I’ve delivered many public lectures during this pandemic—probably more than in normal times. All but two have been virtual (and those two were a mix of real and online). The transition from stage to screen has been interesting and at times difficult.

First, the setting. A live audience enlivens the atmosphere. By contrast, staring into a blank screen—at one’s own face or uniform blank boxes—does nothing to stimulate the artistic juices. While the participants can multitask (even cook supper) with their cameras off and microphones on mute, the speaker is left talking into a lonely space, without the benefit of the buzz of the occasion. Much better to have human faces on screen, even if only to see them respond occasionally with a nod of the head or a laugh at your attempts at humour. Instead of a long presentation I now ask to be interviewed, maybe after a brief introduction, with questions from the audience afterwards. This keeps us all alive.

Second, the time of meetings. Many webinars or speaking engagements are now timetabled for the evening—perhaps because organisers believe that it maximises the chances of an audience. In the real world an evening event would be a big occasion, often preceded by networking and refreshments or followed by dinner. Not so in the virtual world. There’s no mingling before or after, no catching up with old friends or making new ones. Dinner still has to be made, the dishwasher emptied, emails and messages answered, having built up during the day. I now try to avoid evening and weekend events—for once, modelling what I preach and addressing my own wellbeing needs.

Third, interaction with the speaker. The person speaking is your guest and should be treated as such. It’s demoralising to end a talk, which one may have spent months preparing, and have no immediate feedback. In real life, delegates don’t just applaud to show their appreciation but often come to the front, or they talk during the breaks and continue the themes of the lecture. In a video conference, as the talk ends the speaker can be left stranded in cyberspace. Better to contact the speaker, give feedback, and provide space and time for a debrief.

While I’ve been rather critical of the new online space for delivering lectures, I have to remember that it wasn’t all rosy in the real world: waiting for the last train home, with peanuts and warm tea as the only refreshments after a long day. Nevertheless, although we’ll never return to “business as usual,” we have to learn from the current normality and protect the best of the past while developing new ways of working for the future.

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PERSONAL VIEW Greta McLachlan and Simon Fleming

Should medical training be something we “survive”? 

The change precipitated by covid-19 has shown us that just because it’s “always been done this way” doesn’t mean it should be, or has to be.

During the second world war, planes would return home with bullet holes in their metalwork. The US military thought, logically, that the way to protect these planes during their next flights was to reinforce the areas that had been hit. Abraham Wald pointed out, however, that these planes had survived enemy fire and made it home. Therefore, the areas of direct harm were survivable. The areas that hadn’t been hit likely represented where other planes had been hit and not made it home. So those were the areas that should be reinforced.

Welcome to the concept of survivorship bias.

All of us have a survivorship bias when it comes to our medicine training. We made it through (at least, thus far) and believe ourselves to be good doctors—therefore, the training must have been good. What we don’t consider are the people who leave. There is no standard practice of exit interviews from training programmes, or debriefing for those who struggled and nearly quit. Where exit interviews exist, they make uncomfortable reading, with bullying and sexual harassment often given as reasons for leaving.

Our training system is not working for everyone. If it were, then more than 12% of surgical consultants and 25% of medical directors would be women, and trainee burnout levels would be much lower. Rates of post-traumatic stress disorder in some specialties are worse than in returning troops. If we want an inclusive world of training, we need to make it fit all shapes and sizes.

Survivorship bias can also be dangerous—particularly when it comes to “in my day” conversations. You know the type, those who go on about how great training was when they worked 100 or more hours a week. How they could do more, sooner, and without any kind of need for help. How trainees were just “pretty capable at resisting stress.”

It’s not the trainees, it’s the system.

“In my dayers” are telling current trainees they will never be as good as those who have gone before them. That they are weak because they are burnt out. That it’s their fault the system isn’t working, rather than it being the system that needs examining. That should medical training be something we “survive”? they shouldn’t be in training, because they can’t live up to the standards previously set.

But here’s the problem: those standards were damaging not only to trainees, but to patients. It is one of the reasons for the National Confidential Enquiry into Patient Outcome and Death.

A retired surgeon recently wrote, “In my youth, the consultant was ‘god’ and as such all elements of the institution tended to acquiesce to their request.” There are good reasons why doctors are no longer seen as gods—I refer you to Harold Shipman and Ian Paterson. Gods cannot be questioned and their behaviours are accepted: gods know best and are undeniably in charge. These attitudes have no place in modern medicine, where we should be striving for compassionate leadership and collaborative team working to achieve the best for our patients. We should be weeding out all forms of “god-like personality” for the destructive behaviour that it allows.

We can’t keep allowing those with a survivorship bias to tell us how to run the modern world of medicine.

