comment

TAKING STOCK Rammya Mathew

Building compassionate and joyful workplaces

Like it or not, work is what we spend most of our waking hours doing. So, finding joy in work isn't a nice to have: it's a necessity. An organisation such as the NHS—the world's largest employer of highly skilled professionals—should conceivably have a highly developed approach to ensuring that people have fulfilling and rewarding jobs that they want to keep coming back to.

This is key in terms of reducing staff turnover, increasing productivity, and improving overall organisational performance. Yet the NHS stands out for having a rudimentary organisational development strategy, and if you speak to staff the stories that you hear don't chime with an organisation that's actively investing in its people and, more specifically, their joy.

There are numerous bugbears in the NHS we mostly just learn to accept, particularly during our training years—for example, not receiving a contract until several months into a job, being perpetually paid and taxed incorrectly, and, worse still, having to jump through hoops such as appraisal and revalidation, which often feel far from being opportunities for development. All of these things grate, but I don't believe that they are what drive people out of the NHS.

The most unforgivable acts can almost always be traced back to a basic lack of kindness. Such as when senior staff don't bother to learn the names of junior staff working for them. Or when we forget to thank or show any appreciation for team members who go above and beyond. Or when acts of bullying or discrimination get swept under the carpet or are diminished because it's easier than dealing with them head on.

If I asked you who in your workplace was enabling you to work to your values, who was nurturing your team and giving you a sense of belonging, or who was looking out for your contribution and actively looking to recognise it, I think most doctors would draw a blank. A failure to cultivate compassionate leadership is what has predominantly zapped the joy from our workplaces.

In his new book, *Compassionate Leadership*, Michael West invites us to re-evaluate how we get the most from our workforce in a way that genuinely translates to better, more cost effective care. Our obsession with target driven care has meant that compassionate and joyful working environments have all but been sacrificed to "value," "efficiency," and "outcomes." Yet if we look at the evidence, cultivating joy at work is exactly what the NHS needs to do to achieve its desired ambitions. It's high time we moved on from myopic short term strategies and made compassion and joy the central tenets of our long term vision.

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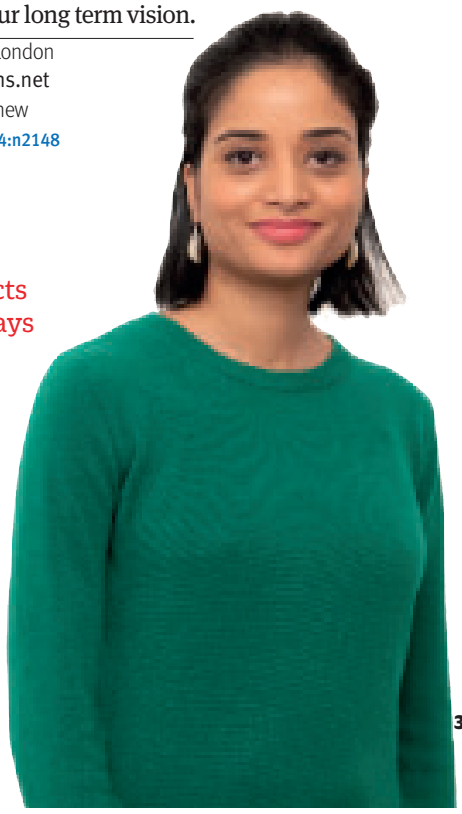
The most unforgivable acts can almost always be traced back to a basic lack of kindness



PERSONAL VIEW Jacky Davis

Data are vital in supporting the assisted dying debate

For too long the conversation between doctors, patients, and legislators has been conducted on opinion rather than fact

In May, Matt Hancock, the then health secretary, commissioned the Office for National Statistics (ONS) to inject fresh evidence into the assisted dying debate. The ONS has been asked to investigate how many dying people in the UK take their own lives and how many travel abroad to access assisted dying. This will help us to understand what effect, if any, the UK ban on assisted dying has on these cases.

This is an encouraging development that should be welcomed by all. The debate about possible UK legislation for assisted dying has never gone away and is about to pick up again. Not only are jurisdictions considering changing their laws, but Jersey will debate whether assisted dying should be legalised after a citizens' jury said it was in favour of changing the law. The matter is also currently being debated in the House of Lords in the form of a private member's bill put forward by Baroness Meacher.

The subject is emotive and the debate often polarised, with more heat than light being generated. Those who support assisted dying legislation want to see more light shed on the subject. Those who argue that the status quo is good enough should be confident of putting their claims to the test.

The blanket ban on assisted dying in the UK undoubtedly forces many terminally ill people to take matters into their own hands and it is right that society—and the medical profession especially—be forced to confront that reality. We believe from evidence in the UK and elsewhere that as many as one in seven suicides may be related to terminal and serious illness.

Concepts of autonomy

My brother took his own life when dying of renal cancer. He had a very good palliative care team, but he didn't want to risk the suffering he had witnessed others endure. Concepts of autonomy, control, and person centredness—which we try so hard to embed in every other area of medical practice—inexplicably became more elusive the closer he got to death. The law did not protect him; it drove him towards a lonely, violent end. It robbed him of the chance to die in peace with his family around him.

MPs must respond with a sense of urgency once the evidence of the impact of the current law is put before them. While their historical trepidation has come at a cost to many, what it has afforded us is the benefit of learning from those who have already adopted legislation. Ten states in the US, soon to be four states in Australia, as well as Canada, New Zealand, Spain, and other European jurisdictions have grasped the nettle. A bill is being scrutinised in Ireland. Scotland will be next. More laws are being passed and not one has been repealed. A law has been in place in Oregon for 24 years. The Oregon Hospice and Palliative Care Association withdrew its case against the law and pledged to respect the rights of dying Oregonians to have this option. No national or state medical body is campaigning to overturn assisted dying legislation.

