

comment

"The successes over the past six months have been locally led" **DAVID OLIVER**

"Earwax may seem trivial, but not all medicine is dramatic and life saving" **HELEN SALISBURY**

PLUS The case for targeted testing; bring back the right of relatives to visit

THE BOTTOM LINE Partha Kar

NICE needs better support to do its job

The National Institute for Health and Care Excellence is simultaneously vilified and admired. The way it assesses evidence, how it's structured, and the very fact it exists have all been criticised and praised, with some asking whether it's still relevant. Yet it still holds a prime position for those who commission services in the NHS, at local or national level.

NICE was set up to review data, assess cost effectiveness, and help a publicly funded health system use its resources judiciously. However, much of the criticism stems from wrongly held beliefs—particularly, that it is responsible for problems around access to the treatments and technologies it recommends.

Take insulin pumps. Here, despite clear NICE guidance as to who should benefit from a pump, access varies hugely, especially in socioeconomically deprived areas. Funding is not an issue in itself: the guidance comes under a technology appraisal, so funding follows the recommendations. The variation may reflect how engaged local specialist teams are in providing access and that, in deprived areas, life often has other pressing priorities beyond diabetes management. The issue isn't necessarily about NICE—it's about the system being unable to adhere to its guidance.

One question that does concern the organisation is whether its guidance is in line with developing science. With diabetes, a common criticism is about it "not being in touch." But how nimble can it be, when it has to try to align recommendations with the funding constraints of a public organisation while trying to balance priorities and demands from specialists, charities, and pressure groups? Data on newer medicines in type 2 diabetes may need reviewing, or evidence on dietary interventions and remission may need to be examined. NICE needs time to assess this evidence, neutrally and free from industry bias, before recommending the use of public money throughout the population, while also balancing areas beyond diabetes.

The organisation still commands immense respect around the world, but it needs to overcome its current shortcomings—such as its approach to technology,

where it seems less surefooted than with medications. Randomised controlled trials struggle to emerge in this sphere; yet, when they do, real world data move perhaps more quickly than formal evidence reviews can keep up with.

NICE's shortcomings aren't necessarily to do with its objectives or processes—more the fact that it needs the right support to do its job. It needs more funding and new structures that can help it adapt to the fast moving world of research data, to carry out non-biased, evidence based review and do so in line with emerging evidence: one arm could deal with medications, another with technology.

Doctors and other healthcare professionals should be asking for NICE to be given more support so that it can help them improve patient care. We should be vocal because, without its guidance, we risk non-evidence based medicine and public money being spent where it may not serve the population.

Partha Kar, consultant in diabetes and endocrinology, Portsmouth Hospitals NHS Trust drparthakar@gmail.com
Twitter @parthaskar

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It needs more funding and new structures to help it adapt to the fast moving world of research data



An efficient and effective test and trace regime is not a numbers game

The UK needs a targeted strategy, not a government blunderbuss

The government's "moonshot" plan to test millions of people daily for covid-19 risks repeating the mistakes of the early days of test and trace.

The ambition to deliver a further substantial increase in testing is welcome, but as the push for 100 000 daily tests exposed, an efficient and effective test and trace regime is not a numbers game. Testing is not a medical intervention and on its own does nothing to control the disease. It only has value if the test is reliable and a positive result triggers a quick and effective response. This means immediately tracing the contacts of the infected person, investigating the source of their infection, and effectively preventing further transmission of the virus.

Identifying large numbers of asymptomatic carriers has the potential to significantly strengthen our ability to manage the disease, but—as the continuing problems with laboratory capacity demonstrate—we are unlikely ever to have the capacity and public compliance to allow us to repeatedly test millions of asymptomatic people and

then report the results and trace contacts efficiently. Even in areas where there are major outbreaks, such as Bolton, randomly offering tests to the public will not work effectively and will waste valuable resources. We need a targeted testing strategy, which is part of a well designed control strategy—not a blunderbuss.

An effective test and trace system needs to move fast, be led by local intelligence, and prioritise those groups and settings where the virus can spread quickly—especially to the vulnerable.

Excessive central control

The speed of response to local outbreaks is currently being inhibited by excessive central control of the testing resources. Local government public health directors, working with the regional health protection teams of what will be the National Institute for Health Protection, need to be able to call in testing services without the inevitable delays caused by a national system delivered by a contractor answerable to ministers.

The folly of running test and trace primarily

We don't need to shoot for the moon—we simply need to follow tried and tested techniques

as a national system can be seen in the ludicrous situation of people being told to drive hundreds of miles to get a test. As well as undermining the effectiveness of the entire covid-19 response, this failure to make testing centres accessible hits the poorest communities hardest, exposing them to even greater risks.

The government needs to prioritise testing. As capacity increases it should expand the scope of testing in a systematic manner. Symptomatic people must be a higher priority than asymptomatic testing. Asymptomatic testing needs to be prioritised to settings which are high risk, like care homes and hospitals, and to settings where compliance with testing is practical and will provide assurance that a setting is safe, such as universities, schools, and perhaps some large workplaces. The risk at universities, when there is evidence that many young people are not following government guidance on

Stop the blanket ban on hospital and care home visitors



Since the start of the pandemic, inpatients and their families have been separated to prevent the spread of covid-19.

Excluding relatives from visiting their loved ones is upsetting and unnecessary. Most distressing are stories of patients dying in hospital with their family unable to visit them or be with them in their final moments.

In some areas of the country, however, individual healthcare staff have been either able to speak out against the policy, or they have had the time and capacity to find ways to enable relatives to visit. Listening to a conversation between Jocelyn Cornwell, founder of the Point of Care Foundation, and Hayley Hughes, head of compassionate care at the Bristol Nightingale Hospital during the pandemic, was refreshing. It was inspiring to hear the practical approach Hughes took to

Visits are an incredibly important and necessary part of patient care

maintain the connection between patients and their families at the Bristol Nightingale.