BMJ OPINION Stephen Bradley

Physician, heal thyself

One of the most satisfying aspects of general practice is the opportunity to guide patients through their options and work out which one best fits their values and preferences. This often involves gauging a patient’s own philosophy with respect to medicine and what they hope it can do for them.

My approach isn’t innovative, but an orthodoxy principle of contemporary practice. Yet, sometimes I wonder if we doctors are reluctant to admit that we have values and beliefs too, which inform how we interpret the evidence and options before us.

That the tenor of disputes between doctors and scientists over the past 10 months has sometimes become just as unpleasant as discourse over Trump or Brexit is one of the most troubling aspects of the pandemic. Political polarisation has engendered nasty disputes that often masquerade as factual debate. We seem to have lost the capacity to take account of others’ values and priorities or even to acknowledge how these inform our own positions. The result is that evidence is preferentially promoted or debunked in accordance with entrenched viewpoints.

Rival policies have been promoted with jarring conviction, rather than the kind of reflection and nuance required to achieve some mutual understanding and collective buy-in for a way forward. We have struggled to navigate the novel hazards created by social media companies that monetise discord. Playing to the online gallery seems to bring many a sense of camaraderie, but insinuating that opponents are either mugs, liars, or sociopaths is hurtful and unpersuasive.

Reflection and nuance are required for a collective buy-in on a way forward.

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Another false dawn for adult social care?

In his post-election Queen’s speech in December 2019, the prime minister Boris Johnson pledged cross party consensus to reform adult social care. He promised to “give everyone the security and dignity they deserve” and “put social care on a sustainable footing,” with legislation to be announced within a year. Cut to chancellor Rishi Sunak’s spending review on 26 November 2020, where a paltry £300m in extra grant funding to support councils in providing adult social care was the only concrete announcement, with some calculatedly vague statements about “sustainable improvement to the system” and “proposals next year.” I’d be delighted to see some meaningful progress on adult social care in 2021.

Sadly, I think it’s set to be one of the many false dawns over the past few parliaments. We’ve been playing this game for years. Since 2010 we’ve seen overall cuts in local government and social care funding; huge reductions in adults receiving personal care at home, even as need has grown; a care home market in crisis over funds and capacity; and a series of short term, quick fix cash injections from central to local government—or permissions for local authorities to raise a bit more revenue through local precepts on council tax.

Right now, however, we also have to deal with the economic impacts of the pandemic and many other demands on government spending. Kicking social care reform into the long grass will be politically easier than dropping other commitments. Put simply, most people don’t use social care, and until it touches their life its funding and provision remain opaque to many. NHS clinicians and managers often see social care through the lens of its direct impact on NHS service use. Cross agency collaboration and communication put us and our patients in close contact with social care. People within the social care sector and local government, as well as citizens accessing support, understandably resent this rather reductive characterisation, as the role of social care goes well beyond care facilities and personal provision. It has a much wider focus on wellbeing and supporting independence, on personal budgets and direct payments on housing, and on safeguarding. But NHS allies and supporters inevitably consider what matters most immediately to their world and what obviously affects their patients.

The policy experts I know are not hopeful of a “big bang” solution in 2021. Their collective best guess is that we’ll see some formulation of Dilnot’s recommendations of a public-state partnership to pay for care, with some kind of lifetime cap on costs. This is a million miles from radical reform, but it would enable Johnson to show he was honouring his most voter targeted Queen’s speech pledge—to “protect individuals from having to sell their homes to pay for care.” This will principally benefit wealthy homeowners. It’s hardly progressive, but it’s probably the best we can hope for.

The role of social care goes well beyond care facilities and personal provision

Such polarisation also drowns out the voices of those of us who have tried to “follow the science” but still aren’t sure where it leads. It seems paternalistic to assume the public needs a lullaby of overconfident assertion. I suspect mature discussions, which acknowledge legitimate disagreement and promote measures as being reasonable and proportionate, would be more reassuring.

Along with everything else we’ve learnt during this pandemic, I hope that we can improve the quality and courtesy of our discourse. Most of us try hard to understand our patients. Trying harder to understand the values and beliefs of those we disagree with, and appreciating how our own views are also shaped in the same way, might help us to disagree better in the future.

Stephen Bradley, GP and clinical research fellow, University of Leeds
Being a good enough doctor

When students enter medical school or junior doctors start specialist training, they don’t aim to be a “good enough” doctor—they want to be the best. They hope to combine outstanding diagnostic acumen with being a caring and empathetic doctor, a brilliant teacher, and ideally a world changing researcher. Somewhere in that mix we also need time for relationships, for hobbies and sport, and to develop into happy people with rounded lives. But there aren’t enough hours in the day, or days in a lifetime, to do it all. Looking over your shoulder, you may see a colleague who seems to be climbing the career ladder while learning Swahili and jazz saxophone, competing in triathlons, and setting up an international charity. Meanwhile, you struggle on, sometimes into happy people with rounded lives.