There is no question about opponents' sincerity, but their fears are hypothetical

Yet, despite being able to learn from the evidence of safe practice overseas, opponents continue to base their opposition on speculation. They fear what "might," "may," or "could" happen. There is no question about their sincerity, but their fears are hypothetical. Meanwhile the suffering of the terminally ill is real. Most people—in the UK and in places that have laws in place—recognise we don't have to choose between better end-of-life care and better end-of-life choices. An assisted dying law is a chance to tackle both simultaneously.

BMJ OPINION Katherine E Sleeman and Gareth S Owen

Assisted dying research must be a priority

The assisted dying debate remains polarised, but there are evidence gaps to fill and we must prioritise research.

The case for legalisation is largely driven by polls that show that around 80% of the UK public support assisted dying. Similar polls from elsewhere, however, have revealed poor understanding of what assisted dying law encompasses. A 2017 New Zealand survey found 66% thought it included turning off life support and 51% thought it included stopping medical treatment. Those who most strongly supported assisted dying were more likely to think it included legal end-of-life practices. Understanding whether similar misconceptions exist in the UK is essential.

Consent (which is composed of mental capacity, non-coercion, and relevant information) is an important safeguard proposed to prevent harm and ensure choice where assisted dying is legal. But reality does not always align with neat boundaries, and it is in the grey areas that potential harms exist. Mental capacity can be affected by illness, medication, depression, and cognitive impairment in ways we are still learning about. Important questions about the effectiveness of consent as a safeguard remain unanswered.

Questions remain about what exactly the role of the doctor should be

In most jurisdictions where assisted suicide or euthanasia is legal, it is embedded within medical practice. However, questions remain about what exactly the role of the

PETER MARSHALL/ALAMY

Evidence is vital. For too long the assisted dying debate has been conducted on opinion rather than fact. Opponents of assisted dying have always declared with confidence that doctors opposed such legislation without any evidence to support this. When the BMA proposed conducting its first survey on assisted dying there were some doctors who voted against it. But we are an evidence based profession. It is vital we know what doctors think about one of the big ethical questions of our time. We now know from the survey that more UK doctors personally support law change (50%) than oppose it (39%) and the majority (61%) have called on the BMA to adopt a supportive or neutral position on the issue. A debate to define the BMA's future approach is taking place at the annual representative meeting on 14 September.

MPs have called for the public debate to be informed by the "best statistics." The BMA survey results have forced people to question their long held assumptions. It is to be hoped the evidence from the ONS will do the same and that the information will be available in time for the House of Lords debate.

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doctor should be. A 2020 BMA survey of doctors found that 37% of respondents supported a law change to permit doctors to administer life ending drugs, and 26% said they would be willing to participate. Those working in specialties most familiar with end-of-life care were among the most opposed. Indepth research to understand the attitudes of doctors is needed.

The UK has a deserved reputation for world leading care of the dying, both in terms of care and research. The rigour with which we expect evidence to be applied to policy decisions is no less relevant in this debate.

Katherine E Sleeman, Laing Galazka chair in palliative care

Gareth S Owen, reader in mental health, ethics and law, King's College London

ACUTE PERSPECTIVE David Oliver

When actions betray value statements

Value statements are intended to list the core principles guiding an organisation, creating a moral compass for it and its employees. All health and social care organisations in the UK have such statements. The NHS constitution sets out values for its entire workforce and services.

I'm not sure, however, that we always live up to those values or even try to. Too often they're reduced to lip service and generic platitudes. A word cloud would identify some recurrent themes: "person centred," "patient centred," "based on individual needs," "supporting patients and their families," "respecting choice, dignity, and priorities," "inclusive," "coordinated," "collaborative," and "compassionate."

I haven't conducted any scientific study comparing the rhetoric with the reality, but I think we fall well short and often make a mockery of our values. Clearly, support for staff is often lacking. The annual NHS staff survey shows growing concern about bullying, unsupportive management, and low morale. Many investigations reveal a culture of bullying or poor leadership.

Meanwhile, instances of patients and the public abusing or harassing staff are increasing, whether in real life, in the news, or on social media. Formal complaints about care and communication are rising. Yet it's generally frontline staff who end up in the complaint resolution or bereavement meeting, the inquest, or the courts for problems often outside their gift to solve, rather than the senior managers who create the working conditions and workforce gaps.

Most importantly, we're urged to provide person centred, coordinated care that respects patients' priorities and preferences and puts them before organisational or professional interests, but do we? Far too often, we base our offer on how organisations like to structure their work and what's convenient for them. The interests or financial constraints of funders and providers are also factors of influence.

Look no further than the arguments over funding for community health and social care, with each service trying to avoid cost or responsibility. Look at our refusal to respect patients' choices if they decide on an option we don't want them to choose: staying in hospital while they regain confidence, going to a care home rather than their own home, or preferring to see a doctor face to face.

Some of those issues require something often seen in value statements: candour, honesty, and transparency. Capacity and resources are so constrained we can't offer the options, access, or timeliness people would like. So, let's level with people, even if it's unpopular. I challenge readers to go back to their organisation, look at its value statements, look at the NHS constitution, and ask themselves, "How much of this do we really live up to? And how could we get a bit closer to delivering on it?"

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We fall well short and often make a mockery of our values

PRIMARY COLOUR Helen Salisbury

Blood bottles, vaccines, and freight

In our clinical work there's always an element of surprise: we never know when our schedules will be derailed by the urgent needs of a sick child or a patient with psychosis. However, our practice managers are experts in planning and organisation. Over years, they hone skills that include knowing which parts of the complicated business of running a GP surgery need to happen when.

These skills are particularly relevant when it comes to the annual flu vaccination campaign: they work out how much vaccine to order in January, plan the clinics, and organise extra staff—or overtime for existing ones—and then book everyone in so that patients are protected ahead of the flu season.

