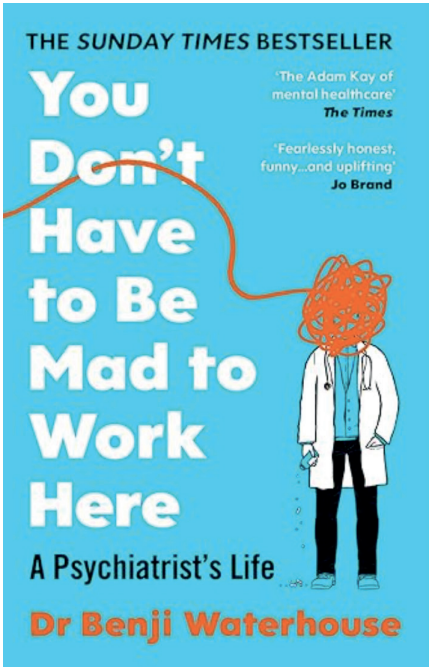
Both have in common hair-raising NHS scenarios, hilarity, demanding work, mirth, long hours, levity and an exploitative working environment. The two books are fun to read. After a particularly disastrous obstetric delivery Kay gave up medicine and became a TV writer and celebrated performer.

Benji's mother was a child psychologist and his father a biology teacher. He grew up in Northumberland, graduated from Leeds Medical School and trained in psychiatry in London.

On his first day in psychiatry, the induction course included prevention and management of violence and aggression plus self-defence techniques that might have been needed with patients. Play acting included "Oi, baldy, I'm gunna cut your head off and eat it"; his response "Um, should we sit down and talk about this?". On the ward, he met the consultant Dr Glick and heard of six admissions overnight.

Gladys, sitting on the edge of her hospital bed in the overheated ward, won't take off her duffel coat because she was cold. She says she is dead. When it is suggested she might lie down on the bed, she responds that she will lie down when she's taken to the graveyard. Her daughter reported her not having slept for a week and she is worryingly thin. She hadn't been drinking and her electrolytes were deranged. When encouraged to take fluid she said "Dead people don't drink". Dr Glick explained she had the Cotard syndrome and that since she hadn't responded to antidepressant drugs she should have ECT at 5pm that day.

Benji decides that he should scupper that and reasons that if he can get her to eat that she won't be fit for the ECT anaesthesia. He comes into her room bearing a cup of tea and a ham



sandwich saying "I thought I'd do room service". Gladys, sitting in exactly the same position on the edge of her bed, informs him that "Dead people don't drink" and ponders whether Benji is also dead. Unable to persuade her he leaves for other pressing duties. The next morning he headed straight to Gladys's bedroom. It was empty. He was informed that she was in the dining room and there he finds her sitting alone with an empty glass of apple juice and a clean plate but for a residual baked-bean puddle.

Having jumped off a bridge into the Thames, a man brought into A&E at 4 am is asked: "Which side of the bridge did you jump off?". Two psychiatric catchment areas border the bridge and the side he jumped off had determined the team to take on his care. The nurse suggested to Benji that the patient be told that next time he should

jump off the other side.

A patient detained in hospital on a section of the Mental Health Act is informed that he can't go home. He shouts "How does a baby-faced twat like you have the power to keep me here against my will?" It warmed Benji's heart to be told that he still looked young

At a social event he's asked by a young woman "OK here's one Dr Psychiatrist, what's the secret to happiness?" He wanted to say "It's really very simple. All you need is a healthy birth, secure attachment, happy childhood, minimal or no trauma, high resilience to stress, loving friends, family and partner, fulfilling work, financial security, manageable targets, 8 hours sleep a night, regular exercise, healthy diet, access to nature, limited use of alcohol drugs and social media, faith or spirituality, an acceptance of failure and death, an ability to process grief, a naturally positive outlook, maybe a pet, a gratitude journal, plus or minus antidepressants, therapy and a 100% charge on your phone". Instead, he took a long sip of his beer.

"In the back of the room dangling ... a rope tied at the end into a classic hangman's noose with a wooden stool just below it. 'Thanks for letting me use your bathroom. I think we need to have another chat, don't we?' "

Further on in his training, now a registrar, Benji goes on a home visit accompanied by a medical student. It was to see a City worker living in a nicer part of the town whom the GP had written was considering ending his life. Knocking on the door elicited no response. The GP had given the patient's mobile number, but it went straight to voicemail. Benji wrote a "sorry we missed you" note and left it in the letterbox half-in half-out. As they were leaving for the next patient's address, the medical student looked back and saw that the note had vanished.

On knocking again the door eventually opened. A thirty-something man was holding the note. Benji explained that they were from the mental health crisis team. "Mental health?" asked the man scratching his head, apparently bemused. Benji and student entered the palatial, multimillion-pound warehouse conversion and Benji wondered if it was an original Banksy on the wall.

Asked about suicide: "Suicide? God no ... I can only think that maybe I said something throwaway which [the GP] misinterpreted". They talk around the point and Benji asks about his work in the city. "It's OK. Work hard, play hard, crazy long hours though". After more probing: "I honestly think you've got the wrong chap here". Benji asks if he can use the toilet before going to the next home visit. "Um. Well. Um …" with his shifting uncomfortably. "Yeah I suppose so". The bathroom was large, a grand room with huge tropical plants and what seemed honest-to-God actual gold taps.

After having washed his hands and turned to go, he noticed it. In the back of the room dangling from one of the steel girders which spanned the warehouse's high ceilings, a rope tied at the end into a classic hangman's noose with a wooden stool just below it. "Thanks for letting me use your bathroom. I think we need to have another chat, don't we?". In phoning for a bed for an informal admission, Benji was told that there were none free at his hospital or in the whole of London and was asked "Is it urgent?". Eventually a bed is found, in Durham.

On another home visit, a little old lady is more or less held hostage by her large son with paranoid schizophrenia who believes she is poisoning him. He asks Benji "Who the hell are you?" and orders him out. Benji makes heroic efforts to find a bed and arrange with another doctor, a social worker and the police to get the son into hospital on a section of the Mental Health Act. While this was going on, he was shocked to hear on the news of

the death of an old woman living with her psychotic son. After frantic efforts to identify her, it turns out not to have been Benji's patient's mother.

In a similar vein, and with plenty of dark humour, other patients are described.

Interspersed are accounts of his visits back home to see his parents, his relationship with them and his liaison with his girlfriend.

Entertaining to read, and illustrative of the life of a resident doctor in psychiatry, I recommend this book.

Reference

1. Kay, A. (2017) *This is Going to Hurt. Secret Diaries of a Junior Doctor*. London, Picador Press, p.268.

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Interested in joining in more?

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