“Social media can make life hard for people who embrace moderation” DAVID OLIVER
“I’m breaking my arm next Tuesday. Can I book an appointment?” HELEN SALISBURY
PLUS Open letter to UK’s chief medical officers; need for face to face GP consultations

TAKING STOCK Rammya Mathew

“Back to school” needs proper covid testing

Children have been back at school for a few weeks. GPs are already seeing a surge in cases of viral illness among schoolchildren, and from around the country I hear reports of surgeries being inundated with calls from parents. They’re not generally seeking medical advice because they’re worried that their child needs to see a GP—they’re confused about whether their child meets the criteria for self-isolation and covid testing.

At first, I struggled to understand their confusion. After all, just three symptoms meet Public Health England’s criteria for covid testing—a new, continuous cough; a fever greater than 38°C; and a loss of, or change to, taste or smell. But does this correlate with the evidence? The Covid Symptom Study app (by ZOE) reports that 52% of children who tested positive hadn’t logged any of those “classic” symptoms, which are typically seen in adults. The app highlights the most common symptoms in children as fatigue (55%), headache (53%), fever (49%), sore throat (38%), and loss of appetite (35%).

To add to the uncertainty, schools often have their own policies about when a child can attend, and social media forums are rife with “hearsay” about what is and isn’t covid. It’s no wonder parents, in all of this noise, turn to their GPs for some advice and reassurance.

But having clear, pragmatic, evidence based advice on when a test is indicated in schoolchildren is only the first part of the puzzle. It’s no good if we don’t have the testing capacity to match the increase in viral illness—a problem that should have been predicted, with schools reopening and winter approaching.

As it stands, if parents can’t get a test within the first five days of their child’s illness, the entire household needs to self-isolate for two weeks. Don’t underestimate the pressure this will put on families. After months of home schooling and juggling many commitments, parents are understandably desperate for their children to have some uninterrupted time at school—even more so, when the government has been pushing for people to get back to work. This pressure is even more acute in low income households, whose wages often aren’t protected if they have to self-isolate.

In my local area, six schools have already reported confirmed cases. Every time a child tests positive, their entire bubble (usually a class group) must isolate for two weeks from the onset of symptoms in the index case. If we don’t urgently get our public health messaging right, or have the testing capacity to back up what we’re asking of parents, this situation will spiral out of control, with parents forced to send children back into school without a test.

We need to make it easy for parents to do the right thing. If not, we have months of chaos ahead of us.

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No wonder parents, in all of this noise, turn to their GPs for advice and reassurance
**BMJ OPINION** Trisha Greenhalgh and 21 colleagues

**An open letter to the UK’s chief medical officers**

As a second wave of covid-19 emerges, we warn the government and its advisers that a complex pandemic needs an adaptive response

Dear chief medical officers, we write to express our concern about the emerging second wave of covid-19. Based on our public health experience and our understanding of the SARS-CoV-2 virus, we ask you to note the following:

We strongly support your efforts to suppress the virus across the entire population, rather than adopt a policy of segmentation or shielding the vulnerable until “herd immunity” has developed. This is because:

- While covid-19 has different incidence and outcomes in different groups, deaths have occurred in all age, gender, and ethnic groups and in people with no pre-existing medical conditions. Long covid is a debilitating disease affecting tens of thousands of people, and can occur in previously young and healthy people.
- Society is an open system. To cut off a cohort of “vulnerable” people from “non-vulnerable” or “less vulnerable” is likely to be practically impossible, especially for disadvantaged groups such as those living in cramped housing or multi-generational households.

- The goal of herd immunity rests on the unproven assumption that reinfection will not occur. We simply do not know whether immunity will wane over months or years.
- Despite some claims to the contrary, there are no examples of a “segmentation and shielding” policy having worked anywhere. Notwithstanding our opposition to this kind of policy, we strongly support measures that will provide extra protection to those in care homes and other vulnerable groups. We share the desire of many people to return to “normality.” We believe, however, that the pandemic is following complex system dynamics and will be best controlled by adaptive measures which respond to day-to-day and week-to-week changes in cases. “Normality” is likely to be a compromise for some time to come.

**Suppressing the virus**

We will need to balance suppressing the virus with minimising restrictions and impacts on the economy and society. This is the balance that every country is trying to find—and every country is having to make trade-offs. This might mean moving flexibly between, say, 90% normality and 60% normality. We believe that rather than absolute measures (lockdown or release), we should take a more relativistic approach of more relaxation or more stringency depending on control of the virus.

Controlling the virus and restarting the economy are linked objectives; achieving the former will catalyse the latter. Conversely, even if policies to promote economic recovery which cut across public health objectives appear successful in the short term, they may be detrimental in the long term.

As evidence accumulates for airborne transmission of the virus, measures which would help control it while also promoting economic recovery include mandating face coverings in crowded indoor spaces, improving ventilation (especially in schools and workplaces), continuing to require social distancing, and continuing to discourage large indoor gatherings, especially when vocalisation is involved. With measures like these, much of society will be able to function effectively while keeping the risk of transmission relatively low.

As we move beyond the acute phase of the pandemic, it is important to restore routine medical appointments. We believe a combination of remote plus face-to-face appointments with appropriate personal

**BMJ OPINION** Martin Marshall

**Now is the time to support general practice, not demoralise GPs**

Just yesterday in surgery I saw patients face to face. In each case, it wouldn’t have been appropriate to care for the patient remotely. I spoke with patients and their relatives and made sure they felt properly heard. They needed the kind of reassurance you can only achieve when in the same room together.

These examples have been replicated by GPs across the country in recent months. Throughout the pandemic, GPs and our teams have worked hard to do the right thing under difficult circumstances. At the peak of the virus, hospitals came very close to becoming overwhelmed—but they weren’t and a significant factor in that was the work that GPs and our teams did at community level. GPs’ response to covid-19 has been remarkable. GPs and our teams have gone above and beyond, knowing full well that we have a difficult winter ahead with challenges none of us have experienced before.