This year's flu campaign has been a challenge. We're expecting to be asked to deliver a third dose of covid vaccine to our oldest patients at around the same time, but at the time of writing this hasn't been confirmed. Logistically, it would make sense to give both vaccines on the same visit, but we still don't have any guidance about whether this is safe. While some of us are hanging on to see if this will be possible, other surgeries have gone ahead and booked their ordinary flu clinics, only to be told this week that vaccine delivery will be delayed by two weeks owing to "unforeseen freight difficulties."

As well as rescheduling vaccinations, reception staff are busy contacting patients to postpone non-urgent blood tests because of the blood bottle shortage. This news can be upsetting and confusing for some ("But the doctor told me I need a blood test—are you now telling me I don't?"), and it's not obvious how we'll clear the backlog once the supply is re-established, as it turns out there's no magic phlebotomist tree.

For reasons entirely out of our control, it's getting ever harder to provide the level of service our patients need. The pandemic was unforeseen, and some of the issues we face (increase in transfer of work from hospitals to GPs; huge delays for outpatient referrals) can be ascribed to covid. However, some of our frustration arises from slow decision making. The booster programme has been repeatedly trailed, but no official decision has been announced, so we can't plan for it. It feels as though we're expected to turn on a sixpence and deliver at a moment's notice.

At the height of the pandemic we willingly gave up our weekends to deliver vaccines, but we can't expect our staff to continue in crisis mode while the rest of the country is told that life has returned to normal. We need timely decision making, better communication, and preparation for the predictable supply chain challenges ahead.

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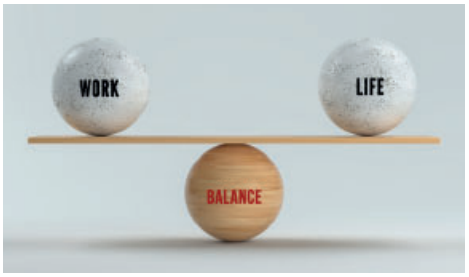
It feels as though we're expected to turn on a sixpence

LATEST PODCASTS



Rota scheduling and burnout

Rotas create stress for the medical workforce when doctors' personal wishes or big life events aren't taken into account, but how can we put an end to their inflexibility? Anas Nader, chief executive of Patchwork Health, describes how technology might help us improve conditions in this Wellbeing podcast:

"At the moment, most algorithmic rostering focuses on spreading supply to meet demand. But we want to look at rostering to include clinicians' preferences (both personal and professional). So whether it is a GP registrar who wants to avoid Friday afternoon clinics because they're a single dad and that's when they have their sons visiting them, or a researcher who wants to make sure that where possible they're never rostered on Mondays and Tuesdays because that's when their lab time at the university is.

"While we know as clinicians that you're not going to get 100% of your preferences, the fact that we're optimising for your needs the same way we're optimising for patient care and safe staffing is a huge step in the right direction."

The complexity of primary care

In the latest episode of Deep Breath In, the team is joined by philosopher Rani Lill Anjum, who talks about the distinction between population based evidence and the relevant information that GPs need to get from a patient to treat them. *The BMJ*'s Jennifer Rasanathan sums up the complexity:

"If all of human health and medicine were as simple as following a guideline, then patients could diagnose themselves and then click themselves in for whatever treatment or therapy they need. But rarely do people align perfectly with the kind of population upon which these guidelines are based. And it's our job as GPs to say, 'How well do you match that? What's my clinical experience telling me?'"

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

ANALYSIS

The threat of a UK-US trade deal to managing non-communicable diseases

Courtney McNamara argues that an agreement between the countries could limit the UK's ability to tackle conditions that account for nearly nine out of 10 deaths unless it includes public health safeguards

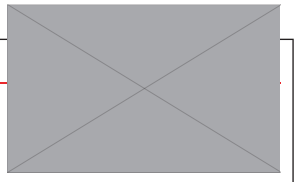
For over four decades, the European Union has handled most of the United Kingdom's trade policy. Now, as the country regains autonomy over its trade policy decision making, the government must carefully consider its approach in pursuing free trade agreements. One of the main trade policy priorities of the UK government is to conclude an agreement with the United States.[1] US trade officials have been circumspect in their statements about such an agreement, but ongoing negotiations remain on the US trade policy agenda for 2021,[2] and several members of Congress have signalled their support for the timely conclusion of an agreement.[3]

Public health discussions around a UK-US free trade agreement have been largely focused on whether the agreement would open up the NHS to American corporations and allow for the importation of poor quality foods, like chlorinated chicken. But another pressing concern has received scant attention in the debate so far—a UK-US free trade agreement could endanger the UK's ability to manage non-communicable diseases.

Responsible for nearly 9 out of 10 deaths in the UK, non-communicable diseases include chronic conditions like cardiovascular diseases, cancer, respiratory diseases, and diabetes.[4] Many of these conditions also place people at greater risk of becoming severely ill or dying from covid-19.[5] Smoking, harmful use of alcohol, and poor nutrition are the major individual risk factors. Economically speaking, non-communicable diseases usher in tremendous financial burdens. Smoking, for example, is estimated to cost the UK £12.5bn every year.[6] Alcohol related harms are estimated to have cost the UK an overwhelming £47bn in 2016 alone.[6]

The US is likely to pursue several provisions in an agreement with the UK that have implications for the management of non-communicable diseases.

Certain clauses would introduce greater corporate involvement in the setting of health regulations



KEY MESSAGES

- A UK-US free trade agreement could endanger the UK government's ability to manage non-communicable diseases
- A trade deal between the two countries should exclude government public health measures from all treaty provisions
- It should also exclude an investor state dispute settlement mechanism and contain no provisions relating to intellectual property on health related products
- Several recent free trade agreements safeguard public health in similar ways to these proposals, indicating their political feasibility
- Adopting these recommendations will also help to protect the estimated economic benefits of an agreement

Potential provisions in a UK-US free trade agreement

Previously negotiated free trade agreements provide a model for the provisions that the US is likely to push for. The provisions that could specifically threaten non-communicable disease management in the UK are those concerning regulatory measures, intellectual property rights, and investor state dispute settlement (ISDS).