Hughes was aware that up to 50% of the patients would not be expected to survive and she was clear that families should be able to visit their loved ones at the end of life. She found that this was something that had not been considered when the facility was built. She based her approach on what she would want if she was in the position of families and carers. She described thinking of family members at home, not knowing what was happening to their loved one, going through "the most extraordinarily terrifying time" of their lives. She says that she "could not even contemplate the fact that you wouldn't be



social distancing, is clear. The current policy at ports of entry must be reviewed and, when capacity allows, testing should be offered in a system which encourages public compliance.

Beyond this, people in high risk occupations such as bus and minicab drivers should be tested regularly, although this must not be seen as an alternative to ensuring staff are “covid-19 secure” at work.

Big numbers will count for little without the right strategy. We don’t need to shoot for the moon—we simply need to follow tried and tested techniques for controlling infectious diseases.

The most hazardous phase of the pandemic is still ahead, with the difficulty of adapting to constantly changing messages, the need to control the virus as we open up the economy, with schools and universities restarting, and as we approach winter flu season. A clear, robust plan is essential if we are to get through the winter without further substantial loss of life.

Maggie Rae, president, Faculty of Public Health
Ellis Friedman, treasurer, Faculty of Public Health

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able to say goodbye to a loved one” and was not prepared to see that happen.

Hughes identified an area away from the main covid-19 ward and set up a visiting policy which included a liaison team who phoned families with news. Initially the plan was for full personal protective equipment (PPE) and a 20 minute visit, but a new infection control lead identified that full PPE was not needed and that masks were enough. This meant that holding hands and touching, which are so important at the end of life, was possible and extra visits were allowed.

Visits are an incredibly important and necessary part of the care of patients. In the same way that we wouldn’t stop prescribed medication and treatments, we should not stop visits.

Carol Munt is a patient partner and advocate

● EDITORIAL, p 364

ACUTE PERSPECTIVE David Oliver

Covid and the value of local leadership

What does our initial response to the pandemic teach us about the balance, and future

rebalancing, of central versus local healthcare leadership? Local clinicians and operational management have led most of the measures that have worked. Specialist medical societies and academic researchers have also had starring roles.

The government and its arm’s length organisations have lost any contest of competence or reputation. Indeed, many locally and clinically led successes have happened despite central failings, which have been well documented.

On the other hand, health policy think tanks such as the Nuffield Trust, the Health Foundation, and the King’s Fund have done a sterling job with policy analysis and commentary. Professional organisations such as the British Thoracic Society, the British Geriatrics Society, and the Faculty of Intensive Care Medicine have put out numerous good practice resources and media responses. Academic groups and journals have published evidence reviews to guide clinical practice.

Most of all, the successes over the past six months have been local. The rapid reorganisation of primary care, with remote consulting and “hot hubs” for covid patients, was locally led. So was the doubling and tripling of intensive care capacity, the splitting of acute care streams and wards into

“hot” and “cold” areas, the creation of additional outpatient care and step-down intermediate care capacity to ensure more people were managed at home, and the reorganisation of roles and rotas to cope with the surge.

I don’t want to overlook concerns about excess mortality from non-covid-19 causes in people who didn’t access acute or elective care—either through fear or because services had stopped—or concerns about transfers to care homes and subsequent outbreaks. Some of these decisions were also locally led. However, we already know from much of the literature on improvement and quality that the key drivers are local organisational culture and clinical leadership, with effective team working.

Of course, in a tax funded national system, central agencies have a legitimate role. However, for some time now the NHS in England has been bedevilled by a top-down, sometimes bullying, culture of control over finances and performance against targets, which threatens and constrains local organisational leaders.

After the pandemic, we need to liberate local clinical leaders and managers and empower them to get on with solutions for their own organisations and local populations. I fear that what we’ll see instead is ever greater central control, as politicians get more anxious about NHS performance and reputation.

David Oliver, consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com
Twitter @mancunianmedic

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We need to liberate local clinical leaders and managers



The hollowing-out of services

Like many GPs, I've spent too long recently discussing the deeply unglamorous topic of earwax—specifically, whether we can or should continue to remove it. Not many years ago, practice nurses spent a lot of time squirting warm water into ears to unblock them: not a particularly pleasant job, but someone has to do it. The question is, who?

Then we were advised by NICE that earwax should be removed by irrigation, using a pump with controlled pressure rather than manual syringing, as this was less likely to damage the eardrum. The alternative is microsuction, where wax is hoovered out under direct vision, which requires expensive kit and training.

No specific funding is provided for this work, and surgeries are increasingly crossing it off their list of services. General practices will be blamed for this, but they can rightly claim that it's not a commissioned activity and they don't have enough nursing hours to provide all of the other care patients need.

As no one takes responsibility for providing or commissioning this service, it's become increasingly unavailable. Our local ENT department will do microsuction for a select few patients with complicated ear pathology, but it lacks the capacity to treat every blocked ear in the county. High street opticians offer it, but many patients can't afford the £50 price tag. I'm concerned that ever more patients who have tried wax softening drops with

minimal success are now just suffering in silence (quite literally).

Not all medicine is dramatic and life saving: doctors spend time treating fungal infections and indigestion as well as heart attacks and major trauma. But our NHS was set up not just to save lives but also to reduce suffering and make lives better. The contract with the British people—the promise of cradle-to-grave care regardless of ability to pay—is looking threadbare.

This reduction in what the NHS can provide is occurring in hospitals and in the community. Once routine surgical procedures, such as hernia repairs and treatment of varicose veins, are now “low value” and are difficult to access unless serious complications are likely. Services are slowly disappearing from primary care too: travel vaccinations and cryotherapy for minor skin lesions are two other areas many practices have withdrawn from.