Now is not the time to demoralise the profession—and this is what NHS England’s recent letter to GPs achieved. It is time to thank GPs for what they are doing and prepare and support them for what’s to come.

Both GPs and patients must have clear, consistent messages from government. In July, health secretary Matt Hancock called for all GP consultations to be “remote by default”—a concept the Royal College of General Practitioners has opposed and a message that is out of sync with the headlines we saw last week. This mixed messaging is counterproductive and unhelpful.
Why polarise healthcare opinions?

Rigid ideology is rarely helpful in public policy or pragmatic approaches to health services. The pandemic has highlighted a tendency in public discourse to polarise opinions on healthcare. Social media, populist politics, and hyperbole can make life hard for people who embrace moderation and balance. But many issues have nuance and truth on both sides.

First, face masks—in shops, enclosed meeting spaces, and public transport. The government’s decision to make them compulsory in England led to endless newsprint, radio phone-ins, and Twitter exchanges. Surely, “anti-maskers” are right to question rushed legislation with little consultation, a contested evidence base, and the timing—several months after the pandemic peak. Meanwhile, people who favour “just wear the mask, can’t you?” can point to WHO changing its stance to qualified support for public mask wearing, the more circumstantial evidence about masks and routes of covid-19 transmission, and a cultural norm of mask wearing in South East Asian countries that have got through the pandemic with fewer cases. Both parties have a point.

Second, the dialogue about creeping NHS privatisation. Many Tory MPs and right wing think tanks dream of increasing private sector involvement in health services. Recent outsourcing of contracts during the pandemic has furthered that impression. Parliamentary votes not to take the NHS off the table in international negotiations are further concern. That said, the proportion of NHS clinical care delivered by the private sector or paid for from insurance remains low. Public resistance to market solutions is considerable, and many system leaders and health services face existential threats, not least workforce gaps, that are arguably more pressing.

Both sides contain some truth about whether we can compare the NHS with other systems that are better funded or staffed or use more insurance and market based delivery. As a nation the UK scores highly in some domains and poorly in others, and claims of inefficiency or poor value are based on ideology, not evidence.

Finally, some commentators oppose hospital admission: admission is harmful and risky, and we should keep more people (especially older ones) out of hospital. But we already have fewer beds per 1000 in the UK than nearly all other OECD countries, and we spend less of our health budget on hospital care than many. Capacity and responsiveness in alternative services outside hospital are often lacking, as is consistent evidence for those services “saving” money. Some people want and need ward based care, and much of it is supported by evidence.

I could pick many examples. But we need to relearn the art of holding contrasting opinions and interpretations in our head at once and accepting that the truth is nuanced.

Claims of inefficiency or poor value are based on ideology, not evidence.

I don’t want to see a completely, or even mostly, remote service long term. It risks further increasing health inequalities, and it’s neither suitable nor preferable for many patients. But the predominantly remote service that GPs have been operating under is an appropriate response to a pandemic, in line with NHS England’s advice to slow the spread of the virus. GPs haven’t chosen to work this way; indeed many are keen to be able to see more patients face to face again.

The RCGP wants to work constructively with NHS England and others to ensure GPs and our teams are supported for this and, looking past the pandemic, to ensure that the GP workforce has the capacity and resources to handle demand in a post-covid-19 society.

Martin Marshall, chair of the Royal College of GPs and a GP in London Twitter @MarshallProf

Trisha Greenhalgh, professor of primary care health sciences, University of Oxford

Please see full list of signatories on BMJ Opinion
Plan your emergency

When I first read about plans to ask patients to book ahead at A&E departments, I assumed it was a joke: “Hello, 111—I’m breaking my arm next Tuesday. Can I book an appointment for 2.45 pm?”

But it’s far from a joke. Patients who need to visit A&E will be encouraged to phone NHS 111, and the service will advise them when to go. Patients may also be advised to self-care or be given a GP appointment instead. As ridiculous as it sounds, the idea comes from a genuine attempt to reduce crowding in A&E during the second wave of the pandemic, although patients seemed to do this spontaneously during the first wave: A&E attendance in April fell by 57%.

The appointments system is being piloted in London, Plymouth, and Cornwall, ahead of a scheduled national rollout by the end of 2020. Our local trust has named 31 October as the start date, but I can’t find any results or analysis of those three pilot schemes—calling their purpose into question, if implementation is going to happen regardless.

We’re reassured that patients without an appointment won’t be turned away. This is a relief, as the headline news summons images of patients quietly exsanguinating outside A&E as they attempt to phone and navigate the 111 triage system. Many features, however, ring alarm bells. One is the capacity of NHS 111, which employs non-clinically trained call handlers working from algorithms to decide where a patient should be seen. My current registrar, fresh from six months in A&E, is quite certain that the number of people sent there inappropriately by NHS 111 exceeded the ill judged self-referrals.

As GPs, we’re instructed to provide appointment slots for the patients NHS 111 doesn’t deem appropriate for A&E. Those slots are already on our systems, having been created for the pandemic, but many GPs will be unhappy at this sudden repurposing without negotiation.

And what about the patients? If they know they won’t be turned away, they may just ignore the system: people don’t go to A&E for fun—they go only if they’re seriously worried, so they’re unlikely to make a phone call first. Others may be put off from seeking help altogether, leading to further avoidable mortality, as happened at the height of the first wave. A few patients may game the system: facing a week’s wait or longer for a GP appointment, they may use 111 to try to bag an earlier slot.

I hope I’m wrong, but I fear that this system may result in a further unresourced transfer of work to primary care. It may also be yet another barrier to care for our least advantaged patients, including those who aren’t confident about speaking English or have no phone credit.