Perhaps the best thing we can do to help others, especially those still in training, is to bring our own mistakes and near misses to the table. What was it that led me to postpone that home visit, with disaster narrowly averted when my colleague picked it up? On another occasion, did my failure to listen to the distress behind a patient’s anger make me less kind than I should have been?

None of us is perfect, and self-criticism can wear us down or burn us out. However, in the long term we’re more use to the world if we can live with our errors, share them, and learn from them. Our patients would prefer that we never harm resulted, and the complaint may not be deserved—but still it reminds you that you’re not perfect. It may even make you question whether you’re good enough.

When trainees are struggling with unrealistic expectations of themselves, I often recommend a 2010 TED talk by Brian Goldman, a Canadian physician. In it he talks about his own mistakes and the inevitability of human error. He’s clear about the need for a change in the culture of medicine, so that we can aim for systems that are safe without expecting the people within them to be perfect. Such systems come about only when you can look at errors in the clear light of day, without blame or finger pointing, and see what factors contributed to them: was it fatigue? Poor labelling? Unmanageable workload? Significant event analyses usually end with a section asking how similar episodes will be prevented. I’ve seen too many conclude that “we must be more careful,” which misses the point.

Perhaps the best thing we can do to help others, especially those still in training, is to bring our own mistakes and near misses to the table. What was it that led me to postpone that home visit, with disaster narrowly averted when my colleague picked it up? On another occasion, did my failure to listen to the distress behind a patient’s anger make me less kind than I should have been?

None of us is perfect, and self-criticism can wear us down or burn us out. However, in the long term we’re more use to the world if we can live with our errors, share them, and learn from them. Our patients would prefer that we never made any, but they accept we’re human and fallible. Learning to admit those errors to patients, and to say sorry, is one of the hardest but most important steps to becoming a good enough doctor.

Perhaps the best thing we can do is bring our own mistakes and near misses to the table.
Why don’t we ask patients more about social determinants of health?

People’s socioeconomic circumstances should be routinely documented in their healthcare record, argue Andrew Moscrop and colleagues.

Health inequities are worsening across Britain. Data from the Office for National Statistics (ONS) show that men in England’s most deprived areas die almost a decade earlier than those living in affluent neighbourhoods.

For women, life expectancy is falling in deprived areas. During the coronavirus pandemic, the strong emerging relation between covid-19 death rates and area deprivation reported by ONS and Public Health England has shown the exacerbation of existing inequities and highlighted the need for more comprehensive datasets in order to understand and reduce them.

The measurement and description of health and social inequities tends to rely on data at the level of geographical areas rather than individuals. We consider the limitations of using geographical data and look at how the collection of individual level socioeconomic data by healthcare systems could help to deliver care that is responsive to patients’ social contexts and research and monitoring of healthcare equity.

Lack of robust individual level assessment means it is not possible to reliably monitor socioeconomic inequities

Box 1 | Problems with using postcode derived socioeconomic data

- UK “postcode” data are drawn from larger geographical areas for which statistics are available—usually lower layer super output areas (LSOAs). An average postcode contains 15 households; an average LSOA contains 672. The larger averaging effects make the data much more liable to blunt extremes of affluence and deprivation, as well as blunting their measured effects.
- Composite deprivation scores (including Indices of Multiple Deprivation, Townsend scores, Underprivileged Area Scores, and the Carstairs index) derived from postcodes conceal the social causes of health effects and obscure potential points of intervention.
- Area data may identify an area of deprivation but do not show the deprivation of an individual from that area.
- Confusion with area effects: postcodes may be associated with deprivation but may also be independently associated with other environmental health determinants.
- Unreliability where populations are heterogeneous or undergoing rapid demographic change.
- Inapplicability to mobile communities and who are homeless or vulnerably housed in the UK.

The problem with postcodes

Between the extremes of life expectancy exposed by the ONS data above, researchers in the UK have described a “social gradient in health.” On this gradient, lower socioeconomic position or greater deprivation is associated with increased cardiovascular and cancer mortality and more mental health problems.

Recognised social determinants of health such as employment status, occupation, education, housing, and household income not only affect people’s health” and health experiences but also their access to healthcare, outcomes of care, and engagement with health protection activities. Yet the UK’s National Health Service has no system for routine recording of patients’ socioeconomic circumstances. Social determinants are not routinely asked about, documented, or coded in clinical settings. The health service is, in effect, blind to those social determinants of health and healthcare.