Regulatory measures

One of the main ways in which governments can manage non-communicable diseases is by regulating the sale of tobacco, alcohol, and unhealthy foods through, for example, taxes, labelling requirements, or advertising restrictions. Recent free trade agreements negotiated by the US, however, include clauses that can make it more cumbersome for governments to introduce these types of regulations.[7 8] If included, these clauses would not only require the UK government to go through several layers of red tape before any new public health regulation could be implemented, they would also simultaneously introduce greater corporate involvement in the setting of health regulations.

Before a new public health measure could be implemented, for example, the UK government would need to allow for comment on the proposed measure from "interested persons," including industry actors.[9 10] The measure would also need to undergo an impact assessment that would allow corporate actors to petition regulatory authorities if they thought there was an alternative regulation that was less trade restrictive.[10] Finally, the government would be required to provide an explanation for any new regulation it sought to implement, whenever the US, or a US based corporation, thought the new regulation might constrain its exports.[10]

These provisions not only create new administrative burdens on governments but also introduce the potential for "regulatory chill."[7] This means that policy makers might be unwilling to consider new regulations aimed at the prevention and control of non-communicable diseases with these impediments in mind. Policy makers already face pressure to design food, beverage, and tobacco regulations in a manner that is consistent with rules of the World Trade Organization (WTO).[11] Such pressures have been shown to be a potentially influential force for regulatory chill[12] and foreshadow how these new administrative hurdles might induce further chilling effects.

Intellectual property protections

Provisions in free trade agreements negotiated by the US generally require stronger intellectual property protections than the WTO requires.[13] In an agreement with the UK, the US is likely to push for set periods of market exclusivity for biological medicines.[13 14] These drugs are made using living organisms and are used to treat several non-communicable diseases including diabetes, arthritis, and cancer. Biological drugs are extremely expensive. Adalimumab, for example, used to treat arthritis, cost the NHS more than £400m each year before its patent expired in 2018, when the door was opened to the use of "biosimilars."[15] Biosimiliars have no clinically meaningful differences from the patented drug, and they can reduce drug costs by 10% to 50%.[16-18]

Regulations in the UK currently stipulate 10 to 11 years of market exclusivity for biological medicines, which is not very different from the 10 to 12 years of exclusivity the US has sought in previous trade agreements. But this period of exclusivity in the UK is rolled over from EU law, so the UK is free to set its own period of market exclusivity, a freedom it would sacrifice if it were to agree to a period set by a free trade agreement with the US.

The US is also likely to pursue clauses that grant patent term extensions for drugs more broadly—when relatively minor changes are made to the use of a drug, for example, or when there are administrative delays to the granting of a patent.[19] Patent term extensions translate into higher drug costs for the NHS by delaying generic alternatives.

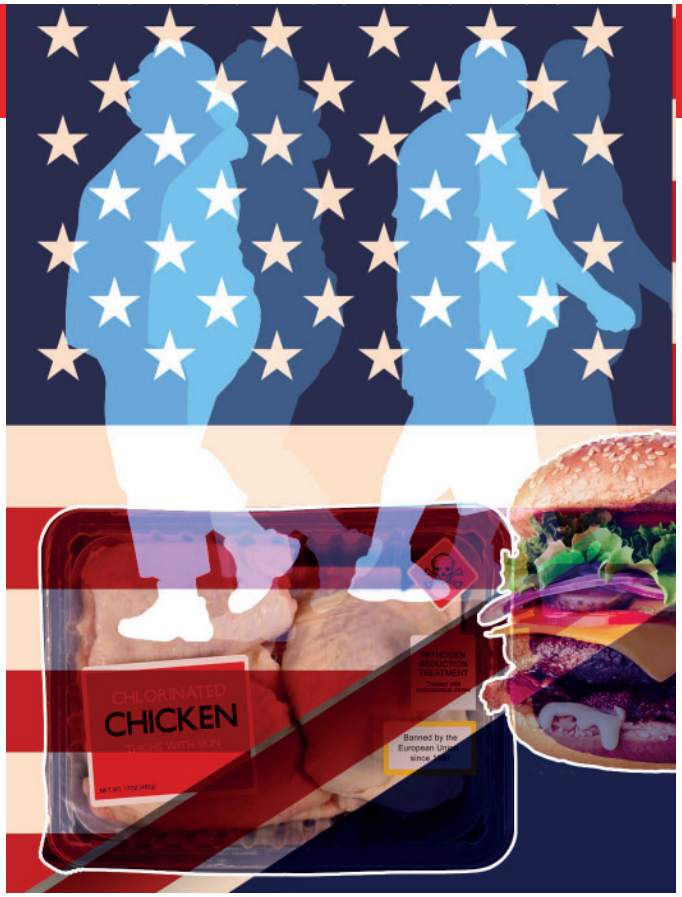
Investor state dispute settlement

ISDS is another common component of US negotiated free trade agreements. In short, it allows private investors to make financial claims against states when regulations reduce the value of their investment. A wide range of non-communicable disease related matters has been challenged through the ISDS system, including measures on taxation, health insurance, and tobacco control.[20]

ISDS is not unique to US led free trade agreements, but including it in an agreement between the US and UK would enable American investors to initiate claims against the UK government by providing direct access to these litigation channels (something that American investors do not yet benefit from). Investors in the US have always been the most frequent users of ISDS,[21] and they have launched several cases against other high income countries, including Canada and Australia.

