

# comment

"Covid-19 has brought into sharp focus issues around care homes" **DAVID OLIVER**

"Now is not the time to take decisions with major implications" **HELEN SALISBURY**

**PLUS** Mourning our dead in a pandemic; trainee GPs in limbo

**WOUNDED HEALER** Clare Gerada

## Understanding burnout

**I**n my early 40s I felt exhausted: I was juggling general practice, motherhood, and carving a career in addiction. More than this, I'd lost my zest for work. It had become routine—and, if I'm honest, caring for patients had become a burden. Until then I'd been an enthusiastic, engaged GP and had loved my work, especially the patient facing aspects. But then, medicine had lost its spark.

Looking back, I had classic burnout—a state of physical, emotional, and mental exhaustion caused by long term involvement in demanding situations. Today, it's the single most prevalent psychological complaint in the caring profession: at some point in our career, anyone working close to human suffering will develop some aspects of it.

Although the intensity, duration, and consequences of burnout may vary among individuals and across time in the same person, it's always a combination of physical, emotional, and mental. After I ran the London marathon in 2004, I was exhausted but elated. That was clearly not burnout.

Burnout is thought to be distinct from depression, but I think of them as part of the same process. There's a considerable overlap between symptoms (hopelessness, poor self-esteem, sleep disturbance), and it may be more acceptable to call oneself "burnt out" than "depressed." But the two are linked. A Finnish study found a relation between burnout and depression, with each predicting subsequent developments in the other.

The covid-19 crisis is adding pressure on doctors and the health system. An Ipsos MORI poll reported that half of workers already believed their mental health had declined in the first two months of the crisis, and if covid-19 has even the same psychological impact as other major pandemics, a vast number of key workers will need support.

The strain on the medical profession is already being felt. A BMA survey conducted this month found that almost half of UK doctors were experiencing burnout, depression, anxiety, or

other mental health conditions relating to work or made worse by it.

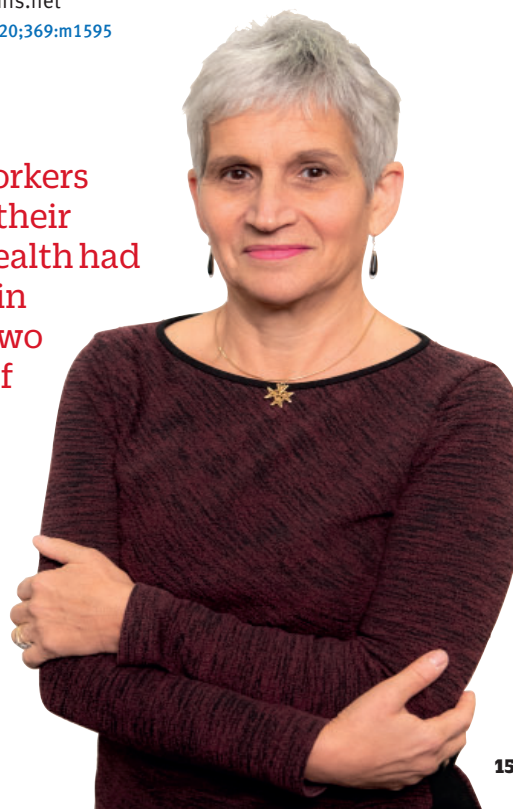
It's hard to prevent burnout—but we have to manage, recognise, minimise, and deal with it. We all have ebbs and flows in job satisfaction, and years of being in the psychological trenches with our patients will have an effect. What's important is recognising when we can't go on; when negative attitudes turn to loss of compassion; when our sense of futility becomes a feeling of helplessness; when our work loses its sparkle, and we need to remove ourselves from the stressor.

I was lucky: I worked for a practice that allowed me to take a sabbatical. Refreshed and reinvigorated, I returned and amended my working practice, which sustained me for the next two decades. The best place to start to reduce levels of burnout is in the workplace.

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**Half of workers believed their mental health had declined in the first two months of the crisis**



**PERSONAL VIEW** Seamus O'Mahony

## Mourning for our dead during the pandemic

The coronavirus is having an impact on how we can publicly grieve

I came back to Ireland in 2001, after working for 14 years in the NHS. I underestimated the re-acclimatisation involved. The most striking cultural difference between Britain and Ireland is how we mourn and bury our dead. In Britain, funerals are private affairs; in Ireland they are communal events. I attended only one funeral during my 14 years living in Scotland and England; when I came back to Ireland, I found myself regularly queueing at removals.