People don’t go to A&E for fun—they go only if they’re seriously worried
The covid-19 pandemic has led to unprecedented uncertainty for governments and healthcare bodies across the world, bringing with it the very real threat of overwhelmed systems. The perennial question for ethicists about if and how to plan on a utilitarian basis to save the maximum number of lives has been brought into stark focus.

In March 2020, this became an urgent operational question in the UK, needing the attention of policy makers, healthcare providers, and clinicians in a way we have not previously encountered. Clearly, in such a situation it was not going to be possible to get everything right.

The pandemic arrives

In the UK, steps were quickly taken to increase intensive care unit (ICU) bed capacity and to protect existing secondary care health structures by cancelling all elective and outpatient work. There was also a recommendation to GPs that high risk groups should have advance care plans in place for decisions around admission to hospital and ventilation with covid-19, as well as around resuscitation status.6

All these steps, however, were taking place in the context of a dearth of national guidance.

What we have learnt has implications for a second wave

Clinicians were able to look to countries affected by the pandemic ahead of the UK to see what might lie ahead. Guidance, most notably that produced by the Italian Society for Anaesthesia, Analgesia, and Intensive Care, suggesting that there might need to be a simple age cut-off for admission to ICU, appeared to many to be too simplistic.

In the UK, an early—and very high level—attempt was made by NICE to provide critical care guidance for the pandemic.5 Within days of publication, however, this was the subject of threatened judicial review proceedings because of concern that its reliance on the Clinical Frailty Score would discriminate against people with learning disabilities or other “stable” cognitive impairments.6 NICE and NHS England published no further detailed guidance as to under what circumstances ICU triage—deciding how to allocate limited ICU resources—might have to be considered or how it should be undertaken.

Not publishing national ICU triage guidance seems likely to have been influenced by political (including health service political) concerns about public reaction to media portrayals of ICU doctors “playing God,” as well as by the ICU expansion policy. It is striking that the first guidance seeking to guide triage decisions in an operational fashion was not published by NICE, NHS England, or the Department of Health and Social Care, but by the Intensive Care Society—and was also not published until after the peak of the first wave in London.7

As a covid-19 ethics working group at a large London teaching hospital, we believe that the lack of practical, detailed national guidance has had other unforeseen consequences that require consideration. What we have learnt from the first wave of covid-19 has implications for a second wave and for subsequent public health emergencies that could place NHS resources under strain.

**KEY MESSAGES**

- There was a lack of detailed practical national decision support guidance during the first wave of the covid-19 pandemic in the UK
- Intensive care bed capacity was not exceeded but resources were stretched and the authors suggest fear driven anticipatory triage impacted admission and escalation of treatment thresholds
- Explicit guidance and open dialogue could have facilitated ordinary decision making in extraordinary times and a renewed emphasis on decision making fundamentals is required
- Transparent ethical guidance and good quality information sharing of hospital bed states with primary care and ambulance services could help reduce unnecessary pre-hospital triage in a second wave of the pandemic

The pandemic arrives

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All these steps, however, were taking place in the context of a dearth of national guidance.
Riding the first wave

As the first wave passes, we have seen the NHS stand up to the many demands of the pandemic without being completely overwhelmed, at least in terms of ICU beds and ventilators. It is important, however, to acknowledge that it has been affected in other points in the system.

The expansion in ICU beds and ventilators also stretched the quality of intensive care such that normal Guidelines for the Provision of Intensive Care Services standards have been harder to meet, and clinical decision making changed in the process. We need to reflect on the impact this has had on patient and NHS staff outcomes and to learn from this for a second wave.

Unexpected consequences of the first wave were a fall in emergency department attendances—at its peak, a fall of 57% in April 2020—and reduced bed occupancy in general hospitals resulting from this, together with a reduction in elective and GP admissions. In light of the numbers of UK deaths and the spotlight on care home deaths, the question must be asked: how did this happen?

Some of the explanation was undoubtedly down to people choosing not to “burden” their local hospitals, even in the presence of non-covid-19 related serious conditions, such as myocardial infarction and stroke presentations.10 11 or being fearful that going into hospital would infect them. This poses complex and challenging questions about the messaging that was used in relation to healthcare—the simple message of “stay home, save the NHS” unfortunately did not, in all cases, equate to “save lives.”

But another part of the explanation, we suggest, is because anticipatory triage was taking place in the community, driven by fear of an overwhelmed system. There is increasing concern that GPs were put in the unenviable position of being asked to contact elderly and frail patients to hastily discuss decisions about ICU admission and resuscitation. This, together with altered ambulance service thresholds for transfer to hospital,12 13 led to barriers to accessing hospital for some who may have benefited from medical treatment, irrespective of whether ICU admission would have been appropriate.

Anticipatory triage

In short, demand suppression resulting from anticipatory triage limited access to hospital care. One hypothesis is that failure to communicate a clear decision making and triage policy resulted in professionals making up the policies in their own minds—without consistency and under conditions of fear—where the worst eventualities were expected with unchecked biases.

Despite not needing to ration ICU beds, the sheer volume of service rearrangement, staff sickness and self-isolation, redeployments, and complex clinical decision making, particularly at the height of the first wave, proved extremely burdensome for doctors.

The lack of data available about covid-19 outcomes at the beginning of the pandemic required a generic approach to management that compounded the challenges involved in managing an illness about which we still have a lot to learn. These factors may have contributed to increased levels of stress and reduced confidence in decision making. Additionally, pressures both to get patients out of hospital to create bed capacity and the anticipation of needing to make triage decisions, in fear of what might lay ahead, may have also been a factor in altered decision making.

The lack of open dialogue and clarity about the tipping point between normal treatment decisions and ICU triage decisions may have played a part in systems imposing higher than usual thresholds for accessing treatment. It seems likely that raised thresholds of transfer to hospital had unanticipated consequences for patients in high risk groups. Put bluntly: what proportion of the “excess” 18 000 care home residents who died during the first wave14 might have gone to hospital for medical care and survived in non-covid-19 times?