Earwax and varicose veins may seem trivial until you have them yourself or a distressed patient is sitting in front of you. When there's competition for inadequate funds, non-life-threatening health issues lack the urgency of cancer care or the political clout of children's services. This is how the NHS is shrinking—not with a radical introduction of upfront payments or insurance but with a gradual whittling away of services. Not with a bang but a whimper.

Helen Salisbury, GP, Oxford
helen.salisbury@phc.ox.ac.uk
Twitter @HelenRSalisbury
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The promise of cradle-to-grave care regardless of ability to pay is looking threadbare



LATEST PODCASTS



Mask shaming

The social norms that guide our behaviour aren't often quick to change, but the imperative to wear a mask in public has rapidly taken hold. Mask shaming is a new phenomenon, but in this Wellbeing podcast, Brandy Schillace, historian and editor in chief of *Medical Humanities*, discusses how ineffective shaming is as a tool for behaviour change.

“What I find interesting is the way that the mixed messaging has led to everyone taking sides against one another. And it's actually been driving a spike between people at a time when we really want people to care about their communities and come together for mutual support and protection. Community mindedness is not driven by shame. It's driven by connection and companionability and seeing in others part of yourself.”

Talking about obesity

The government has urged the public to lose weight to help beat covid-19. With this greater public awareness, more patients may be asking GPs how to lose weight, but how do GPs respond? In this episode of Deep Breath In, GP Stephanie deGiorgio talks about how to approach weight management in primary care in a way that doesn't stigmatise people.

“We have to accept that as individuals, we all sometimes have our own prejudices, and for some people that's weight. So if that's within oneself, you have to look at that and say, this isn't OK. It's really important to take all that background baggage, acknowledge it, and then change how you respond to the person in front of you. And understand that the person in front of you may well have had hideous experiences when they've gone to see healthcare professionals before. We have to think very carefully about what's gone on for that person before and how you would want to be treated in that scenario.”



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

ANALYSIS

It's time to assess the evidence for the appraisal and revalidation of doctors

The pause in the compulsory UK process during the covid pandemic offers an opportunity to reflect on its real value and to consider its future purpose argue **Victoria Tzortziou Brown and colleagues**

The GMC adopted a more flexible approach to regulation at the start of the covid-19 pandemic, with revalidation and appraisals largely suspended to allow doctors to focus on clinical safety and workload.¹

With reinstatement planned, we argue for urgent clarification of their purpose, an evidence based approach for their implementation, and ongoing evaluation.

Medical revalidation and appraisal

No consensus exists on the definition, mechanisms, and appropriate design of revalidation, and practices vary widely.² Some countries have no formal process³ while others rely heavily on evidence of continuing medical education.²

The GMC is the first regulator to implement a compulsory and comprehensive revalidation process⁴ and has more than 335 000 doctors on its register.⁵ According to the GMC, revalidation “gives your patients confidence that you’re up to date.”⁶ A cost-benefit analysis in 2012 showed that, in England alone, revalidation would cost the NHS nearly £1bn over 10 years.⁷

The expected benefits included increased public trust and confidence in doctors, improved patient safety and quality of care, reduced costs of support for underperforming doctors, reduced malpractice and litigation costs, better information about care quality, and positive cultural change in the medical profession,⁸ but there is no evidence that these have materialised.

Appraisal is the only route to revalidation and must contain supporting information under six defined categories: continuing professional development, quality improvement activity, significant events, feedback from patients and colleagues, and complaints and compliments.⁹ Most doctors (97%) revalidate through annual appraisals and a five yearly recommendation to the GMC from their responsible officer, based on the outputs from their appraisals.⁹

Disagreement remains about whether the mode of revalidation and its key component, appraisal, should be summative (a pass or fail test against a defined standard) or formative (a flexible, informative exchange of information).¹⁰⁻¹² This tension results from unclear articulation of what problem appraisal is trying to solve



Current tension results from unclear articulation of what problem appraisal is trying to solve

while responding to numerous stakeholders with competing priorities (see supplementary table on bmj.com).¹³

The current roles of appraisal can include a combination of assuring a doctor's fitness to practise, performance management, personal and professional development, and providing coaching, mentoring, pastoral care, and support. As a result, appraisal has become a mini industry, with numerous staff planning, overseeing, recording, or performing appraisal and commercial and membership organisations offering tools to complete it. In the absence of a clear and consistent aim of appraisal, we evaluate each of these purported purposes.

Fitness to practise

The government white paper on medical regulation in 2007¹⁴ proposed that appraisal should remain central to the revalidation process, with a greater emphasis on summative aspects “which confirm that a doctor has objectively met the standards expected.” However, there is no relevant research on what tools, data, and processes can objectively show these minimum expected standards.

KEY MESSAGES

- Appraisal has several objectives, including revalidation, performance management, and personal and professional development
- Responding to these distinct, often competing priorities, requires different processes
- There is little evidence that the current system achieves its objectives
- Before appraisal and revalidation processes are restarted after the pandemic, we need clarification of their purpose
- Research is needed to identify the appropriate tools and outcomes, measure intended and unintended consequences, and evaluate cost effectiveness

The Medical Board of Australia dropped the term revalidation and uses a “professional performance framework” to identify doctors at risk of performing poorly, with strengthened assessment and management of medical practitioners who have received multiple substantiated complaints.¹⁵

The appraisal process in the UK has a strong focus on collecting, recording, and reflecting on supporting information. However, written reflection is not necessarily translated into ongoing reflective practice,¹⁶ and there is no robust evidence that appraisal improves safety or patient outcomes or that it gives patients confidence in doctors.¹⁷ Even if some patients believe appraisal guarantees their doctor is up to date and fit to practise, without objective evidence this could be false reassurance.