Ritual comforts the bereaved and guides the words (“sorry for your trouble”) and behaviour of mourners. We Irish are famous for our wakes. Many of the rituals (and “games”) associated with wakes were pre-Christian in origin; by the 19th century, wakes had become such Dionysian extravaganzas that the Catholic hierarchy tried to ban them.

Wakes have become increasingly uncommon, but the old funeral customs—the traditional sequence of rosary, removal, funeral mass, and burial—are still adhered to in rural Ireland. In the cities, these customs are slowly withering, victims of secularism and atomisation. The Catholic church, once the pre-eminent force in the country, saw its power collapse over a single generation. The Celtic Tiger years showed that the Irish weren't

quite as mystical, spiritual, or, well, Celtic as we had led the world to believe. We could do greed and materialism with the best of them.

More than 90% of the population in the Irish Republic is nominally Catholic, but fewer than half regularly attend mass. Vocations to the priesthood have plummeted. Priests from Kerala, Nigeria, the Philippines, and Uganda have come to work in Ireland: in a bizarre historical reversal, we have become a mission country. We may not go to mass anymore, but we still call on the Church for big events: birth, marriage, and death—particularly death.

### New regulations

Which brings me to the covid-19 pandemic. On 31 March, the Irish government announced new regulations on the conduct of funerals, burials, and cremations: “Immediate family members can still attend funeral services, burials, and cremations, provided that social distancing rules are respected. This relates to all funerals, including those arising out of covid-19 deaths. While we know this is difficult, in general, numbers attending should not exceed 10 persons in places of worship and at the graveside.”

Many Irish priests—including five bishops—are over 70 and are cocooned.

**People are angry with the virus, not the government. Public good comes before private grief**

Some bishops have recommended a policy of praying at the graveside only, with the funeral mass held behind closed doors without a congregation. Those dying from covid-19 are often buried without close family members present, as they self-isolate after contact with the dying person.

A Scottish friend emailed me recently, saying he was perplexed and intrigued by the public's general acceptance of increasingly stringent restrictions on basic civil liberties such as the right to assemble. Worse, in his view, was the deprivation of rights surrounding death and dying. He was in favour of informed consent for the public to participate in these activities, lest their denial be “the straw that breaks the back of social cohesion.” He asked me whether the Irish were in rebellion against these restrictions. Bereaved families have certainly spoken of their heartbreak, how shaken, angry, and hurt they have been by the loss of the comforting rituals and the contact with the dead person. But none has talked of defying these restrictions. There is an acceptance,



**BMJ OPINION** Jessie Colquhoun

## Covid-19 leaves the future of 1500 GP trainees in limbo

Last month the GP clinical skills assessment exam (CSA) was cancelled by the Royal College of General Practitioners (RCGP). The exam is an ideal breeding ground for virus transmission as there are well over 100 people involved in each sitting. It is only held in London at the RCGP headquarters and all the examiners are GPs. It's amazing to think any sittings took place in March at all and it was right the exam was suspended.

The RCGP explained that the exam would be rescheduled for, “a time when we can run them safely and reliably.” What many trainees had hoped was that the RCGP would instead look at the nearly three years of training and assessments they had already done and allow those who were on track to pass to qualify. Sadly, this has not been the

### The RCGP and GMC should show some adaptability

case. Around 1500 final year GP trainees, who expected to be fully qualified in August, are now in limbo.

It's worth mentioning that, on average, 97% of candidates pass, a figure almost unheard of in medical exams and there have been calls to scrap it for this reason alone. We already have a GP entrance exam, and have “work based assessments” throughout training. Many would argue this is enough.

Medical schools have shown impressive flexibility in allowing students to graduate as doctors without sitting their final year exams. Retired GPs have been allowed to return to practise and are exempt from reappraisal and





both among the bereaved and in society at large, that there is no alternative. They are angry with the virus, not the government. Public good comes before private grief.