When patient level socioeconomic data are required, composite deprivation scores are commonly used. These scores are based on averaged area data, inferred from the postcode of the patient’s home address. Area based deprivation scores are then applied to individuals and used in clinical research, service evaluation (including NHS England’s GP patient survey), and even some clinical decision making (including cardiovascular risk calculation tools).

Although geographical data and area based deprivation scores may be appropriate for comparing groups, they cannot be used to characterise individuals from within those groups. Living in a “deprived area” is not the same as being deprived. For this reason and others (box 1), a patient’s postcode is an unreliable indicator of their socioeconomic circumstances. The socioeconomic components of research, evaluation, and clinical decisions that use postcode data therefore have their reliability undermined too.

KEY MESSAGES

- Socioeconomic factors such as education, employment, occupation, housing, and household income affect patients’ health as well as their healthcare access and outcomes.
- These social determinants are not routinely documented in UK healthcare settings.
- Robust individual socioeconomic assessments could facilitate supportive interventions for those whose social circumstances leave them at risk of poor health.
- Social prescribing in primary care would be more equitable and effective when combined with routine documentation of patients’ socioeconomic circumstances.
- Monitoring healthcare access and outcomes using individual level socioeconomic data would create a basis for fairer healthcare.

Andrew Moscrop and colleagues
Duty to ensure equity

Lack of robust individual level socioeconomic assessment in healthcare settings means that doctors are unable to identify people whose socioeconomic circumstances increase their risk of adverse health outcomes or treatment failures. Accordingly, it is not possible to identify those who may benefit from care plans acknowledging their social context, or to reliably monitor socioeconomic inequities in healthcare.

The World Health Organization has emphasised the importance of monitoring equitable service coverage across wealth and education gradients as part of achieving universal health coverage.17 Michael Marmot, one of the UK’s leading public health researchers, has also advocated using markers of health equity such as socioeconomic position and education to monitor health and healthcare as a first step in confronting inequities.18 The British Medical Association suggests that doctors should consider patients in the context of social factors, noting the adverse health effects of poor housing, unemployment, poverty, and low educational achievement.19 But these recommendations have not been incorporated into UK policy, or led to any appreciable shift in practice.

The irony is that even when they are not acknowledged overtly, patients’ socioeconomic circumstances and their health effects are unavoidable, especially in primary care.20 General practitioners spend large amounts of consultation time on non-medical issues relating to welfare benefits, housing, or unemployment.21 But the socioeconomic circumstances and difficulties discussed are rarely or only inconsistently recorded. Health practitioners’ questions and their documented “social histories” continue to focus on socially influenced behaviours such as diet, exercise, alcohol consumption, and smoking habits.

By not asking patients about their social circumstances or recording socioeconomic data, doctors help to conceal these problems from public view and from the political agenda. These are important but often unacknowledged moral choices (box 2). Ending the complicity of the medical profession in health and healthcare inequities begins with data gathering: documenting the social contexts that affect patients’ health and care outcomes, thereby evidencing inequities, aiding research into their causes, and monitoring changes.

Learning from US and Canada

Healthcare systems elsewhere are beginning to take patients’ socioeconomic contexts more seriously. In the US, during the Obama healthcare reforms, it was recognised that identifying and meeting patients’ social needs could restrain healthcare spending and improve health outcomes. The US National Academy of Medicine delivered specific recommendations for practitioners on the assessment and recording of patients’ education level and their experience of financial hardship.22 Subsequent research has shown the feasibility of routine assessment of these and other social health determinants in US healthcare settings.24 Clinicians have reported useful adaptations in patients’ care plans,25 improved communication,26 and that patients referred onward through social prescribing networks benefit from better access to community resources.27 28 Evidence is still awaited on the ultimate health and cost effects of socioeconomic assessments and social referrals in the US. Nonetheless, UK practitioners might take note. Social prescribing is already part of the NHS long term plan for England.29 Characterised as embracing everything from debt counselling for the insolvent to dance classes for the lonely, social prescribing is intended to link patients with suitable non-medical resources from the voluntary or community sector. The aim is to meet social needs while reducing pressures on primary care services. If this initiative is to meet the needs of the most deprived people and respond usefully to inequities and adverse social conditions, reliable individual level socioeconomic data are needed.

In Toronto, Canada, routine collection of patients’ social data, including housing and household income,
Midwives in the UK already routinely ask every expectant mother about financial security, occupation, education, and housing

Proposals for action

Healthcare teams in Toronto have adopted the single screening question: “Do you (ever) have difficulty making ends meet at the end of the month?” Affirmative answers have proved to be a good predictor of poverty. Further questions could cover occupation, current or recent unemployment, education level, housing tenure (or homelessness), and household income bracket. Primary care seems the appropriate setting to start asking patients about these socioeconomic factors. Information may be gathered through registration forms or by healthcare providers, with sensitivity and respect to ensure that patients feel comfortable and empowered.