Challenges from private investors are not always successful. But when states win, they can still face extremely burdensome costs. Eli Lilly, a US drug company, brought a C$500m (roughly £300m) ISDS claim against Canada after the country's domestic courts denied the firm patent extensions. The tribunal ruled against Eli Lilly, but the Canadian government spent C$15m defending the case and was only awarded one third of this in costs and legal fees.[22]

ISDS is thus another source of regulatory chill, as governments might find themselves being sued over actions they've taken to protect public health. The US government, at the behest of industry actors, has previously challenged attempts by its trading partners to introduce measures to protect health, like food labelling requirements or tobacco control policies, using the WTO dispute settlement system.[12] That ISDS clauses give corporations direct access to litigation channels means that their chilling effect is likely to be even larger than those generated by the WTO system.[12 23]



Increased corporate power can translate into greater availability of harmful commodities such as tobacco, alcohol, and highly processed foods

Increased corporate sector influence

Regulatory provisions that allow for direct corporate involvement in policy making are likely to transfer considerable power to the commercial sector. This is also true of provisions related to intellectual property rights and ISDS, which by their nature legitimise corporate interests.

The elevation of corporate actors in free trade agreements undermines action on non-communicable diseases in several ways.[24] Increased power can translate into greater availability of harmful commodities such as tobacco, alcohol, and highly processed foods.[25 26] It can also strengthen the ability of commercial actors to support their interests through the entrenchment of policy preferences that have been successful in producing macroeconomic conditions that undermine non-communicable diseases[27 28]—for example, by keeping wages low, labour unions weak, and inequality high.[24]

Moving forward

Although free trade agreements negotiated by the US typically contain allowances for countries to pursue their own policy objectives, including health goals, the language used to frame this right is often aspirational or self-limiting, making it difficult for countries to do so.[9 10] In this context, a UK-US agreement must exclude government public health measures from all treaty provisions; exclude ISDS; and contain no provisions relating to intellectual property on health related products. This could limit regulatory chill and protect the government's ability to undertake new public health measures. It would also go some way towards containing the costs of drugs for non-communicable diseases, protecting public finances, and limiting corporate sector influence.

Provisions of this sort are not without precedent, indicating their political feasibility. The Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP), for example, a new free trade agreement between 11 countries around the Pacific Rim, includes a clause that excludes tobacco control measures from ISDS.[29] Similarly, in the recent Peru-Australia Free Trade Agreement, any measure designed to protect public health is excluded from ISDS.[29] In a UK-US agreement, this sort of text could be broadened so that public health measures are excluded from the entire agreement, not just ISDS.

Exclusion of ISDS from free trade agreements is also not without precedent. In the CPTPP, ISDS is excluded between New Zealand and Australia.[29] The free trade agreement recently signed by the US, Mexico, and Canada (USMCA) also limits the application of ISDS, excluding it entirely between the US and Canada.[10] Finally, both the CPTPP and the USMCA were amended before ratification to limit stronger intellectual property provisions around biological medicines.[29 30]

The language used in trade agreements negotiated by the US to frame the right of countries to pursue their own policy objectives is often aspirational or self-limiting

The economic case for a UK-US free trade agreement

The negotiation of a UK-US free trade agreement is happening not only during an enormous public health calamity but also at a moment of great economic uncertainty, with many people having lost their jobs due to the pandemic. How then, should we think about the balance between safeguarding health and the economic effects of the agreement?

There are two main considerations to bear in mind. First, the overall economic gains from an agreement are likely to be relatively small. The US and UK economies are already quite open, and the economic ties between them reasonably deep. Tariffs between the UK and US, for example, are around 3% on average.[31] Further, the US is the single largest investor in the UK and vice versa.[32] Thus, the UK government estimates a boost of just 0.07% to 0.16% to the country's gross domestic product from an agreement with the US.[33]

Second, however small, these estimated gains neglect to account for the potential implementation costs of the agreement, especially those related to increased regulatory burdens, higher drug prices, and defending ISDS claims. When these costs are factored in, the economic case for the measures described above becomes clear. Excluding public health measures from the provisions of the agreement, eliminating ISDS, and limiting intellectual property protections for health related products would not only safeguard public health (which also translates to cost savings) but also help to protect the estimated economic gains of the agreement.

Conclusion

A UK-US free trade agreement could endanger the UK government's ability to manage non-communicable diseases and should be health proofed before ratification. A free trade agreement between the US and UK should exclude government public health measures from all treaty provisions; contain no ISDS; and contain no provisions relating to intellectual property on health related products. Public health practitioners and scholars are urged to draw greater attention to the links between non-communicable diseases and a UK-US agreement. In doing so, they can point to other recent free trade agreements that include safeguards for public health, as well as to the argument that health proofing the agreement would also help protect its estimated economic benefits.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

What is driving the surge in disordered eating?

ROSE LLOYD

As Feinmann points out, the effect of the covid-19 pandemic on disordered eating is striking and seems to be international (Feature, 24-31 July). Reports from North America and Europe accord with our observations in New Zealand of distinct increases in both adult and paediatric patients requiring treatment. Identifying relevant mechanisms is crucial to guide the effective management of these disabling and potentially lethal disorders.

Feinmann's conference report includes the suggestion that "enforced social avoidance" during lockdowns might occur at a crucial developmental stage in children and thereby cause increased disordered eating. Our experience, by contrast, is that the surge in clinical demand for adults rivals that of children, consistent with the idea that lockdown environments exert a powerful influence regardless of age. This fits with evidence that social disruption and altered home environments are common triggering themes. We propose that it is the uncontrollable disruption of social relationships, rather than isolation itself, that drives the problem. In our experience, and as described in India, increased (and unwelcome) social contact during lockdown also seems to have triggered serious exacerbations of disordered eating.