The Irish have had to find new ways of mourning. On 20 March, in Ballyferriter, a remote village in the Dingle Peninsula, the entire parish, each person observing correct social distancing, lined the 2 km road to the graveyard to honour Betty Ryan. Funeral masses are being live streamed. Well wishers can post their condolences on funeral websites; social media has suddenly become a force for good. The situation will eventually end, and then the bereaved can publicly mourn. But deferred mourning can never be quite the same. Bereavement counsellors are predicting a delayed epidemic of pathological grief and depression.

Many of us hope the post-covid world will be a better, kinder, less frenetic place. Having been temporarily deprived, we might once again value the creatureliness of mourning rituals and the community embrace.

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revalidation. We receive regular emails from the RCGP about the need to adapt at pace to the current crisis. The RCGP and GMC should show some of this adaptability too.

As a group of trainees we have written to the RCGP and the GMC to ask them to allow the 1500 affected doctors to become fully qualified GPs in August. The RCGP has said it is still in discussions with the GMC, Health Education England, and others, and that it will do its "utmost to ensure everyone has the same opportunities to sit the CSA."

We await the GMC's reply. For now it looks like there will be 1500 fewer GPs than expected in August, a disaster in a pandemic.

Jessie Colquhoun is a GP specialty trainee year 3 in Lewisham and Greenwich NHS Trust and former editor of *BMJ* Student. Twitter @dr\_on\_a\_bicycle

## ACUTE PERSPECTIVE David Oliver

### Care homes: the lessons to remember

Care homes have been badly hit by covid-19. This has highlighted historical neglect and belatedly brought them into the spotlight. We shouldn't forget the lessons. By mid-April, the government was criticised for reporting only in-hospital deaths and not those from the wider community. By 22 April the Office for National Statistics reported 1000 care home deaths from coronavirus in five days.

Media stories of unprotected and overwhelmed care home staff have mounted, as have untested residents dying. Distraught relatives describe their upset at being unable to visit loved ones. Large care home providers have described outbreaks in a third or more of their homes.

The healthcare consultancy LaingBuisson says around 410 000 over 65s live in the UK's 11 300 nursing and residential homes, outnumbering adult hospital beds by around three to one. Care homes have been far less prominent in the public consciousness than acute hospitals or GP surgeries—but they're now on the front line as much as the NHS.

The Coronavirus Act and additional funding and permissions have enabled more homes to take residents from hospitals far sooner and use any spare capacity, but often with no more staff. At the best of times, residents have complications and die from acute illness such as viral infections.

Their survival rate from resuscitation is vanishingly low. When they're taken to hospital in blue light ambulances it's often distressing and bewildering, and around a

third die there. It's always been right to do more advance care planning for residents, document decisions on resuscitation, and help residents stay put unless they really need to go to hospital. The pandemic hasn't changed that.

Covid-19 has meant many residents isolating in their rooms and avoiding communal areas. Already overstretched teams now carry out all checks, assistance, and supervision within rooms. There are no visiting relatives to provide companionship or reassurance. Staff are going off sick or are self-isolating because of sickness in their families, and agency staff may be reluctant to work in homes with positive cases.

Care homes still lack appropriate personal protective equipment. Fearful teams don't make for good morale despite their selfless efforts. It's been very hard to test residents for covid-19 so far. Meanwhile, many homes now have far more acutely ill residents on site who would normally have been conveyed to hospital, which puts further strain on them—not least those that don't employ registered nurses or don't have quick access to general practice, district nursing, or geriatrician support.

The pandemic has brought into sharp focus issues around funding, staffing, and support for care homes that we should have tackled many years ago. Let's not forget this when the crisis is over.

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Care homes have been far less prominent in the public consciousness than acute hospitals or GP surgeries





## Not the time for major decisions

The world's been turned upside down in the past six weeks, and familiar routines of work, school, family, and friends are gone. Although GPs are not immune, the disruption we face is comparatively mild. We've changed our way of working, consulting mostly by phone or video, but most of us are still going into the surgery and meeting colleagues, albeit at two metres.

Many GPs are also staffing covid clinics in the community, and we're getting used to donning and doffing masks and aprons. In our practice we had a phase of reorganisation, followed by a strange lull when almost all patient contacts were about coronavirus, and now a flood of patients who realise that their symptoms won't wait until this is over. It feels good to get on with ordinary medicine again, picking up threads with patients who stayed away fearing that we were too busy.