The process is often seen by doctors as onerous and bureaucratic.¹⁸ Accordingly, appraisal and revalidation were largely suspended at the start of the covid-19 pandemic “to free up capacity to maintain essential care.”¹⁹ Retired doctors were automatically re-registered with the GMC and told they did not have to engage with revalidation.²⁰

Performance management

Another summative role of appraisal, especially in hospital settings, is performance management. According to NHS England’s Revalidation Support Team, medical appraisals may be used to ensure doctors are working in line with the priorities and requirements of the organisation in which they practise.²¹

The Review Body on Doctors’ and Dentists’ Remuneration goes further by recommending linking pay progression to achievements assessed at appraisal.²² The incorporation of job planning, performance reviews, and pay progression within the appraisal process introduces inherent conflicts of interests and challenges around confidentiality,¹³ whereby health service managers may wish to have access to confidential appraisal folders. Doctors may be asked to include evidence of mandatory training, an organisational but not

GMC requirement, adding to confusion and conflict.²³

Furthermore, the responsible officer is often a senior clinician or head of service within the organisation. This can make it difficult for those being appraised to raise contractual, safety, or management concerns as they are reliant on the responsible officer for registration, and hence income.

Performance management in general is poorly underpinned by evidence.²⁴ A rapid evidence assessment²⁵ by the Chartered Institute of Personnel and Development showed that although appraisal can contribute towards performance, often it has no effect on, or even worsens, performance. The review suggested that performance management should be continuous and not a discrete process occasionally revisited, and recommended separating developmental performance from administrative issues, as they require different types of professional behaviour.²⁵

Learning and professional development

A formative element of appraisal is continuous professional development. Appraisal is meant to help doctors identify, reflect on, and plan to meet their educational needs.²⁶ However, reliance on formal annual assessment of learning needs risks turning learning from a reflexive and responsive process into a narrow and fixed one.²⁷

Evidence that the appraisal process produces improvement in practice is limited.²⁸ A systematic review of multisource feedback found little evidence of benefit on professional behaviour.²⁹ A 2014 NHS Revalidation Support Team report summarising research on the effect of medical revalidation³⁰ found that only a quarter of 2499 doctors reported they changed their clinical practice as a result of their last appraisal. In a cross sectional survey of 276 GPs, less than half reported that appraisal enhanced learning or improved practice, and just over half said that it encouraged continuing professional development.²⁸ Findings are often based on self-reported, subjective



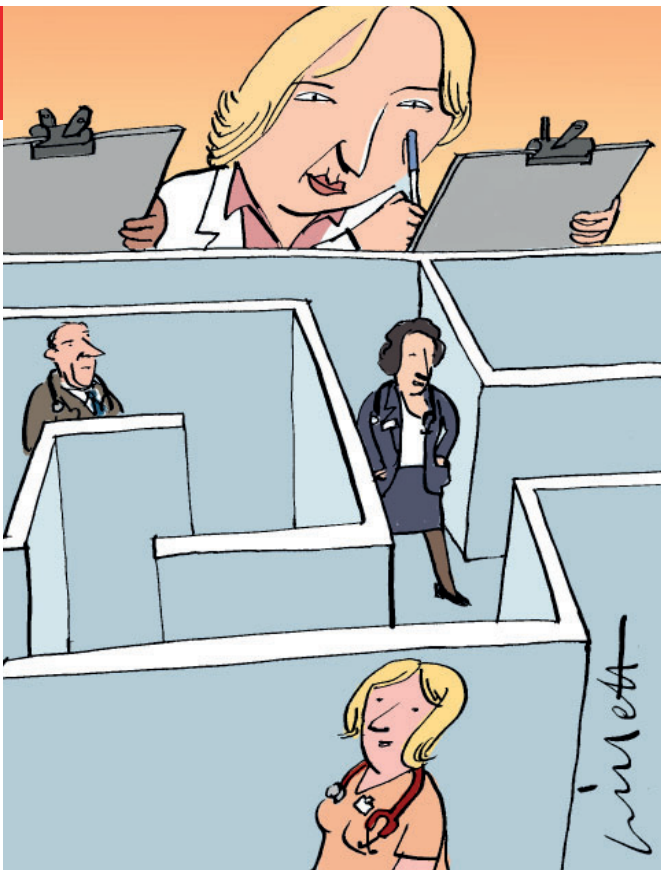
assessments of the effect of appraisal and results can vary widely. For example, feedback in 2019 using the NHS England medical appraisal policy questionnaire, found that 91% of 13 440 doctors agreed that appraisal was useful for promoting quality improvement,³¹ but only 34% out of 1100 doctors responded “yes” to this question in the 2017 Royal College of General Practitioners’ survey.³¹

Appraisal provides a means to document practice but may not necessarily improve it. Some doctors identify negative effects on practice and professional autonomy.¹⁶ In a survey of over 1000 UK GPs and trainees in 2017, “70% stated that summative, written reflection is a time-consuming, box-ticking exercise which distracts from other learning.”¹⁸ Another study reiterated the perception of a tick-box process which creates the impression of accountability,³² adding that doubts over the value of appraisal, or lack of trust, mean it is more likely to be regarded as purely procedural.

Professional coaching and mentoring

Appraisal may go beyond identifying learning needs and agreeing professional development plans. It is sometimes seen as an opportunity for doctors to reflect on careers,

Evidence that the appraisal process produces improvement in practice is limited



Some doctors perceive the appraisal process as having a negative impact on morale and burnout

consider aspirations, and develop potential. Appraisal may thus adopt elements of career coaching and mentoring. However, these rely on the development of a trusting relationship over time rather than a single annual encounter, and both depend on confidentiality, an unconditional positive regard for the person being supported, and a non-judgmental approach.³³

Most organised mentoring schemes attempt matching of participants,³⁴ but this is not possible in the existing appraisal process. Although coaching and mentoring are increasingly advocated within the NHS, such interventions, if effective, should therefore occur outside the appraisal process.