We saw higher numbers of "new" patient presentations in both adults and children after lockdown, indicating that an increased incidence of eating disorders might be occurring alongside exacerbations of existing disorders. Children are more likely to be early in their disease trajectory, but many adults we saw during this time were experiencing a first inpatient admission, consistent with the idea that the problem is being driven by social disruption rather than developmental stage.

Finally, we note that anorexia nervosa is the predominant diagnosis in our inpatients and outpatients seen during and after lockdown. This extends the article's rather limited focus on binge eating and purging in adults. Given the mortality associated with restrictive eating disorders, an increased pandemic related prevalence of anorexia nervosa should be an urgent concern for clinicians, service planners, patients, and their families.

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David B Menkes, associate professor of psychiatry, Hamilton, New Zealand

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COVID EFFECT ON PRACTICE

Covid-19 and GPs: the unmeasured goes unnoticed

Thank you for publishing this piece about how being listened to by her GP helped one patient through a traumatic time (Essay, 24-31 July).

Her point about the unmeasured going unnoticed is critical to protecting what we do as GPs. Increasingly burdensome regulation and evaluation of our services dominate our working lives. There is so little space left for learning from what went well.

We often help the marginalised, the soon-to-be departed, and those without a voice. Our best work happens with these patients and our worst probably with the loudest, most privileged, and influential. What primary care does best is to stand alongside patients, just being with them and resisting the urge to always "do something," particularly in that initial consultation. Future GPs should be supported to feel that, in that first consultation, simply achieving a therapeutic relationship through quiet listening is often enough. We don't need to tick every box or prescribing incentive.

Ellen S V Fallows, GP, Brackley

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GLIOBLASTOMA

Intraoperative monitoring and tumour classification

Glioblastoma is the most common primary brain cancer in adults (Clinical Updates, 17 July). In addition to cortical mapping in awake craniotomies and other operative adjuncts, there is also a place for intraoperative monitoring under general anaesthesia. This is used in lesions involving (or near) the motor cortex. Cortical mapping using intraoperative cortical stimulation is also used to guide maximal safe resection to maintain the patient's quality of life, and this is usually predictive of motor outcome.

The World Health Organization classification of central nervous system (CNS) tumours has been updated. Major changes were introduced focusing on the role of molecular diagnostic methods and emphasising the role of "layered reports," which refers to a reporting style that includes an integrated diagnosis, molecular information, CNS WHO grade, and the histopathological classification of the tumour. Additionally, several new tumour types are included, based on new diagnostics such as DNA methylome profiling.

Ikenna I Ogbu, trust grade fellow—neurosurgery, Stoke on Trent

Cite this as: *BMJ* 2021;374:n2095

VACCINATING CHILDREN

The need for patience

The UK shows restraint in rolling out covid-19 vaccination for adolescents by reserving it for vulnerable children (This Week, 24-31 July). We commend such prudence.

Junior doses of hepatitis A and B vaccines induce better antibody responses than adult doses, so covid-19 vaccine trials with lower doses and vaccines considered "too weak" for adults could be conducted.

The European Centre for Disease Prevention and Control considers the IgG immune response after one vaccination in previously infected people equal to that after two. We could offer IgG antibody testing to adolescent contacts of confirmed SARS-CoV-2 cases and save vaccine doses. This strategy is not in the guidelines; opponents argued that it was too costly. But some covid-19 vaccines are more expensive than IgG tests. We could donate saved vaccines to countries with vaccine coverage <2%. Expeditious global vaccine rollout would be in everyone's interest by avoiding vaccine resistant mutant reservoirs.

Peter A M de Beer, specialist physician and adviser in global health and tropical medicine, Maastricht
Koenraad Van den Abbeele, consultant physician, Slough

Cite this as: *BMJ* 2021;374:n2172

ETHNIC DISADVANTAGE IN TRAINING AND REGULATION

Will the GMC admit its potential racial bias?

Esmail and Everington call for the GMC to eradicate faster the disadvantages faced by ethnic minority doctors in medical education and regulation (Editorial, 24-31 July).

I had an unblemished career for over 40 years until I was reported to the GMC for the death of a patient. Deaths like this happen under white doctors without resulting in prison sentences or suspension of registration. I was imprisoned and lost my career as a colorectal surgeon, even though I was belatedly exonerated in court and at the MPTS.

It took over half a century for the GMC to acknowledge racial disproportionality in referrals. The *Fair to Refer?* report confirmed what we knew. We need similar independent investigation into how ethnic minority doctors are treated after coming in front of the GMC and the MPTS.

Will it take another 50 years for the GMC to admit that its own processes may be racially biased?

David Sellu, honorary consultant surgeon, Hillingdon

Cite this as: *BMJ* 2021;374:n2149

Tackling the climate of fear

Doctors, particularly those from ethnic minorities, have been working in a climate of fear since the high profile prosecutions of Hadiza Bawa-Garba, David Sellu, and Omer Karim.

As well as large protests outside the GMC offices, over £300 000 was raised through fundraising efforts to support a legal challenge to appeal against the GMC's decision to strike Bawa-Garba from the medical register. Similarly, an employment tribunal agreed that Karim was inappropriately investigated by the GMC given that similar complaints against a white colleague were dropped. Doctors fear that they will be unfairly held criminally responsible for honest clinical

errors amid wider systemic failings, such as staff shortages.

Medical students and trainees should feel represented equally and fairly. The GMC must acknowledge its previous mistakes in these past cases and continue to review its practices to ensure that it does not further perpetuate ethnic disadvantage and a climate of fear and blame.

Daniel J Warrington, final year medical student; Anish Verma, final year medical student; Gavin H T Ball, final year medical student; James G S Whiteway, final year medical student; Manchester

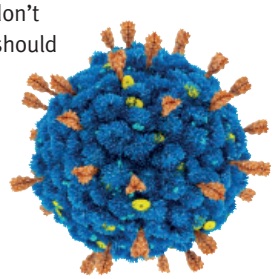
Cite this as: *BMJ* 2021;374:n2171

UK'S COVID-19 HEALTH CRISIS

Improve care pathways now for the next pandemic

How did we let it get to this stage, Abbasi asks (Editor's Choice, 24-31 July). Despite its numerous failures, an emboldened government finally gets the release it needs: attempted herd immunity.