And—even more bluntly—what proportion of those residents chose not to go to hospital, and what proportion had the choice made for them?
What proportion of the “excess” 18 000 care home residents who died might have gone to hospital and survived in non-covid-19 times?

The core of the challenge

We know from existing evidence that difficult decisions around levels of and access to treatment are psychologically challenging and associated with moral distress in healthcare professionals.15 16

Many hospitals, including our own, have responded to the first wave by developing decision making guidance and support to aid the process and share its burden. Work is still required to embed supported decision making, enabling doctors to move away from the (often self-imposed) culture of independent decision making in complex clinical situations.

On reflection, it may be that the main challenge for doctors during the first wave was adjusting to ordinary decision making (not based on triage) in extraordinary times (when an encounter with triage loomed) and that this compounded the high volume of decisions and lack of time to make them, as well as any psychological distress that arose in the process.

If this is an accurate analysis of the situation, it may be that having more decision making support in place for the second wave will allow ordinary decision making that is better adjusted and confident. In doing so, this may in turn allow a change in the psychological language away from “distress” to “adjustment” and “resilience” instead.

How to do it better

We now have time to pause and reflect on the UK’s first experience of the pandemic and think about what else needs to change in preparation for a second wave. With ICU expansion, we did not run out of ICU beds. Frontline staff were, however, placed under significant strain and other resources, including some drugs, syringe drivers, and renal replacement therapy, were stretched across the community and hospitals.

We suggest that political reluctance to tackle the possibility of ICU and ventilator triage has had a damaging effect on more widespread decisions around access to healthcare. The worst did not come to pass but the vacuum of open dialogue about carefully considered and detailed ethical ICU triage guidance—and a failure to delineate when ordinary decision making should stop and extraordinary decision making start—is likely to have contributed towards implicit triage in the community, on the wards, and by patients themselves.

This pre-hospital and pre-ICU decision making was, in many cases, influenced by fear rather than the reality of the situation. It is hoped that the starting position will be different, with more knowledge and systems in place, in facing a second wave of the pandemic. We suggest that in addition to this, patient and staff outcomes could be improved by introducing transparent ethical guidance (with a degree of detail) and decision making support at all access points to healthcare.

Also it is necessary to ensure good quality information sharing between hospital and community that is visible to individuals and teams making clinical decisions. The latter could involve sharing hospital bed availability with primary care and ambulance services to prevent unnecessary pre-hospital demand suppression.

Responsibility for implementing these changes lies at a local level, but ultimately within a national framework so as to ensure consistency.

These changes, that we suggest were an omission from the Third Phase of the NHS Response to Covid-19,17 would also be crucial to ensure that the backlog of other NHS procedures that were put on hold in the first wave does not become any longer.

The pandemic may last for another year—and for years without a vaccine. We need to think longer term about how to ensure that a fatigued system is adequately supported.

- Rachel Buman, consultant in palliative care
- Ruth Cairns, consultant in liaison psychiatry (older adults)
- Sergio Canestrini, consultant in critical care
- Robert Elias, consultant in renal medicine
- Victoria Metaxa, consultant in critical care
- Gareth Owen, consultant in liaison psychiatry
- Hazel Polat, senior solicitor
- Alex Ruck Keene, barrister
- Emer Sutherland, consultant in emergency medicine, Covid-19 Ethics Working Group, King’s College Hospital, London

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LETTER OF THE WEEK

“Covid-mitigated” is less misleading than safe or secure

We have been in countless meetings that have included discussions about making the workplace covid-secure or covid-safe. This language is problematic as “safe” implies that we can make places 100% safe for staff, which will never be possible, and “secure” indicates a high degree of certainty requiring excessive measures. This language can drive irrational behaviour. Covid-secure transport to hospital, for example, requires patients not to use taxis or public transport or even to walk—they have to find someone who has self-isolated for two weeks to drive them.

A more useful way to think about workplaces (and other public and private spaces and activities) is to describe them as covid-mitigated. This follows standard risk assessment approaches. Factors that need to be considered include the estimated prevalence of infection in that space, contact time and distance, and the degree of aerosolisation.

The term covid-mitigated emphasises that there is always a residual risk and that steps should be taken to reduce that risk (including personal protective equipment and barriers). It also emphasises the dynamic nature of risk. It discourages people and organisations from taking extreme steps to eliminate negligible risks and gets people to think about their own safety in a considered way.

The risk of infection is broadly the same for everyone in the workplace, but the consequences of infection are different depending on age, ethnicity, and comorbidities. This now becomes a familiar two axes risk assessment (likelihood versus impact). Further or specific mitigations might be needed to ensure safety in the workplace, but the consequences of infection are not without potential for harm, yet blatant disregard for the right to proper consent is still occurring.

Covid mitigation is a less misleading way of describing how we should prepare to start activities and open places. A simple algorithm to help assess the risk and plan the appropriate mitigations would be helpful.

Catherine E Urch, consultant in palliative medicine and divisional director of surgery and cancer, Imperial College Healthcare NHS Trust; Andrew J T George, chair, Imperial College Health Partners.

Cite this as: BMJ 2020;370:m3616

COVID-19: ENGLAND’S EXCESS MORTALITY

People died at home to “save the NHS”

There are many reasons for England having the highest excess mortality for covid-19 (This Week, 8-15 August). As the government became aware of the risk of demand for hospital beds overwhelming supply, it launched mitigating strategies. Potentially the most effective was a message perfectly tailored to British sensibilities: “Stay home. Protect the NHS. Save lives.”

The slogan was operationalised into advice that people with a high temperature and new cough must stay at home, not visit the GP or go to hospital. Get advice online or phone 111. Older people might have been put off seeking help. How many people stayed at home to protect the NHS and died? Thousands, maybe tens of thousands.

With the failure of test and trace, politicians can repeat the mantra: protect the NHS. We must call this out. We need urgent investment in the NHS, not hollow praise, to stop us having the worst excess mortality again.