Clear processes must be in place for data use and how to respond to patients identified as facing socioeconomic challenges.

Once identified, patients whose socioeconomic circumstances put them at risk of poor health and care outcomes can be flagged for enhanced care plans and targeted for specific interventions. For example, patients may be offered referral to local social prescribing networks, enhanced follow-up for chronic disease management, and additional information and encouragement to engage with health protection initiatives such as cancer screening and vaccines; they could also be given longer appointment times for discussion of health issues. In hospitals, patients with socioeconomic risk factors might receive enhanced discharge planning to reduce readmissions. Other healthcare teams use socioeconomic information for planning patient care and evaluating service equity.

Further research may be required to confirm the best approaches, such as the most appropriate questions to ask and how often to ask them. It will be important to seek the views of a range of patients. Adequate electronic record templates and clinical codes to record socioeconomic information will also be necessary. In primary care, Quality and Outcome Framework payments could be used to encourage the collection of socioeconomic data (as previously occurred for ethnicity data), with materials and messages developed to communicate the purpose to patients and staff, guidance produced on how best to audit and use the data, and the value of socioeconomic information emphasised in postgraduate training.

Doctors can make these changes happen. So why have they not done so already and why have socioeconomic inquiries been widely neglected? The omission may not be entirely unintentional. Our lack of process for asking about and documenting patients’ socioeconomic circumstances may reflect learnt professional priorities, limited perceptions of the role of healthcare, and perhaps the relative socioeconomic privilege of doctors.

Some cautions and caveats have been raised around asking about socioeconomic circumstances. These include concern about a lack of time and the prioritisation of biomedical factors over social determinants. Another common concern is the supposition that patients would object, yet so far there is little evidence of this in the US and Canada. Moreover, midwives in the UK already routinely ask every expectant mother about financial security, employment status, occupation, education, and housing. It is a collective failure that the children born to some of those mothers will have their lifespan diminished by as much as a decade because of socioeconomic circumstances. It is time for doctors to act on the knowledge that social determinants affect people’s health.

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Box 3 | Patient perspective—talking about income makes sense

“For me, keeping healthy is a full time job, and it takes most of my disposable income. When I came to the family health team at St Michael’s in Toronto, I was asked about my physical conditions, my medications, the usual. But the doctor also asked me about my work (I had stopped working for a few years) and then about my sources of income, how I paid for my medications, and about my social and emotional life.

“I left the doctor’s office with all my regular prescriptions plus an appointment to see a clinical social worker and a nutritionist. Healthcare providers talk about food with patients diagnosed with type 2 diabetes, high cholesterol, or after a heart attack: why not have a “food” talk with someone who is un(der) employed or lives on disability income?”

has been introduced in four large health organisations (including the family health team at St Michael’s Hospital, where two of us are based). Doctors have used these data alongside an online tool to identify social benefits for which patients may be eligible, employed or lives on disability income?"
t could work?

So, could or should Slovakia’s model be transplanted to England? A crucial question is whether it worked. The testing programme coincided with large reductions in cases, of up to 60% in some areas. But was this due to the testing programme or to the lockdown and curfew measures that preceded it? One month before the mass testing exercise, the country introduced a partial lockdown. Just one week before mass testing strict curfew measures were implemented. A pre-print analysing the results concluded that it was not possible to disentangle the effects of the testing and the lockdown, although the authors believed that the results were better than would be expected with either on its own, with isolation of contacts of those testing positive likely playing an important role.

In other words, mass testing is not a substitute for a lockdown, but rather a complement. Moreover, to work, it is likely to require far higher degrees of adherence to isolation than has been reported in England. There are also other concerns. England has no comprehensive accurate population register. Instead, the privatised testing system has relied on a credit rating agency to assess eligibility for covid tests, even though many people will be excluded. Second, although voluntary, the Slovakian restrictions on movement imposed on those refusing a test, backed up by checks of permits by the police, employers, or shop staff, would be extremely difficult to replicate, with the British police already concerned about the pressures they are facing when enforcing less restrictive regulations. Third, there remain many outstanding questions about the performance of the rapid tests currently available, with the Innova test used in Liverpool achieving only 58% sensitivity when self-administered. Fourth, there are questions about logistic capacity. With a population ten times higher than Slovakia, the challenge of procuring test kits would be enormous. Then there is the problem of finding the personnel needed to run the programme.