We must escalate our concerns to manager, regulator, and then publicly. It's not too late to expand basic healthcare capacity to manage the oncoming deluge. We are witnessing the effects of the extreme rationing the government is forcing us to enact—delayed cancer treatment, frailer patients, loss of rehab services, and loss of empathy from a morally injured staff. We should expand our capacity to manage covid cases, in novel ways if needed, so we don't have to ration other care. Most critically, we should improve the clinical care pathways for covid so when the next variant or pandemic hits we're not at the mercy of the scientifically uneducated dictating clinical guidelines.



Daniel K Goyal, consultant physician, Oban

Cite this as: *BMJ* 2021;374:n2138

DEFINING COVID-19 ELIMINATION

Beware of surveillance bias

Surveillance bias occurs when health conditions have differential intensity across populations, over time, or according to care setting or type of patient.

On 16 December 2020, the rolling seven day average of new confirmed covid-19 cases was 310 per million people, with a rolling seven day average of 5.1 tests per 1000 people. The number of people in hospital owing to covid-19 was 18 671. Seven months later, the rolling seven day average of new cases was 304 per million people, the number of people tested was 16 per 1000 people, and the number of people in hospital was 1907. Thus, despite similar incidence rates, the epidemiology of covid-19 was strikingly different owing to broader testing and the spread of vaccination (Editorial, 24-31 July).

Public health decision makers must consider other indicators and changes in detection strategy together with the number of new cases to make sound mitigation policy decisions.

Stefano Tancredi, fellow in public health, Fribourg and Modena; Daniela Anker, postdoctoral research fellow and epidemiologist, Fribourg; Laura Rosella, professor of public health and epidemiologist, Toronto; Arnaud Chiolero, professor of public health and epidemiologist, Fribourg and Montreal

Cite this as: *BMJ* 2021;374:n2126

HEALTH AND CARE BILL

The government doesn't want to limit privatisation or integrate services

I am pleased that the BMA has come out against the Health and Social Care Bill (This Week, 24-31 July). If passed, it will disrupt a struggling NHS while diverting time and effort away from patients, making the service even less accountable to local communities.

The secretary of state will be given 138 new powers; repeated reference to "flexibility" leaves plenty of room for reduction in services. The new integrated care systems have populations up to 3.2 million, chair appointments will be signed off by the secretary of state. Chairs can appoint other members and there is no bar on private companies taking seats. Private hospitals have just been given £10bn in the biggest ever privatisation of clinical services.

Some may believe that a government that gave billions to incompetent suppliers and contractors headed by cronies and donors wants to limit privatisation and integrate services. I am not one of them.

John Puntis, consultant paediatrician, Leeds

Cite this as: *BMJ* 2021;374:n2139

OBITUARIES

Tom McGinley

GP (b 1934; q Galway 1958; FFARCS, MRCGP), died after a cerebral haemorrhage on 29 January 2021

Tom McGinley undertook a GP locum role at what was to become Aberfoyle Medical Practice, Derry, stayed on as a partner, and remained until retirement in 1998. His own marathon running inspired many to join him in a cross community, exercise based fundraising campaign, which became the major source of finance for the home care team, and led to the inauguration of the inpatient unit of the Foyle Hospice in 1991. Tom was its chairman and medical director for the first 20 years of operation. He never drew a salary from the hospice. He was able to provide full home care for Deirdre, his wife of 40 years, throughout her terminal cancer illness. She died in 2004. Tom died in the hospice he founded. He leaves four children and seven grandchildren.

Patrick McEvoy

Keith Munro

Cite this as: *BMJ* 2021;373:n1419

Martin George Addy

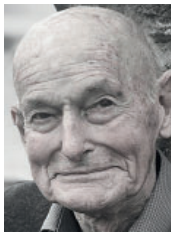
Consultant paediatrician (b 1933; q Bristol 1958; FRCP), died from frailty and multiple pathologies on 12 March 2021

Martin George Addy was born in Stroud, Gloucestershire, the son of Walter and Helen Addy. Soon after qualifying he spent three years of national service as a captain in the Royal Army Medical Corps, a period of his life that he looked back on with pride. He trained in Bristol and Gloucester and was a senior registrar in paediatrics in Oxford and in the Birmingham rotation. He was appointed consultant paediatrician in Burton on Trent in 1973—the first and, initially, the only paediatrician. He had to build up a new department as well as taking responsibility for the whole of paediatrics in Burton. He retired in 1998 and later moved to the Cotswolds. He leaves his wife, Wendy; two sons; two daughters in law; and a granddaughter.

Doug Addy

Cite this as: *BMJ* 2021;373:n1401

John Craig Hay



GP (b 1931; q Glasgow, 1955; DObst RCOG, MD Bangkok, FRCS), died from frailty and heart failure on 9 May 2021

John Craig Hay was a much loved doctor in Uig and Bernera, Isle of Lewis, for more than 30 years until retiring in 1997. His life and career were built on his Christian faith. While at Glasgow University he met Fay MacLeod, who was studying history and Gaelic, and they recognised kindred spirits in both life and faith, deciding to devote their lives to Christian mission. They signed up with the Overseas Missionary Fellowship and served at Manoram Hospital in central Thailand for over nine years before returning to Scotland. John worked briefly as a surgeon in Dundee before responding to an advert for the GP post in Lewis. Predeceased by Fay in 1999, John leaves four daughters; 12 grandchildren; and six great grandsons.