Life coaching and wellbeing

A relatively new role for appraisal is life coaching, which explores issues such as work-life balance, wellbeing, and pastoral care.^{31 35} The GMC report *Caring for Doctors, Caring for Patients*³⁶ recognises that organisations which prioritise staff wellbeing provide better quality of care, see higher levels of patient satisfaction, and retain more of their

Victoria Tzortziou Brown, Institute of Population Health Sciences, Barts and London School of Medicine and Dentistry, Queen Mary University of London
V.TzortziouBrown@qmul.ac.uk

Margaret McCartney, general practitioner, Department of Primary Care, University of St Andrews
Carl Heneghan, director, Centre for Evidence Based Medicine, University of Oxford

workforce. The GMC has committed to working with relevant stakeholders towards improving doctors' working lives. However, it is unclear how appraisal can meaningfully contribute towards wellbeing.

Doctors being appraised are expected to use their own judgment when making health declarations. If a health concern is identified during an appraisal, the matter is dealt with through other processes—for example, by an occupational health assessment—and not within a performance framework.³⁷ The Academy of Medical Royal Colleges has advised that a once a year intervention is not the right form of support.³⁸ Furthermore, a qualitative study showed that if appraisal data are used as evidence for revalidation, it can inhibit doctors from openly exploring difficulties or limitations.³⁹

Patients are likely to want to be protected from “burnt out” doctors and may see appraisal as a way of monitoring or supporting doctors to avoid this. However, the evidence base for interventions aiming to identify and prevent mental health conditions among healthcare professionals is limited,⁴⁰ and there is no evidence that appraisal helps. On the contrary, it may take resources away from other services and initiatives.

The NHS Staff and Learners' Mental Wellbeing Commission recommended a coordinated approach to promote staff wellbeing, including suitable, safe, and confidential work spaces where staff can socialise, share, and discuss experiences as well as quick access to proactive occupational health, emotional, and psychological support services.⁴¹

Furthermore, some doctors perceive the appraisal process as unhelpful, time consuming, and of low value,^{18 42} having a negative impact on morale and burnout and contributing to GPs and consultants leaving the profession.^{43 44} It has been argued that this may be because of the inflexibility and time consuming nature of appraisal and that women aged between 30 and 39 are disproportionately affected, with higher numbers giving up their licences.⁴⁵

Redesigning appraisal

Appraisal has been designed from two perspectives—regulation and professionalism—that have different drivers and aims and require different processes.¹⁰ Despite the engagement of most doctors on the register, the enthusiasm and hard work of appraisers and responsible officers, and the efforts to understand its impact and improve its processes,⁴⁶ there is little objective evidence that appraisal achieves its distinct and often incompatible goals.

The pause of appraisal and revalidation during the pandemic offers a unique opportunity for critical thinking and reflection. Clarity of purpose from the government and GMC is the fundamental priority,⁴⁷⁻⁴⁹ followed by defining the processes and outcome measures to evidence change.

If the primary purpose of revalidation is assuring fitness to practise, it requires clear separation from the other appraisal roles, which should sit outside a GMC mandated system to reduce the risk of conflict and bias. Any redesign should include patients and the public as key stakeholders if the aim includes improving public trust.^{48 49} UK health services, royal medical colleges, and professional bodies should assess the costs and effects on workload and workforce.

Insufficient evidence is available to know whether it is possible to accurately assess fitness to practise prospectively, and whether appraisal is the most sensitive, specific, valid, and reliable tool for this.⁴⁹ Other revalidation models should be explored—for example, online self-declarations, clinical audits, and data signals that could indicate concerns—but given previous difficulties⁵⁰ this may be a problem with no ready solution. We would favour this honesty and the admission that we need to design a new solution, while pausing appraisal, in the same way that we would not recommend a costly and unevidenced clinical intervention that might do more harm than good.

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EDITORIAL

Humane and person centred care must not be sidelined by covid-19

To achieve this, patient and family involvement must be strengthened

The public swung solidly behind health and social care staff during the early phase of the covid-19 pandemic and applauded professionals' commitment, selflessness, and hard work. But patient organisations, including *The BMJ's* patient and public advisory panel, were dismayed to see how rapidly the hard won policies that embed the principle of patient and public involvement in healthcare decision making were swept away in the rush to respond to the crisis.¹ Nearly nine months on, they are still being ignored or sidelined.

One important concern has been the blanket application of restrictive visiting rules that have prevented parents from staying with their children in hospital, barred fathers from labour wards, stopped families from visiting sick or dying relatives, and inhibited much needed comfort and support for those with physical or learning disabilities, mental health problems, or dementia.²

The need for social distancing to prevent transmission of the virus is well understood, but a humane approach to visiting policies in hospitals and care homes need not be incompatible with an effective pandemic response. Family contact can, and in many settings is, being maintained through video conferencing,⁷ garden visits,⁸ and the opportunity to discuss concerns with staff, but a more flexible approach is required to allow family members to be with high risk patients, especially at the end of life. While some providers offer this, most do not.⁹ A Canadian group has called for named family members of high risk patients to be treated as essential



partners in care, who could be exempted from visiting restrictions if they agree to abide by established safety protocols.¹⁰

Although many patients have welcomed the rapid switch to virtual consultations and online health advice, the devil is in the detail. Patients need support and information to know what to expect and how best to prepare to ensure the quality of remote consultations, and health professionals need to learn how to conduct them well.¹¹ Access to personal health records online will help empower patients, and now that multidisciplinary team meetings are conducted remotely, patients could be invited to join them.