Slovakia’s achievement, combining lockdown and testing, was clearly impressive. However, the practical and political challenges of doing the same in England are probably insurmountable. As infection rates are already falling, there may be better ways to use the vast amount of resources that would be required. A good start would be to fix the dysfunctional testing and tracing system and provide meaningful support for those who must self-isolate.
LETTERS

Selected from rapid responses on bmj.com

COVID-19: “JUST STAY AT HOME”

Long covid: saddened by lack of professional curiosity

Jensen’s poignant perspective reflects the experiences of many patients who were very sick at the peak of the first wave of covid-19 but were denied proper medical assessment and told to “stay at home” (What Your Patient Is Thinking, 7 November).

As part of an online group of more than 500 doctors affected by long covid, we are disappointed that the learning points don’t include “doctors should assess and investigate patients properly.” Before the pandemic, symptoms such as low oxygen levels and tachycardia would warrant examination and investigation, especially when persistent and in previously fit and healthy patients.

It saddens us to hear such low expectations from general practice and secondary care. This is a new disease, and we are surprised by the lack of professional curiosity. The medical profession needs to evolve rapid transformative pathways to deal with the long term sequelae of covid-19 that include full investigation of patients.

Amal U Lokugamage, consultant obstetrician and gynaecologist and honorary associate professor, London; Mary-Ann Bowen, GP, Kidderminster; Jennifer Blair, consultant anaesthetist, Sutton

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PAROSMIA

Treatment, mechanism, and types of smell anomalies

Rimmer states that there is no cure for parosmia (Sixty Seconds On, 14 November), which is correct, but there are drugs that specialists have used for decades. These include sodium valproate, gabapentin, and pregabalin. I am not aware of a formal trial of any of these, but they seem to work quite well. The probable mechanism of parosmia is ephaptic firing in demyelinated neurons—a form of short circuiting. After the olfactory neurons remyelinate, the afferent signal is no longer distorted and the symptom disappears, a process that can take years but usually occurs eventually.

Cacosmia is a form of parosmia that entails an unpleasant hallucination—as most are. I have never come across a pleasant parosmia, although it does happen. The illusion of an odour (phantosmia) that occurs without sniffing can represent an epileptic phenomenon and can indicate the presence of a tumour, usually malignant, in the medial temporal pole.

Christopher Hawkes, honorary professor of neurology, London

Cite this as: BMJ 2020;371:m4739

DETOXIFYING DNACPR DISCUSSIONS

ReSPECT dispels fear of DNACPR decisions

At Resuscitation Council UK, we are concerned by reports of people being subjected to do not attempt cardiopulmonary resuscitation (DNACPR) decisions without their consent or with little involvement during the pandemic (David Oliver, 31 October).

The public’s understanding is limited that a DNACPR recommendation should not affect any other aspect of emergency care, resulting in fear that people will not receive emergency care when needed.

In recent years we have been developing with experts, patients, and their families the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) to improve, personalise, and widen conversations about emergency care planning and to make those conversations work for people when it matters. ReSPECT extends far beyond DNACPR decisions.

ReSPECT supports well structured and person centred conversations between healthcare professionals and patients to develop a shared understanding of the patient’s condition, values, and fears and how emergency treatments and interventions fit into this.

Sue Hampshire, director of clinical and service development; Zoe Fritz, chair, ReSPECT subcommittee, Resuscitation Council UK, London

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LETTER OF THE WEEK

Shielding should not be taken lightly, it can be devastating

I agree that people who are clinically extremely vulnerable should receive a letter advising them to stay at home as much as possible, including not going to work if they cannot work at home (Seven Days in Medicine, 14 November). The letter needs to be easy to understand. The sender needs to take ownership and responsibility in dealing with questions. Recipients should not be signposted to general practice with their queries—there is no capacity.

I hope the “experts” have considered potentially significant statistical confounding factors. Death rates rise during winter in the absence of a pandemic. Some of these people will test positive for covid-19 in the 28 days before death and this might be recorded as the cause of death when it is not.

The accuracy with which people were deemed clinically extremely vulnerable during the first lockdown was questionable. Historic and inaccurate Read codes were used, which led to people being contacted and advised to shield who did not need to. Many patients were confused and called their GP.

I hope that our collective learning has informed the decision to update the inclusion criteria of the clinically extremely vulnerable group. During the first lockdown, this work was inappropriately delegated to frontline clinical staff, diverting them from seeing patients. Jointed-up thinking and high quality diagnostic Read coding is essential in reducing error.

Shielding was designed with the best of intentions to mitigate risk, but it also adversely affects psychosocial and mental health functioning. The process of accurately stratifying risk and notifying thousands of people should not be taken lightly. The consequences could be devastating if this process is poorly designed or executed. We need to learn from our previous shortcomings to protect vulnerable people, suppress the virus, and support our health service, education system, and economy.