There are several things we're not missing, and we're breathing a collective sigh of relief as the regulatory burden is (temporarily) lifted. The Quality and Outcomes Framework, the Care Quality Commission, and annual appraisals are all on hold, and many of us feel able to focus for the first time in years on providing the best care possible to our patients, without constantly worrying about the hoops we need to jump through to keep practices afloat. We're prioritising work according to our professional, clinical judgment.

Few of us have had the time or headspace to consider the 87 page contract in detail



Alas, this relief may be short lived. At the end of last year a new part of the GP contract was proposed—the primary care network direct enhanced service (DES)—which didn't go down well. A revised version has been presented that's slightly less bad, but a special conference of local medical committees on 11 March voted against accepting it. Some fear practices will lose their autonomy, with activity judged at the network rather than the practice level. There are also major concerns that the extra funding may not compensate for the work involved.

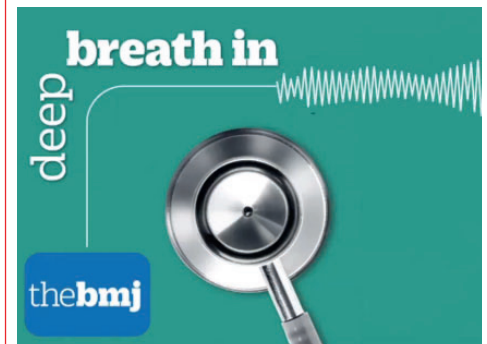
Each practice must say yes or no next month, but now is not the moment to be taking decisions that will have major implications for the future of our practices and the way we work. Few of us have had the time or headspace to consider the 87 page contract in detail. We need to meet, discuss, and take decisions together: there's much uncertainty about what will happen if a few of us say no or if many opt out. Perhaps NHS England is hoping that we won't have the energy to scrutinise what's on offer and will sign up anyway.

I have no illusions about this reprieve from micromanagement lasting; indeed, it may get worse. One of the many likely outcomes of this DES is yet more box ticking and hoop jumping—all of it of marginal benefit to our patients.

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## LATEST PODCASTS



### Deep Breath In: Teleconsulting

Last week *The BMJ* launched Deep Breath In, our new podcast aimed at GPs. Now that coronavirus has altered the landscape of business as usual for GPs, the first episode of the series focuses on remote consultations. Here Trisha Greenhalgh, a former GP and professor of primary care health sciences, talks about what she's learnt from 10 years of studying video consultations:

"The change from face-to-face to remote consultations is probably the biggest change organisationally and operationally in primary care since the inception of the NHS. So one of the things I want to do is to try to reassure people that this doesn't necessarily have to be a disaster. It's going to take a bit of getting used to but, actually, the research is relatively reassuring about the quality and safety that can be achieved, particularly by video, but also on the phone."

### Feeling the fear

We all experience fear, but how can it affect doctors' approach to patients and their practice? This episode of Deep Breath In explores these questions. Here Danielle Ofri, an internist and author of several books on topics such as medical error and how doctors' emotions affect their practice, argues that fear can actually be "an animating impulse of how we work."

"Part of the problem is that, historically, at least, in our training, fear is viewed as a weakness, and so we learn pretty quickly not to show our fears. But I think fear also has a salutary benefit when titrated appropriately. If we completely eradicate fear, we get cowboy doctors who will do anything and that's really dangerous. And so I feel like we need to negotiate an armistice with our fears."



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

# LETTERS Selected from rapid responses on bmj.com

## LETTER OF THE WEEK

### Protecting and testing—let's learn from Ebola



Problems with supply chain and policy are hampering our response to covid-19 (Editor's Choice, 4 April). Resource shortages are understandable given the massive worldwide demand for personal protective equipment and testing materials.

But we seem to be ignoring past lessons in virus testing that could reduce risk to healthcare workers and increase the number of samples processed. The NHS and others have followed the World Health Organization's guidance on handling patient samples, in which the virus is transported "live" in a preservation media that must be kept cool and has a limited life due to degradation. NHS guidance requires these samples to be handled as containment level 3 pathogens from the time of sampling at the point of care through shipping to inactivation in the initial processing at analytical laboratories. This limits laboratory testing and increases risk to healthcare workers.