Emotional literacy

Meanwhile, provider organisations need to acquire greater emotional literacy in how they deal with patients. Automated messages telling people not to bother the busy doctor are unhelpful and have surely contributed to the large reduction in uptake of non-covid care, storing up problems for the future.^{12 13} Patient advocates have deplored the suggestion that health professionals do not need to collect patient feedback or respond promptly to complaints during the pandemic.¹⁴ Listening to patients and collecting, analysing, and using patient experience data are essential for maintaining and improving the quality and safety of care during and after the pandemic.¹⁵

Backing away from a person centred approach to treatment and care erodes trust and will cause more problems than it solves. Draconian implementation of policy responses to covid-19 have exacerbated health inequalities and ridden roughshod over human rights in some settings.¹⁶ Shared decision making is essential for good care and can be facilitated by providing patients and families with personalised information about covid-19 risks and decision aids to help them

make informed choices.¹⁷ General practices are finding that care and support planning for those with long term conditions can be provided remotely,¹⁸ and hospital clinicians are using advance care plans to promote discussions with patients and families about resuscitation and palliative care.¹⁹

The willingness of patients and public to share responsibility for eliminating the virus is evident from the widespread acceptance of social distancing and mask wearing and the large numbers who volunteer to participate in research studies. Millions of people in the UK, US, and Sweden provide daily reports to the covid symptom study, the largest citizen science project ever mounted in health research.²⁰ And the UK Health Research Authority's public involvement matching service has recruited 6000 lay volunteers keen to help shape covid-19 studies.²¹

The covid-19 pandemic is no reason to roll back person centred care. The arguments for it are sound and evidence based and, with effort and through co-design, can be achieved even without face-to-face contact. Ignoring the key role of families in the care of vulnerable people, failing to involve patients in decisions about their care, abandoning efforts to co-create services with those who will use them, and designing studies without consulting lay people is incredibly short sighted. It risks throwing away recent gains in higher quality, safer, more appropriate, effective, and efficient care.²²

It could also undermine public solidarity at a point when healthcare providers need strong public support and understanding as they face the challenge of dealing with the fallout from delayed and disrupted care.

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OPINION, p 358

Angela Coulter, freelance researcher, Eynsham, Oxfordshire A Coulter angela@angelacoulter.com
Tessa Richards, senior editor, patient partnership, *The BMJ*, London

LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK



Covid-19: understanding human and societal behaviour

The potential for the humanities and social sciences to contribute greatly to tackling covid-19 merits consideration (Editorial, 8-15 August). This could be where the most important academic advances arise, as better understanding of human and societal behaviour is essential if robust strategies to maximise human safety are to be identified and implemented effectively.

Phenomena such as the behavioural psychology around variations in people's desire to embrace risk taking, the growth of vaccine denial, and the organised "fight back" against the wearing of face masks demand attention. Researching the reasons behind emerging claims that the covid-19 virus is not a serious threat to health is also important. Better understanding of behavioural phenomena of this sort is needed to limit further dissemination of the disease. Emergent zoonoses are undoubtedly a serious threat to human life, so we need to better understand the key drivers behind the international (and often illegal) trade in rare animal species to formulate realistic preventive action.

Prevention is always better than cure, and it is essential that vital public health medicine and epidemiology resources are properly funded. That said, it is the study of politics, economics, and ethics that helps us acquire the understanding we need of the differing responses of different countries—and their governing authorities—to security threats, which in turn will allow us to formulate more effective international responses.

Accordingly, we should rethink where academic attention and resources would best be focused. Moreover, as everyone looks apprehensively towards the future, minds should be concentrated on anticipating—and planning—for the likely emergence of other, potentially lethal, infectious successors to covid-19 and predicting how they might behave and spread in societies.

Stephen T Green honorary professor of international health and consultant physician, Sheffield; Lorenzo Cladi associate head of school (teaching and learning), Plymouth

Cite this as: *BMJ* 2020;370:m3523

AIMING FOR "ZERO COVID"

We need population (herd) immunity

Torjesen asks whether the UK should aim for zero covid (News Analysis, 8-15 August). Of course it should, but how? My suggested strategy includes herd immunity, which I call population immunity given antipathy to the word herd.

In the absence of a vaccine we should allow young people under 30, particularly women, to get the infection voluntarily, preferably in controlled circumstances. This kind of approach has been modelled by others and is already happening in unplanned and haphazard ways.

I estimate that about 40-50% population immunity would be sufficient to suppress an infection with a reproduction number of about 1 or slightly more, which requires continuing, reasonable control measures. Allowing infection in people at low risk is justifiable if we make it safer for them than allowing it to occur uncontrolled.

Population immunity through a mixture of vaccination and natural infection is the only long term solution for zero covid.

Raj S Bhopal, emeritus professor of public health, Edinburgh

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INTERVENTIONS AGAINST CORONAVIRUS

Work is the new front line

Michie and West argue for the development of behavioural, environmental, social, and systems interventions against covid-19 (Editorial, 8-15 August).

The only thing I would add is that the workplace has become a new front line, and this requires an understanding of organisational issues. We have found that diverse work-related and personal factors predict transmission and that transportation is important—both in terms of people getting to work and having a transport related job. We should think about behavioural factors in the context of people earning livelihoods. This will call for setting up research teams in novel ways—important work in economics, environmental health, psychology, management science, and public policy would benefit from being brought together more effectively.

If we are to understand how transmission operates in the economy, we need to broaden the research expertise applied and research funding remits.

Paul Anand professor of economics, Open University

Cite this as: *BMJ* 2020;370:m3432

Patients must be at the heart of our response

Amid the development of excellent diagnostic, treatment, and infection prevention algorithms and guidance for covid-19, understanding the health perceptions and beliefs of patients and ensuring their involvement in the design, implementation, and evaluation of complex interventions has been overlooked.

We asked people with covid-19 admitted to our specialist tropical and infectious disease unit in Liverpool about the care they received. The feedback covered areas including personal care, involvement in treatment decisions and discharge planning, nutrition, and sleep quality. We are reviewing this feedback and will compare it with responses received before covid-19. We hope this will help us to establish what we did well and what we can do better.

We must all strive to ensure that people, especially from underserved and high risk groups, remain at the heart of our social, economic, clinical, and public health response to covid-19 in the UK and beyond.