Carter Singh, GP, Sutton in Ashfield

Cite this as: BMJ 2020;371:m4727
**OBITUARIES**

**Roger Hanif Armour**
Consultant surgeon (b 1934; q King Edward VII Medical College, Lahore, Pakistan, 1956; FRCS Ed, FRCS Eng, DTM&H, FRCP Lond), died from heart failure on 17 September 2020.

Roger Hanif Armour (previously Ahmed) came to Britain in 1956 and worked in as many surgical specialities as time allowed before choosing general and vascular surgery. He had initially intended to return to Pakistan but the combination of the heat and the politics stopped him. To improve his prospects of a consultant appointment in Britain he changed his surname. In 1972 he moved from Liverpool to the Lister Hospital in Stevenage. He retired in 1996 and designed an award winning lens free direct ophthalmoscope, which is the size of a pen torch and gives a view comparable to a standard ophthalmoscope at a fraction of the cost. He leaves Gillian, his wife of 62 years; three children; and two grandchildren.

Peter Kelly, Roger Hanif Armour

Cite this as: BMJ 2020;371:m4071

**Keith Budd**
Consultant in pain management and director of pain management services Bradford Hospitals NHS Trust (b 1937; q Leeds 1962; FRCA, FFPMRCA), died from pneumonia and congestive cardiac failure on 27 July 2020.

Keith Budd was appointed as consultant in Bradford in 1972. He set up first the obstetric epidural service and then the pain service in Bradford, which became internationally renowned. Before he retired in 1997, he held many prestigious posts in professional bodies. He was the author of many publications and several books, and an international expert on opioid analgesics. He acted as a consultant adviser to various organisations and featured nationally and internationally in the media. His hobbies included squash, steam trains, sailing, and music. He leaves his wife, Christine; two children; and three grandchildren.

Simon Budd, Carolyn Evans

Cite this as: BMJ 2020;371:m4073

**Joseph Masters Holmes**
Consultant obstetrician and gynaecologist (b 1924; q 1947; MD Lond, FRCOG, FRCS), died in his sleep on 8 September 2020.

Joseph Masters Holmes became university postgraduate tutor and resident obstetrician at Queen Charlotte’s Maternity Hospital in 1957. He developed an interest in photography and published a book entitled Illustrated Obstetrics and produced a series of film strips showing safe methods of fetal delivery. He contributed many publications to the Lancet and the Journal of Obstetrics and Gynaecology of the British Empire. As a consultant at University College Hospital, he remained a dedicated labour ward practitioner and continued with comprehensive obstetrics until retirement. As a distraction from a demanding obstetrics practice he built an Olympic class sailing dinghy. In retirement he became a talented portrait painter and keen competitor at a local contract bridge club. He leaves his wife, Joan; two children; and four grandchildren.

Joseph Masters Holmes

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**Charles Gregory Francis Munton**
Consultant ophthalmic surgeon Kent County Ophthalmic and Aural Hospital, Maidstone, Kent (b 1933; q Birmingham, 1960; FRCS, FRCOphth), died from a gastrointestinal haemorrhage on 23 July 2020.

Charles Gregory Francis Munton (“Greg”) initially trained in engineering. However, while studying he developed tuberculosis and with it a love of medicine. He was consultant in Maidstone from 1967 to 1996, where he performed several thousand cataract and strabismus operations, as well as treatment for retinal detachment, corneal graft surgery, and lamellar keratoplasty. Greg published research on tissue adhesives, and driving and vision, and he was chairman of the Visual Standards Committee, College of Ophthalmologists (1989-95). He fully retired from practice in 2003. In retirement, he was chairman of the Kent Association for the Blind (2005-10). He leaves his wife, June; four children; and two grandchildren.

Robert Froud

Cite this as: BMJ 2020;371:m4085

**David Bowen Hargrave**
General practitioner (b 1951; q King’s College London/Westminster Hospital, London, 1974), died from metastatic renal carcinoma on 19 January 2020.

David Bowen Hargrave trained at Westminster Hospital, where he met his future wife, Libby, a trained staff nurse in the accident and emergency department. David joined a GP partnership on Portland in Dorset in 1980, and remained there until he retired in 2011. He was particularly interested in respiratory medicine and also became an advanced life support trainer. His Christian faith infused everything that he did. David had a tremendous sense of humour and enjoyed participating in numerous community activities. He spent many happy hours working in his greenhouse and garden. He leaves Libby, his mother, five sons, and 10 grandchildren.

Paul Mason

Cite this as: BMJ 2020;371:m4078

**Peter George Herbert Summers**
General surgeon, anaesthetist, ophthalmologist, occupational health physician (b 1934; q London Hospital 1963; FRCS, DipAnaesth, DOccMed (Auckland)), died from heart failure secondary to aortic valve disease on 15 September 2020.