In past Ebola outbreaks, methods were developed that enable samples to be denatured by immersion of swabs in a chemical denaturant, which allowed subsequent processing by laboratories at containment level 2, a major reduction in risk in the analysis chain. This method, using high molarity guanidine thiocyanate solutions, was shown to effectively denature both Ebola and influenza A viruses and is compatible with high throughput processing. Using an inactivating storage buffer would not only lower risk but also increase the speed and number of laboratories able to process samples. This method also stabilises the samples, reducing the need for cold shipping and improving sample consistency.

We must be willing to try new ways of working in these extreme circumstances. Changes need to be expedited, and healthcare providers must be supported to use the allowances in the EU's in vitro diagnostic regulations to make greater use of both physical resources and the experience of academics and healthcare staff in the UK.

Robin Maytum, principal lecturer in biomedical science, Luton

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## DOCTORS' DEATHS

### Legal duty to notify coroner

The deaths of NHS healthcare workers (Seven Days in Medicine, 4 April) will cause speculation about whether occupational exposure was responsible for a higher risk of contracting covid-19 and of dying from it. Occupational epidemiological research should give us some answers.

But what about these workers as individuals? Under UK law, doctors have a legal duty to notify a senior coroner if they suspect that the death was due to "disease attributable to any employment held by the person." The obligation to notify Her Majesty's coroner is triggered by a mere suspicion on behalf of the notifying doctor.

The coroner would consider whether an inquest was warranted and might summon relevant witnesses to be questioned and to testify under oath. The coroner is entitled to make Reports on Action to Prevent Future Deaths, which are a matter of public record and valuable tools in ensuring that lessons are learnt.

Raymond M Agius, emeritus professor of occupational and environmental medicine, Manchester

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## LONG TERM CONDITIONS

### New ways to manage rheumatic conditions

Chronic rheumatic conditions are likely to be negatively affected by the covid-19 pandemic (Feature, 28 March). Recommendations on how to manage patients with autoimmune diseases, how to deal with anti-cytokine drugs used by about 20% of these patients, and how to keep disease activity under strict control in the context of covid-19 are still lacking.

The mainstay for optimal chronic arthritis management is the treat-to-target strategy, which involves frequent clinical assessment of disease activity. How this could be performed in the future needs rapid evaluation and response. Services set up to shorten the delay between symptom onset and diagnosis and treatment—the main prognostic factors for achieving clinical remission—

are currently not running properly, with all efforts being focused on patients with covid-19.

Rheumatologists should start organising new ways to follow their patients to avoid a major backwards step, losing the fantastic clinical results obtained over the past 15 years.

Roberto Caporali, rheumatologist; Ennio Giulio Favalli, rheumatologist, Milan

Cite this as: *BMJ* 2020;369:m1633

## CHALLENGES FOR HOSPITALS

### Protecting access to neurorehabilitation

Another challenge for NHS hospitals in the covid-19 epidemic (Editorial, 28 March) is ensuring the safety of patients who would normally be in hospital at this time of year, such as those undergoing neurorehabilitation. Many of these patients are over 60, making them "sitting ducks" for acquiring covid-19.

Our department is populated with a mixed age group of patients with multiple comorbidities. Immediate departmental recommendations have been put in place to safeguard these patients, including restricting the number of visitors, higher thresholds for home visits and ward leave, limitations on social dining, and therapy sessions limited to the immediate bed space.

Therapists are at risk of contracting covid-19 based on contact time and shortage of protective equipment. We need an urgent national guideline on how continued access to rehabilitation could be achieved for a high risk group at a time when the NHS could do with the improved bed flow.

Jonathan Mamo, consultant in neurorehabilitation; Beenish Feroz, specialist registrar; Sazan Mahmood, specialist registrar, Reading

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## OBITUARIES

### Mark Erik Victor Petersen

Consultant cardiologist (b 1961; q London 1984; MD, MRCP), died from glioblastoma multiforme on 22 December 2019

Mark Erik Victor

Petersen was educated at City of London School

and St Mary's Hospital Medical School. He secured house posts at St Mary's and had internal medicine training as senior house officer in Sheffield and as registrar on the Westminster/Guildford rotation. He then selected cardiology and worked with Richard Sutton at Westminster and Chelsea and Westminster hospitals clinically as registrar for one year and research fellow for three years. He concluded this period with 21 publications and his MD London thesis. By the end of 1996 he had achieved the consultant post he desired in Gloucester. He brought modern cardiology to the region, together with his three young colleagues. In 2016 Mark was diagnosed with glioblastoma multiforme and had to withdraw from work. He leaves his wife, Victoria, and two children.