Leone Ridsdale, professor emeritus, London

Cite this as: BMJ 2020;370:m3515

CUMBERLEGE REVIEW

Behavioural and psychosocial treatments escape scrutiny

The Cumberlege review (Editorial, 22-29 August) does not consider potential harms to patients from behavioural and psychosocial treatments. Clinical researchers often have vested interests in the success of interventions they are investigating. But good scientists should challenge their own beliefs, by designing trials to prove that a treatment doesn’t work, not to confirm that it does.

Some behavioural and psychosocial treatments for chronic and poorly understood conditions, such as myalgic encephalomyelitis, are politically and organisationally entrenched. There is little interest in research that might challenge their use, such as withdrawal trials or surveillance studies.

Behavioural and psychosocial treatments escape the greater scrutiny given to drugs and medical devices. Patients are disbelieved if they report harm and blamed if they don’t get better. They are labelled anti-sciene if they point out obvious methodological flaws in the studies responsible for embedding the assumption that these interventions are effective and safe, when they are neither.

Caroline Struthers, senior research fellow, Oxford

Cite this as: BMJ 2020;370:m3593

Blatant disregard for proper consent

The Cumberlege report found that the healthcare system was “disjointed, siloed, unresponsive, and defensive”. Of deep concern is “the testimony from hundreds of patients reporting lack of informed consent.”

Asymptomatic people are also affected. Medical interventions used in screening are not without potential for harm, yet blatant disregard for the right to proper consent is still occurring.

Two examples illustrate this. The first is an experiment to determine the effects of manipulating invitation information provided to around 6000 asymptomatic women “to increase uptake” of breast cancer screening. The second is the NHS breast screening programme AgeX trial, which has recruited millions of women. Efforts to challenge this trial, with its flawed consent process, have met with “siloed, unresponsive and defensive” attitudes.

What can be done to end this abuse of the right to properly informed consent and tackle the lack of engagement?

Hazel Thornton, honorary visiting fellow, Leicester

Cite this as: BMJ 2020;370:m3592
Prioritising rehabilitation

Fraser states the urgent need for post-covid physical and psychological rehabilitation pathways in the NHS (Editorial, 8-15 August).

In many cases, these will need to be designed from scratch or repurposed from existing intensive care follow-up clinics and rapidly expanded. This will require healthcare systems to act flexibly as they plan to create sufficient capacity to meet demand. Uncertainty about the clinical course of recovery is one barrier, particularly in patients with milder symptoms who are not admitted to hospital.

Studies have reported debilitating long covid symptoms in otherwise fit and healthy people. Primary care doctors are often left to manage these patients in the community without direct access to rehabilitation services.

Rehabilitation pathways need to cater for patients who were not admitted to hospital as well as those captured through hospital follow-up. This will require substantial funding and a commitment to preventing long term morbidity alongside reducing mortality from covid-19.

Irfan Ahmed, GP, London
Cite this as: BMJ 2020;370:m3381

Isolating the term “quarantine”

Although “quarantine” and “isolation” involve similar measures (Sixty Seconds, 22-29 August), their purposes are different. Quarantine is the separation of people who are not ill but may have been exposed to infection to monitor their symptoms, whereas isolation is the separation of ill or infected people from others to prevent spread.

Why does this matter? Their durations are currently similar, but this will change with better understanding of covid-19. Patients who test positive for covid-19 can shed viral RNA but are not infective within 8-10 days of symptom onset, so they are safe for discharge from isolation when not symptomatic—some countries release after 10 days, whereas others demand 21.

The UK doesn’t differentiate between quarantine and isolation. But if the isolation period for infected people changes while quarantine duration remains the same, this will create confusion, reduce public confidence in government advice, and erode adherence to covid-19 measures.

Shyan Goh, orthopaedic surgeon, Sydney
Cite this as: BMJ 2020;370:m3674

Planning ahead for phone and video consultations

Gray and Back discuss communication and covid-19 (Education, 22-29 August). Conversations are complicated by personal protective equipment, which particularly affects professionals and patients who are deaf or have other sensory impairments, dementia, or learning disabilities.

Visiting has been restricted in UK hospitals, with a move towards telephone and video consultations. Communication for inpatients when key contacts cannot be present might require an interpreter, signing expert, or specialised technology. Clinicians should plan ahead and consider what needs to be communicated, who to lead the call, the most appropriate mode, the time and place required, and who else needs to be on the call.

Organisations should consider educating staff to use phone and video calls; supporting patients and key contacts who have learning or communication difficulties; the management of challenging situations; and guidelines for consent for filming, transmission, and storage of images and video.

Joanne Wilson, Macmillan consultant nurse palliative care; Jane Hawdon, medical director, consultant neonatologist; Sarah Lally, acute liaison nurse; Danielle Wilde, group lead for dementia, Royal Free London Hospitals NHS Foundation Trust
Cite this as: BMJ 2020;370:m3671

Hierarchical communication

Good referrals can come from any grade

I am co-creator of Buku Haematology, the app mentioned in Thornton’s article (Feature, 8-15 August). The haematologists in our region are notoriously approachable, so it was disheartening to read about the doctor’s poor experience.

The liaison haematology phone can be incredibly busy, receiving up to 30 calls a day from hospital clinicians, GPs, dentists, midwives, nurses, and others. We could require registrar or consultant only medical referrals, but this is not particularly welcoming or practical.

High quality referrals come from good preparation and gaining skill and confidence through practice and can come from any grade. I have had referrals from consultants who had to look up every piece of information I needed, which drew out the conversation to the frustration of us both.

Hierarchical communication doesn’t benefit anyone. Appropriate escalation in the referring team and adequate preparation are key to save frustration and improve efficiency.