With a father and aunt who were GPs and an uncle a chest physician in Edinburgh, it was almost inevitable that Peter George Herbert Summers would pursue a medical career. After surgical training in Plymouth, Liverpool, and London and anaesthetic and ophthalmological training in Kent he embarked on a varied and peripatetic career. His overseas appointments were under the auspices of the Ministry of Overseas Development. In 1990 he emigrated to New Zealand. After retraining in occupational medicine in 2000 he continued in practice at Whangarei until the age of 77. He leaves his wife, Primrose, and sister, Rosemary Hanbury.

Damian Hanbury

Cite this as: BMJ 2020;371:m4086
Neil McIntyre

Professor of hepatology and author of game changing research on intestinal hormones

Neil McIntyre (b 1 May 1934, q 1958; BSc, MD, FRCP), died from pneumonia on 19 July 2020

In 1963 Neil McIntyre, a research fellow, joined the Royal Free Hospital in London to work for hepatologist Sheila Sherlock. He was seconded to the diabetes department where, experimenting with glucose intolerance in liver disease, he found taking glucose orally induced a considerably higher rise in plasma insulin levels than taking it intravenously.

He arrived at the game changing conclusion that an intestinal hormone stimulated insulin. His doctoral thesis in this in 1967 made a major contribution to knowledge of insulin secretion and opened up a new area of research into the overlooked role of gut hormones.

In academic medicine, McIntyre had found his niche. His intellect was apparent early—as a medical student he achieved the considerable coup of having his research published in Nature and the British Journal of Experimental Pathology. His successor at the Royal Free, Humphrey Hodgson, said, “Ours is one of the most specific, precise types of medical study, and it suited Neil’s rigorous approach.”

In 1966, McIntyre was awarded a travelling fellowship by the Medical Research Council and spent two years in Massachusetts, USA, with Kurt Isselbacher, studying cholesterol metabolism. He returned to the Royal Free in 1968 as a senior lecturer, and was made a clinical subdean in 1976 and professor in 1979.

Described by a colleague as “bringing rigour to modern hepatology” with an encyclopaedic grasp of the literature, McIntyre published over 200 papers. He made a substantial contribution to the specialisms of liver physiology and biochemistry, with research into Wilson’s disease, carbohydrate metabolism, haematological disorders in liver disease, and much more. In 1983 Sherlock retired and McIntyre took over as head of the liver unit for the next 16 years.

In his new role, McIntyre continued the trajectory of excellence established by Sherlock, but he brought a new freedom into what had been a fairly autocratically run department. He was described as “a fantastic mentor, quite selfless and generous,” and under his wing a generation of influential hepatologists were encouraged to shine.

McIntyre cared profoundly about medical training and patient care. In 1983, with the philosopher Karl Popper, he wrote a paper, The Critical Attitude in Medicine, arguing that doctors should admit and analyse their errors in order to improve. As well as editing textbooks such as the Oxford Textbook of Clinical Hepatology, he supported interdisciplinary working and was interested in improving standards of patient management. On a visit to Vermont in 1973 he was excited by a demonstration of the Patient Reported Outcomes Measurement Information System and the potential of the computer. He also espoused the system of problem oriented medical records and, according to his successor, kept immaculate notes himself.

Rugby, statues, and history
McIntyre was born on 1 May 1934 in Ferndale, in the Rhondda Valley. He was an only child, his father worked for the Co-op and his mother was a dressmaker. Although he made his career in England, he was a patriotic Welshman and supported the Welsh rugby team. He enjoyed golf and cricket and was an adept ballroom dancer, winning a prize in the 1970s.

After his education at Porth County Grammar School for Boys, in 1951 McIntyre moved to London to study physiology at King’s College, receiving a first class degree in 1955. Clinical studies at King’s College Hospital followed, and he graduated in pathology and applied pharmacology in 1958.

A man of eclectic interests, while a medical student, McIntyre wrote a biography of Robert Bentley Todd, the founder of King’s College Hospital, concluding that it was appropriate he was immortalised in a statue. He said he had no idea how many other doctors had statues and hunting them down became a lifelong passion. He discovered more than 300, and it took him to many places, such as Madrid to view a bronze bust of Alexander Fleming installed by bullfighters grateful for penicillin.

In 1960 McIntyre joined the medical branch of the Royal Air Force to do national service and spent the next three years in the British Crown colony of Aden. When he was demobbed, he returned to London in 1963 and began his career at the Royal Free.

Through his teaching, McIntyre met medical student Wendy Kelsey. The couple married in 1966, made their home in London, and had two children, Waveney in 1968 and Rowan in 1969. McIntyre was interested in many aspects of history and was president of the Osler Club of London.

He leaves Wendy, Waveney, Rowan, and three grandchildren.

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