Richard Sutton

Cite this as: *BMJ* 2020;369:m1426



### Jane Elizabeth Irwin

General practitioner Grange over Sands, Cumbria (b 1952; q Manchester 1975), died from metastatic colon cancer on

10 January 2020

Jane Elizabeth Irwin

initially trained as an obstetrician but switched to general practice after she got married in 1978 and moved to Cumbria. With her husband, she worked at Nutwood surgery, providing 24 hour cover for 18 years until the out of hours service was established. Jane was variously chair of the Cumbria local medical committee, social secretary of the Furness division of the BMA, a member of the South Cumbria Health Authority, and chair of the local out of hours cooperative. She also worked as a racecourse medical officer at Cartmel. She loved skiing, running marathons, swimming, surfing, fell walking, and she also cycled the length of Ireland. Her cancer was diagnosed only three months after she had retired. She leaves her husband, Richard; three daughters; and five grandchildren.

Richard Norman

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### Jimmy James

Consultant plastic surgeon (born 1940; q St Andrews 1966; FRCS(Ed)), died from metastatic prostate cancer on 4 December 2019

John Henri James

("Jimmy") was born

in Lusaka (then Northern Rhodesia). He attended St Andrews University to study classics but changed to medicine in his first year. He started married life as a student being supported by his wife, Judith, a teacher. From 1977 to 1981 he was consultant reconstructive and leprosy surgeon (and, incidentally, pilot) with the flying doctors' service in Nairobi, which he described as the best job in the world. He left in order to educate his three children in the UK and took an anatomy demonstrator job before becoming a plastic surgeon in Shotley Bridge, where he stayed for 14 years. In 1996 he went back to Africa, to Blantyre in Malawi, to help develop the burns unit at the Queen Elizabeth Central Hospital. He retired in 2009. James leaves his widow, Judith; three children; and eight grandchildren.

Christine Evans

Cite this as: *BMJ* 2020;369:m1481



### Remo E Maclaurin

Consultant anaesthetist (b 1932; q 1956; FRCA), died from a massive stroke on 19 February 2020

Remo Maclaurin was born in Honduras, where his father was growing bananas. He was sent home to boarding school aged 7, and then went on to St Edward's School, Oxford, and the Middlesex Hospital Medical School. He married Philippa in 1957 and deferred his national service by starting anaesthetics at the Middlesex. He entered the Royal Airforce Medical Service as a junior specialist anaesthetist, and spent two years at the RAF hospital in St Athan. He returned to the Middlesex for further training and obtained a consultant post at Mount Vernon Hospital, Northwood, and at Harefield. He enjoyed the outdoor life, especially gardening, sailing, and golf. In retirement he developed a love of opera and ballet, with trips to Covent Garden. He leaves Philippa, three children, and seven grandchildren.

Michael Inman

Cite this as: *BMJ* 2020;369:m1430



### Rosemary Jane Chambers

Consultant cardiologist and radiologist (b 1935; q London 1959; FRCP (Edin), FCRPC), died after a road crash on 20 February 2019

Rosemary Jane Chambers ("Jane") was a house surgeon in the cardiothoracic unit at Barts and a registrar at the National Heart Hospital. In 1967 she became a senior research fellow at the cardiac unit in Cape Town. Two years later she was appointed to her first consultant position in Durban. She moved to the Cleveland Clinic in the USA and subsequently trained as a radiologist in Ottawa, Canada, where she was appointed as a consultant director of cardiac radiology at the University Heart Institute. In 1995 she returned to England and was appointed consultant in cardiothoracic and transplant radiology at Harefield Hospital. It was with great sadness that we learnt this kindly lady had been fatally injured in a road crash near her home in Gerrards Cross.

Barbara Bonner-Morgan

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### Andrew Wu

Consultant liver surgeon (b 1942; q University of Queensland 1969; MD, FRCSE, FRCS), died from myocardial ischaemia on 3 September 2019

Andrew Wu was a consultant surgeon, musician, artist, and sailing enthusiast. After qualifying he had to choose between medicine and music as a career. He did his first clinical jobs in Tasmania and Hong Kong and came to London in 1971. His first job was at London's Whittington Hospital; in 1974 he moved to Ormskirk General Hospital. Merseyside was his base, but he also spent a year at Harvard University as a research fellow in vascular surgery. A sabbatical in Paris to study liver surgery was followed by a consultant appointment at Aintree University Hospital, Liverpool, in 1988. He contributed to surgical conferences and the publication of papers and textbooks. Andrew leaves his partner, three children, and five grandchildren.