Alex J Langridge, specialty trainee year 6 haematology, Newcastle upon Tyne
Cite this as: BMJ 2020;370:m3595

Sympathy for supporters and naysayers of the rule

I sympathise with both the supporters and naysayers of hierarchical communication. When you talk to a doctor in the same grade, you are more likely to receive the pertinent information, probably because you have similar medical experience. It is not about undermining juniors, nurses, or allied professionals.

Nevertheless, taunting junior callers is unjustifiable. When I receive inappropriate questions, I wonder whether these were initiated by the callers’ seniors. Juniors might not want to challenge their seniors’ decision making—they are often told to just do the job rather than understand the rationale.

Eugene Y H Yeung, retired doctor, Lancaster
Cite this as: BMJ 2020;370:m3495

Quarantining

Many juniors are not taught how to appropriately refer and provide pertinent information to each advisory specialty. Although face-to-face referrals reduce hostility, they are not always feasible. If health institutions want to reduce bullying, they should consider recording phone conversations for the purpose of quality improvement. Advisory specialties should make it clear what information they require for referral.

Shyan Goh, orthopaedic surgeon, Sydney
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Long Covid

Studies have reported debilitating symptoms, whereas isolation is the separation of ill or infected people from others to prevent spread.
Changes in the management of multiple sclerosis since covid-19

The pandemic has forced rapid change in the delivery of services. Some have the potential to make healthcare more efficient and responsive to patients’ needs. Gavin Giovannoni describes providing remote care to patients with MS.

The sudden switch to remote working

With the onset of lockdown all NHS staff who could work from home were asked to do so. This meant that they had to be given remote access to IT systems. Prior to covid-19, consultants had to wait years to be granted access to electronic patient records from home. Suddenly, within days we were given the freedom to create virtual private networks on our home computers. Some adopted the accuRx platform, others attendanywhere and clinic.co, Zoom, Skype, Google Meet, and the Blue Jeans video meeting platforms have also been used. The only stipulation our NHS managers and NHS Governance made was to get consent from patients to contact them in a particular way.

Remote follow-up appointments and “second opinions” requiring advice and decisions based on pre-existing information and investigations have been relatively easy to conduct remotely. But for new patients who require physical examination and investigations it is more difficult.

Initially many consultations were postponed. This provoked much concern so we now talk to new patients online and undertake virtual neurological examinations on some. The quality of examinations performed this way have not yet been validated, but we are currently comparing three stage online neurological examination (virtuEx) with face-to-face examinations.

Video consultations are much better than telephone consultations. Eye contact and the opportunity to pick up subtle facial communication cues are important. We invite interpreters into the virtual room, where needed. Sharing screens and digital documents in real time has proved a good way to share information and graphics.

We now contact patients prior to their virtual appointment to advise them how to prepare by self-assessing their neurological function and quality of life. Tools to do this include a web EDSS (Expanded Disability Status Scale), a self-administered timed 25 ft walk and 9-hole peg test. We also ask all patients to complete the MSIS-29, a quality of life survey.

Our experience suggests most patients can be assessed and a management plan made on the basis of a single video consultation—provided it is organised and conducted well.

Management of relapsing disease

A common cause of a relapse in MS patients is urinary tract infection. We ask patients to screen themselves using urine dipsticks, prescribed by the GP or purchased online. If they have difficulty reading dipsticks we suggest they photograph them and share the images with us via email.

We avoid prescribing steroids for relapses unless these are disabling or associated with pain and intractable sensory symptoms. Evidence that steroids improve the outcome from a relapse is weak and there is a theoretical risk that immunosuppression increases the risk of getting covid-19. Those who are put on short courses of high dose steroids are advised to self-isolate or quarantine themselves for 14 days after completing treatment.

To enable patients to be treated at home we have switched from IV steroid to oral methylprednisolone tablets (500 mg per day for 5 days) or a liquid formulation.

Dramatic scaling back of face-to-face appointments

During the initial three months of lockdown one of us did only three face-to-face consultations compared to hundreds done virtually.

Before a face-to-face appointment takes place, patients are screened for covid-19 using an NHS pre-screening questionnaire. Their temperature is taken on arrival at hospital and they are given a pass to move about the hospital. In the future the number of face-to-face appointments looks set to
remain low to reduce the potential for exposure to and spread of the coronavirus.

New protocols and new home care services

In response to the pandemic, the MS community produced new guidelines on disease modifying treatments. For example, “extended interval” dosing was advised for patients on natalizumab. Infusion rates speeded up, and post-infusion monitoring times reduced or eliminated. Routine blood tests for those deemed at low risk of developing problems were reduced.

By working with a private provider some patients were able to have a home infusion service.

The cancellation or delay of all non-urgent MRI studies made us rethink how often we request imaging for our patients. Moving our weekly multidisciplinary team meeting online via Starleaf has enabled us to invite staff from referring hospital departments. In collaboration with Neuroresponse, a social enterprise, a home phlebotomy service was set up.

New online resources for patients

We set up a microsite called MS-Selfie (MS self-management) with a dedicated Q&A feature where people can ask personal questions, anonymously if they wish, which we answer promptly. This archive has enabled patients to learn from each other’s experience. We have also conducted webinars for healthcare professionals, patients, and families on covid-19 and MS, and posted relevant covid-19 research findings on the Barts-MS Research blog.

Gavin Giovannoni, professor of neurology, Barts and the London School of Medicine and Dentistry, Queen Mary University of London

Alison Thomson, lecturer in public engagement and patient public involvement, Barts and the London School of Medicine and Dentistry, Queen Mary University of London

Rachel Horne, member of the Barts MS Patient Advisory Group

PATIENTS’ PERSPECTIVES

Rachel Horne, (left) member of the Barts MS Patient Advisory Group, and Alison Thomson, facilitator of the group, underline the importance of good communication and shared decision making

Almost all patients felt anxious during the early days of the pandemic knowing people with chronic diseases are at particular risk from covid-19. There was also much concern that some of our drug treatments might put us at increased risk of infection and in-hospital treatment and appointments would be delayed or suspended. For MS patients from a black, Asian, and minority ethnic background, there was further apprehension after it became clear that the death rate of ethnic minority populations from covid-19 was disproportionately high.