Meng-San Wu, specialist trainee; Fatima Hayat, core medical trainee; Libuse Ratcliffe, consultant physician in infectious diseases and general internal medicine; Mike B J Beadsworth, consultant physician in infectious diseases and general internal medicine; Sylviane Defres, consultant physician in infectious diseases and general internal medicine; Tom Wingfield, honorary consultant physician in infectious diseases and general internal medicine, Liverpool

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OBITUARIES

David Charles Banks

Consultant physician
(b 1938; q London
Hospital 1962;
FRCP), died from
cardiorespiratory disease
on 23 January 2020



David Charles Banks moved to Nottingham as a lecturer in medicine at the newly established medical school. After a secondment to Boston, USA, he became a consultant physician at Nottingham City Hospital, where he worked for the rest of his career. In the 1980s, at a time of administrative turmoil in the NHS, he was appointed as a stop-gap district general manager, a post he was to hold, in addition to his clinical work, for the next seven years. He took much pleasure in following the progress of his growing family, and in later years sang enthusiastically with a local male voice choir, learnt to play the piano, and spent summers cycling in France, Germany, and Austria. He leaves Judith, his wife of 56 years; four children; and nine grandchildren.

Peter Banks, Peter Toghil

Cite this as: *BMJ* 2020;370:m2662

Alastair John Forrest

Head of school of
psychiatry Kent, Surrey,
and Sussex Deanery
(b 1942; q University of
Otago, 1965; FRCPsych),
died from metastatic
renal cell carcinoma on
11 March 2020



Born and educated in New Zealand, Alastair John Forrest joined the London Hospital psychiatry rotation and the training schemes at St George's Hospital. His first consultant post was at Netherne Hospital in Surrey, where he worked for 15 years. He then joined St George's NHS trust, where he worked as a consultant in adult mental health for 20 years. He was appointed as specialty adviser for the London Deanery (renal medicine, neurology and stroke, and psychiatric specialties) in 2001. After his (first) retirement in 2010, Alastair continued at the London Deanery, before moving across to Kent, Surrey, and Sussex Deanery in 2013. Alastair leaves his wife, Mandy; four children; and six (soon to be seven) grandchildren.

Sarah Forrest

Cite this as: *BMJ* 2020;370:m2226

Rosemary Joyce Mattingly

Community doctor
(b 1929; q St Bartholomew's
Hospital 1954), died from
frailty and complications
after a hip fracture on
17 February 2020



Rosemary Joyce Willing met her future husband, David Mattingly, who was the resident medical officer at the Royal Devon and Exeter Hospital, on his 33rd birthday in 1955. She moved to Surrey to work and they were married in 1956, while David was working at St Thomas' Hospital. They returned to Exeter in 1963, and Rosemary combined family life with three children and working in general practice, school health, community paediatric clinics, and as the doctor for the local Marks and Spencer's store for many years. In retirement she and David took up bowls and took two wonderful trips to Australia and New Zealand. Rosemary sang in more than one choir in Exeter. She leaves three children (the eldest a GP), five grandchildren, and one great granddaughter.

Clare Seamark

Cite this as: *BMJ* 2020;370:m2680

James Marshall Munn

General practitioner
(b 1927; q Aberdeen
1954), died from
pneumonia on
12 December 2019



James Marshall Munn was born in Maybole, Ayrshire, and completed his schooling at Ayr Academy. During national service he experienced active service with the King's Own Scottish Borderers in Palestine. At university he is remembered as a popular captain of rugby and a talented scrum half. After completing various hospital posts, Marshall entered general practice and was a partner in Muirkirk for six years before moving to Stirling. He initially worked at the Allan Park practice before setting up a new practice at Orchard House Health Centre. Retirement in 1990 gave Marshall more time to follow his love of the countryside and game shooting—but his real love was working his black labradors, enjoying nature, the camaraderie, and above all the ever cheery banter. He leaves his wife, Fiona, and two sons.

Pierre Fouin, Gavin Munn

Cite this as: *BMJ* 2020;370:m2733

William Thompson

Professor of obstetrics and
gynaecology (b 1937;
q Queen's University
Belfast, 1961; MD), died
from congestive heart
failure on 9 September 2019



William Thompson ("Billy") was appointed professor of midwifery and gynaecology at Queen's University Belfast in 1980 and later became head of department. He was instrumental in introducing diagnostic obstetric ultrasound in Northern Ireland, genetic counselling services for families, and a specialised infertility service and regional fertility clinic at the Royal Maternity Hospital, Belfast. Billy helped to shape IVF services nationally through his contributions to the Warnock Committee and helped establish the first hormone replacement clinic in the province. After a short period of ill health, Billy went on to enjoy his many other passions. He was primary carer for Anne, his wife of just short of 60 years, after her diagnosis of motor neurone disease. He leaves Anne, four children, and 10 grandchildren.

Christine Thompson, Andrew Thompson

Cite this as: *BMJ* 2020;370:m2732

Pat Beresford West

Medical officer
North Devon Hospice,
Barnstaple (b 1956;
q Edinburgh 1980),
died from metastatic
bowel cancer on
15 January 2020



Pat Beresford West (née Bagley) did not follow a conventional path in her career, in no small part a reflection of her free spirit and sense of fun. After working in Cornwall, the Caribbean, north Devon, and the Outer Hebrides, she moved to Southeast Asia, where she got married. She returned to Edinburgh for the birth of her son, Ben. The family eventually settled in north Devon. In 2005 Pat was appointed as medical officer to North Devon Hospice in Barnstaple. Sadly, she was diagnosed with bowel cancer in 2017. Pat bore her illness with courage, dignity, openness, and humour. She achieved her wish to remain at home, with support from her family and friends. She leaves Ben; his partner, Leanne; and her brother, Michael.

Murray Fletcher, Anne Francis

Cite this as: *BMJ* 2020;370:m2663

OBITUARIES

Tom Arie

Pioneer in the development of psychiatric services for elderly people

Thomas Harry David Arie (b 1933; q Oxford, 1960; CBE, DPM Eng, FRCPsych, FFCM RCP (UK), FRCP Lond, FFPHM RCP (UK)), died from metastatic prostate adenocarcinoma on 24 May 2020

Tom Arie was born Tomas Arje in Prague, to parents Otto, a lawyer, and Hedy (née Glaser), a modern language teacher. He recalled a happy early childhood until the Germans invaded Czechoslovakia.