Kenneth H Wu

Cite this as: *BMJ* 2020;369:m1429





# Max Rendall

Consultant surgeon who became an addiction specialist in retirement

Max Rendall (b 1934; q 1959),  
died 20 December 2019

Max Rendall, who has died at the age of 85, was a consultant surgeon and superintendent at Guy's Hospital, London. In retirement, he developed a second career in addiction medicine and wrote a book criticising the century old "noble experiment" of outlawing mood altering drugs other than alcohol and nicotine.

After a year at Harvard, he became a consultant at Guy's Hospital at 34. Soon, his manifest organisational skills got him elevated to superintendent, where his tact and politeness enabled him to defuse the resistance to change that some older surgeons displayed. Unusually for a London teaching hospital consultant, Max had no private practice. Colleagues and students remember him as a skilled and kindly surgeon and an excellent teacher. He was also an innovator, introducing problem oriented medical records, audit systems, and weekly surgical meetings to discuss treatment failures, as well as successes, and how to learn from them. He wished politicians would adopt the self-examination and self-criticism that are as routine in academic medicine as they are rare in politics.

## Addiction medicine

After retiring from the NHS in 1994, Max was able to spend more time on his hobbies, such as furniture making and gardening. He also took a kindly and protective interest in a young relative who had consulted me (CB, the author) about his misuse of heroin. Soon, Max became so interested that we made use of the surgical skills that made him ideally suited to inserting implants of the opiate antagonist naltrexone. The longest acting versions can block all opiate effects for about six months and can prevent lethal respiratory depression for another three, but Max also familiarised himself with other addiction treatments, such as disulfiram and opiate maintenance, as well as the talking and listening that are such important adjuncts to pharmacological treatments. He continued working at the Stapleford Centre in Belgravia, London, (now the Opiate and Analgesic Dependence Clinic), until 2015.

Familiarity with the lives and problems of addicts made him reflect on the policy of prohibition, imposed on a largely reluctant world by a triumphant and briefly puritanical USA after the first world war. Though forced a decade later to concede that, where alcohol was concerned, prohibition caused more problems than it solved (particularly widespread crime and corruption), the US

continued to claim that it would work for the less fashionable intoxicants that were widely used in other cultures. Max was sufficiently impressed by the unintended but damaging consequences of prohibition and its ineffectiveness that he wrote a book about it. *Legalize: the Only Way to Combat Drugs* was well argued and readable. Its references to literature, history, and anthropology, as well as medicine and pharmacology, reflected his wide reading and interests. Although it received little attention when it was published in 2011, similar books by other writers were positively reviewed a few years later and showed that Max was ahead of the curve in addiction, as he had been in surgery.

## Early life

Max Rendall was born in London. Both his parents died young, leaving Max orphaned in his 20s. Max's ancestry included Edward Wilson, physician to Scott's last polar expedition, which may have reinforced the stoicism with which he faced the debilitating illnesses that clouded his final years. After Winchester, he read medicine at Cambridge before clinical studies at the Middlesex Hospital, where his contemporaries included Jonathan Miller and Oliver Sacks.

At 28, he married Mary Debevoise, an American art historian and restorer. Their marriage was a happy one throughout its 60 years, and they have one son, Julian, who is a mediator. Although they were generous hosts and supplied good vintages to complement the products of an inventive kitchen, Max was always quietly spoken and a good and attentive listener. These qualities were particularly appreciated by his patients, who were used to being patronised, infantilised, or treated with active hostility in many addiction services. As well as their apartment in Holland Park, where Max's cabinet making skills were very visible, they rented and maintained part of an Arts and Crafts house and its Gertrude Jekyll garden. Their old house in France near Cluny gave him even more scope for working with wood and entertaining. Lord McColl, a fellow consultant at Guy's, was one of the eulogists at his cremation service. Like Max, it was non-religious and the music not at all solemn. Mary, Julian, and two grandchildren survive him.

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**Familiarity with the lives and problems of addicts made Rendall reflect on the policy of prohibition**