Fears could have been allayed if the Barts MS Team had let patients know—via text, email, phone call, or post—how the trust was reconfiguring its services and what changes to expect to treatments and services. It would also have been helpful to tell patients that they could access the Barts MS Research blog and use the MS-Selfie platform to pose questions.

Mixed views about remote consultations

Telephone consultations were deemed “fine” in an emergency, but video consultations are preferable. Good preparation for either was seen as vital. Patients need to know exactly what is expected of them in advance—for example, will we be asked to demonstrate walking? Will we need to complete a sit-to-stand exercise? Or will there be some other form of remote assessment?

Some, including those who live at some distance from the hospital, reported highly positive experiences: “My [remote] annual consultation saved me money in taxis and a lot of time,” said Mark Harrington.

Enthusiasm for self-monitoring

Patients welcomed the chance to take on a greater role in self-monitoring and self-management. It helps build understanding and makes consultations more efficient. Some of our group were already able to use self-monitoring tools but others need to be informed about them and supported to use them. A survey conducted in July 2020 found that most patients had still not been asked to self-monitor prior to their appointment.21

All of us are positive about continuing with remote services. It makes sense to reduce unnecessary visits to hospital. It also would be a real boon to patients with mobility issues to continue to have a phlebotomist come to them to take blood. But timely communication of new approaches to management is essential, and patients should be involved in developing the shape and running of new services.

CONCLUSIONS

- The move to assess and manage patients with MS in virtual clinics has been transformational and has the potential to empower patients and improve efficiency
- Virtual clinical consultations have proved easy to set up and cheaper to run than face-to-face clinics but patients need to be fully briefed on what to expect
- Self-monitoring post-covid-19 is becoming the norm and patients are keen to be more active participants in their care, but encouragement and support is needed alongside advice on how to prepare for appointments
- The impact of remote services on patient satisfaction and clinical outcomes must be evaluated
- The NHS should support creative development of services codesigned with patients.
OBITUARIES

Mohammad Omar Ali
Clinical assistant in care of the elderly Queen’s Park Hospital (now Royal Blackburn Hospital), Blackburn, Lancashire (b 1932; q Dhaka Medical College, Bangladesh, 1959; DT&M&H), died from pneumonia on 13 December 2018 Mohammad Omar Ali (“Omar”) moved from his native Bangladesh to the UK in 1968. His family joined him, and they eventually settled in Blackburn, where he worked in the department of geriatric medicine for almost 25 years. Omar came as a registrar, then stayed on as a clinical assistant, supporting the rehabilitation day hospital. After retiring in August 1997, he kept himself occupied with frequent trips to London, where both his children had settled. During his final short illness he was an inpatient in his previous department and was treated by former colleagues and trainees, which brought great comfort to his family. He leaves a wife, Zerina; two children; and four grandchildren.

Runa Ali, Feisal Ali, Zerina Ali
Cite this as: BMJ 2020;370:m3014

Hugh James Hoyland
General practitioner
Hoyland House, Painswick (b 1931; q London Hospital 1954; MA), died from old age on 30 April 2020 Hugh James Hoyland (“Jim”) was a general practitioner of the old school. After house jobs at the London and the Royal Devon and Exeter hospitals he worked at Gloucester Royal Hospital in obstetrics and gynaecology and orthopaedics, before moving up the Cotswold scarp slope to start in Painswick. Jim married Jane in 1956. Rural general practice then was a family affair, and Jane would take the calls at evenings and weekends for more than three decades. Jim was chairman of the internationally renowned Three Choirs Festival for 22 years. A devout Quaker, he was also very, very funny and endlessly entertaining to work with. Jane predeceased Jim by only a few weeks, after 64 years of marriage. Jim leaves five children, 15 grandchildren, and five great grandchildren.

Kevin Barracough
Cite this as: BMJ 2020;370:m3011

Paul Anthony Bramley
Consultant oral surgeon and dean School of Clinical Dentistry, Sheffield University (b 1923; q Birmingham 1952; FRCS, FDS RCS Eng, FRACDS, FRCS Eng, Hon DDS Birm, Hon DDSc Prince of Songkla, Hon MD Sheff), died from old age on 7 June 2020 Shortly before qualifying Paul Anthony Bramley met Morag; they married in 1952 and went on to run a 100 bed hospital in Kenya. After a year, they returned to the UK. Having completed his specialty training, Paul was appointed to a consultant post in Plymouth, Devon. He was national president of the British Dental Association from 1988 to 1989. He published extensively, served on the Royal Commission on the NHS (1976-79), and received a knighthood in 1984. In retirement he was a director of the Medical Protection Society and chairman of Dental Protection. Predeceased by Morag, he leaves four children, 12 grandchildren, and 11 great grandchildren.

John Williams
Cite this as: BMJ 2020;370:m3013

Donald Macgregor Brown
Consultant anaesthetist and pain specialist (b 1932; q Glasgow 1960; FFARCS, DRCOG), died from pneumonia after a short illness on 29 October 2019 Donald Macgregor Brown was a trusted and respected consultant anaesthetist, who spent many devoted years at Glasgow Royal Infirmary. He was an enthusiastic and calm teacher. After national service in the Royal Army Medical Corps, he gained the entry qualifications to the University of Glasgow. He enjoyed the sporting life, played rugby for the university, and was secretary of the athletics club. Having initially planned a career as a GP, he trained in anaesthesia and moved his family to Glasgow. He never lost touch with the parental farm in Corriebracie on the Isle of Arran. In retirement Donald played golf, helped his brother on the family farm, gardened, and made sticks. He leaves his wife, Anthea (“Ann”); two children; and four grandchildren.