He vividly remembered attending the local school and visiting his paternal grandparents in Dobris, outside Prague, where his grandfather was the rabbi. Less happily, he also remembered the destruction of the synagogue and the discrimination his mother faced when obtaining an exit visa to leave Czechoslovakia, and his beloved German nanny having to leave the family after the Nuremberg race laws. Aided by

a refugee organisation, the Arje family fled Prague on 17 August 1939, on the penultimate train out of the city.

Although he spoke little English, Arie settled into a London primary school. He was evacuated during the blitz and only allowed back when his parents found accommodation with an air raid shelter. The man who took his family in, George House, later became a Labour MP for St Pancras, London. Otto Arie trained as a welder but found work with the BBC monitoring service. Arie attended Reading School and was always grateful for the excellent education he received there.

He read classics at Oxford before he switched to medicine. He was interested in the sociology of medicine and finally specialised in psychiatry, becoming an expert in “old age psychiatry.” He underwent further training in psychiatry at the Maudsley Hospital and in social medicine at the Medical Research Council’s social medicine unit at the London Hospital.

Arie’s wife to be, Eleanor (née Aitken), was also a medical student at Oxford. They married in 1963 and had three children—Laura, Sophie, and Sam.

Goodmayes Hospital

In 1969 Arie set up a psychiatric unit for old people at Goodmayes Hospital, Ilford, revolutionising care for the elderly. In a 1996 interview he recalled, “A job was advertised at a place I had never heard of, Goodmayes Hospital, to set up a psychiatric service for old people. I thought, this is really back to what I’m after, going to an un-posh place in the outer east end of London, seeing if one could make a service for old people tick. So that’s what I did.

“Most people thought I had taken leave of my senses. I started work on 1 January 1969. Up the road, at Claybury Hospital, there was Brice Pitt, who was about two years ahead of me in setting up an old age service—I think his work had given the idea to the people at Goodmayes. They had been puzzled—who could this chap be who had opted to come out of the teaching hospital to look after old people whom nobody wanted? It somewhat rocked my confidence, everybody being so negative.”

At Goodmayes, Arie trained a generation of clinicians and academics who all went on to made great contributions to advancing the discipline and clinical service. He was a staunch

advocate for female doctors and one of the first consultants who made it easier for married women to complete their training while also raising families.

Nottingham University

In 1977 Arie was appointed foundation professor and head of the department of healthcare of the elderly at Nottingham University, where he worked until 1995; he became professor emeritus on retirement. He established the concept of giving old people, many of whom had dementia, a much more caring and specialised type of care than they had previously received.

Students from more than 30 countries flocked to Arie’s courses in Nottingham, including Ed and Helen Chiu, who reflected, “We returned to Hong Kong to practise the ‘Arie model’ of high quality, holistic, and humane mental health service delivery adapted for our own populace.”

During his career Arie travelled the world, lecturing and teaching his approach, and several hospital wings are named after him.

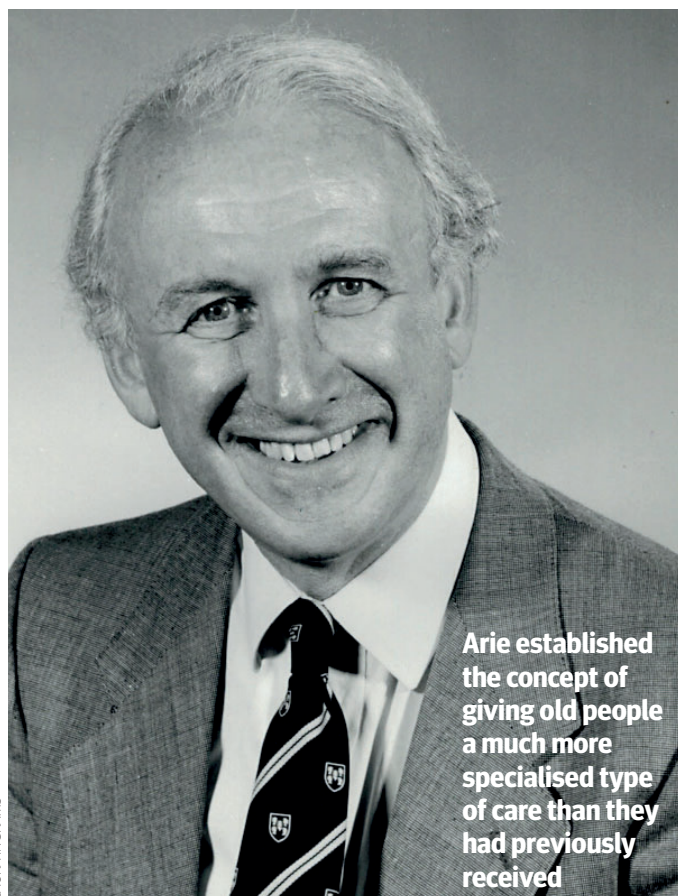
After retiring in 1995, he and Eleanor enjoyed a peaceful and active life in the village of Kenninghall, Norfolk. He continued his work with age related charities and read a great deal. The couple went on annual holidays to Prague, to which he felt a strong connection all his life.

He was awarded a CBE for services to medicine in 1995. His many honours include the British Geriatrics Society founder’s medal in 2004 and a lifetime achievement award of the old age faculty of the Royal College of Psychiatrists in 2012.

He leaves Eleanor, three children, and six grandchildren.

Rebecca Wallersteiner, London
wallersteiner@hotmail.com

Cite this as: *BMJ* 2020;369:m2580



Arie established the concept of giving old people a much more specialised type of care than they had previously received

LAURA INGRAMS