Iain D M Brown
Cite this as: BMJ 2020;370:m3012

Runa Mackay
Consultant paediatrician
Medical Aid for Palestinians (b 1954; q Edinburgh 1944; MD, FRCP), died from ischaemic and valvular heart disease on 31 May 2020 In 1954 Runa Mackay went for a six month locum at the Edinburgh Medical Missionary Society’s hospital in Nazareth. She stayed 30 years. After 20 years in Palestinian hospitals, she wanted to work in the community, helped to set up the Galilee Society of Health, Research, and Service, and also worked for the Israeli Ministry of Health. After retiring in 1985 Runa sat an honours degree in Arabic and Islamic Studies. During the vacations, she worked for Medical Aid for Palestinians (MAP) in refugee camps in Lebanon and in 1990 in a small children’s hospital in Hebron. Runa became a trustee of MAP, whose lifetime award she received in 2014. She has now been immortalised in the “Travelling the Distance” installation at the Scottish Parliament.

Graham Watt, Lesley Morrison
Cite this as: BMJ 2020;370:m3008

Alfa Saadu
Associate medical director and consultant physician care of the elderly Princess Alexandra Hospital, Harlow (b 1952; q University College Hospital Medical School, London, 1976; DTM&H, MSC, PhD, FRCP), died from covid-19 on 31 March 2020 Alfa Saadu was originally from Nigeria and had a distinguished 40 year career in the NHS. Alfa was interviewed for the post of medical director at Ealing Hospital NHS Trust some eight years ago and impressed the panel with his, passion, enthusiasm, focus on patient care, and his deeply held principles. He went on to the Princess Alexandra Hospital in Harlow as associate medical director/care of the elderly consultant physician, before retiring in 2017. After the required statutory period, he worked part time at the Queen Victoria Memorial Hospital in Welwyn, where he was working at the time of his unexpected death from covid-19. Alfa leaves his wife, Diane Macaulay; two sons; a daughter in law; and two grandsons.

William Lynn, Jayantha Arnold
Cite this as: BMJ 2020;370:m3007
Barry Hoffbrand

National leader in postgraduate medical education

Barry Ian Hoffbrand (b 1934; q Oxford/University College Hospital, London, 1958; DM, FRCP), died suddenly from cardiac arrhythmia on 24 April 2020.

From 1980 to 1994 Barry Hoffbrand was editor of the Postgraduate Medical Journal. In this position he created a viable and successful clinical educational journal to rival the best.

Barry’s experience in postgraduate education was developed in his position as consultant physician to the Whittington Hospital, in north London. Eventually an academic centre for postgraduate medicine was established there, and Barry was its director from 1975 to 1981.

Hoffbrand was regarded as the physician other doctors would consult about their own medical problems.

Whittington Hospital

After his appointment as consultant to the Whittington in 1970, Barry rapidly built up a reputation as a brilliant diagnostician and wise medical opinion. Over his nearly 30 year tenure in this post, he came to be regarded as the physician other doctors would consult about their own medical problems.

Barry was also an honorary physician to the Italian Hospital. This appointment prompted him to learn Italian, so that he could converse with his patients there.

In addition, he held numerous key positions in the medical world. He was honorary secretary, honorary librarian, and a vice president of the Royal Society of Medicine (RSM) and president of its clinical section. He was a founder member and senior secretary of the RSM section of nephrology. He was a member of the council and an examiner for the Royal College of Physicians. He served as president of the Harveian Society of London and of the London Jewish Medical Society.

He was editor of The Apothecary from 2003 to 2005.

Early life and career

Barry was the older of two sons, both of whom achieved eminence in medicine. He was born in Bradford, Yorkshire, to Philip and Minnie (née Freedman) Hoffbrand. His father ran a bespoke tailoring business, and his mother ran the household. His parents were both from Jewish immigrant families, originally from eastern Europe.

He was educated at Bradford Grammar School, from where he was awarded a place to read medicine at Queen’s College, Oxford. He left a permanent record of his time in Oxford on the Quondam’s Cup, a large, silver trophy kept behind the bar in the Queen’s College sports pavilion. This has a list of years engraved on the side, with each having a name and a number next to it. For a year in the 1950s it said “Barry Hoffbrand 13.6.” This was because he had managed to drink a yard of ale in 13.6 seconds.

After holding junior hospital appointments at University College Hospital and St Luke’s Hospital, Bradford, Barry spent a year at the Cardiovascular Research Institute in San Francisco. After junior hospital appointments at University College Hospital and the Brompton Hospital, he was appointed consultant physician to the Whittington Hospital.

He had a strong specialist interest in renal disease and hypertension and published well over 100 original papers, book chapters, and review articles on these and related topics.

Retirement

After retiring from the Whittington in 1999, he remained vocal in his advocacy for the hospital. In letters to the press, he articulated powerful arguments against the proposed closure of the emergency department, citing its value to the integrity of the hospital as a whole and its importance to the large local population as well as to postgraduate education. From 2009 to 2015, he was founding chairman of the Whittington Hospital organ donation committee.

In addition, Barry studied at the Hampstead School of Art, where he showed, according to his teachers, “remarkable ability, knowledge, and intuition as a painter.” He also became a not insignificant art historian.

As well as being a kind, compassionate doctor, Barry had an infectious and irreverent sense of humour. He frequently had letters about the health service, Brexit, antisemitism, and Israel published in both the national and local press. His enthusiastic support for Brexit was regarded as wildly idiosyncratic by most of his north London friends, but his obvious generosity of spirit meant that his opinions never lost him friends.

In 1961 Barry married Marina Morduch, a fellow student at University College Hospital, London, who became a psychiatrist. He was devoted to his wife and their three children, Sara, Julia, and Rachel. Barry leaves Marina; their children; and seven grandchildren.

Philip Graham, emeritus professor of child psychiatry, University College London

Cite this as: BMJ 2020;369:m2581