Angus McKellar

Cite this as: *BMJ* 2021;373:n1418

Muriel Davies

Ophthalmologist (b 1934; q Royal Free Hospital, London, 1957; DO Eng, MRCOphth), died from old age and exhaustion, and finally covid pneumonitis, on 7 February 2021

Muriel Davies enjoyed her time at the Royal Free Hospital and worked in various places after qualifying. She was working at St Paul's Eye Hospital in Liverpool when she met her future husband, Stephen. They were married in 1963 and moved to Halifax in 1967 when he became a consultant at the Royal Halifax Infirmary. They worked together in the eye clinic between 1967 and 1990. My mum's work was particularly focused on helping children with squints. In retirement she moved to Ogmore by Sea in south Wales. She made many friends there as she walked her dogs on the beach and common. She was a member of Ogmore Evangelical Church. Predeceased by Stephen in 1999, she leaves two children.

Peter Davies

Cite this as: *BMJ* 2021;373:n1402

Rajinder Prasad Bhutiani

Consultant general and paediatric surgeon (b 1950; q Maulana Azad Medical College, University of Delhi, India, 1974; MS, FRCS), died from covid-19 on 18 February 2021

Rajinder Prasad Bhutiani ("Raj") contracted covid-19 in the course of his NHS duties caring for patients. He was admitted to Northwick Park Hospital on 31 March 2020 and later to Harefield Hospital. He died at the Royal Brompton Hospital. Raj showed tremendous and relentless strength, courage, and determination to overcome covid-19 and make a full recovery. He embraced life with pragmatism and a great sense of humour. In his more than 46 years as a doctor and 43 years as a surgeon, Raj enjoyed a near 34 year tenure with London North West University Healthcare NHS Trust. He was a pioneer of day surgery and proud to establish the first dedicated day care surgery unit in the country at Northwick Park Hospital. Raj leaves Nidhi, his beloved wife of 36 years, and their two children.

Nidhi Bhutiani, Akshay Bhutiani, Aleka Bhutiani

Cite this as: *BMJ* 2021;373:n1434

Nalliah Sivananthan

GP (b 1945; q Colombo, Sri Lanka, 1970), died from natural causes on 20 April 2021

Nalliah Sivananthan ("Siva") trained in Sri Lanka and the UK. He was director at the Alexandra Surgery in Haringey, north London, from 1989 onwards. He occupied leadership positions at independent human rights organisations, media companies, and medical consultancy firms, and was recognised as a forward thinking adviser, tutor, and scholar in primary care, for over three decades. Siva was a junior doctor at the Jaffna Teaching Hospital before moving to the UK in 1981. He served on the Enfield and Haringey medical audit advisory group to improve the quality of patient care and pioneered self-directed learning groups. His passion for change through education led to his being appointed as a postgraduate GP tutor by the London Deanery. Siva leaves his wife, Yogeswary; three daughters; and four grandchildren.

Ainkaran Sivaaji

Cite this as: *BMJ* 2021;373:n1431

Michael Atkinson

Gastroenterology pioneer

Michael Atkinson (b 1925; q University College Hospital, London, 1946; FRCP, MD, MA), died after a heart attack on 9 April 2021

Michael Atkinson's towering status in gastroenterology was highlighted by a device he made from household utensils. The Atkinson tube helps patients with oesophageal cancer to swallow. But asked on retirement for his outstanding career memory, he replied: "Watching Geoffrey Boycott score his 100th century in the test match at Leeds."

Early life and career

Atkinson was the stereotypical Yorkshireman. Innately kind and dedicated, he also had his prickly side, according to friends and colleagues. He studied medicine at University College London during the second world war, winning the Fellowes gold medal as the best student of the year. He became house physician to the illustrious firm of Harold Hemsworth, later secretary to the Medical Research Council, and Max Rosenheim, later Lord Rosenheim, president of the Royal College of Physicians.

The advent of fibreoptic endoscopy enabled Atkinson and others to bring gastroenterology into the medical mainstream

Atkinson became a resident medical officer in Leeds in 1950, where he met his wife to be, Iris Bowman, an anaesthetist. They married the following year after an apparently frosty first meeting when she firmly rebuffed his offer of help with a crossword. In 1952 he moved to the Hammersmith Hospital, London, as a registrar and medical tutor, reporting to the formidable Sheila Sherlock, chair of medicine at the Royal Free Hospital.

Together they produced ground breaking liver research, some of which was allegedly ethically controversial. Sherlock is cited more than 20 times in *Human Guinea Pigs: Experimentation on Man* (1967), the incendiary book by the medical ethicist and tutor Maurice Pappworth, which claims that it had become "common for medical investigators to take risks with patients of which the patients themselves are frequently unaware." Denying any personal wrongdoing, Atkinson, who is cited twice in the book for papers jointly authored with Sherlock, bemoaned the fact that he was one of the first investigators named in the references on account of having a name beginning with "A."

But Atkinson was indebted to Sherlock even though their relationship was not easy. Having the informal qualification BTA (been to America) was more or less mandatory for academics with lofty ambition. Sherlock procured Atkinson a Nuffield travelling scholarship to the US, where he worked on intestinal motility under the leading US gastroenterologist Walter Palmer. This was another major influence on his career.

Atkinson returned to University College Hospital, London, as registrar to the dean, who was also president of the Public Schools Exploration Society. In one of his own favourites from a vast fund of anecdotes, Atkinson recounted how every summer the dean would declare: "Well I'm off exploring the Arctic. Look after the shop, Atkinson. I'll be back in the autumn." Yes, this was a wholly different era.

Postgraduate education centre

Atkinson also spent several years in Leeds researching gut disorders with Geoffrey Watkins and Geoffrey Chandler before moving to Worcester, where he was instrumental in setting up a postgraduate education centre. The Charles Hastings Education Centre was the first such institution in a district general hospital. The initial meetings were held around the same board table used by Charles Hastings when he founded the BMA in Worcester in 1832. The table is still in use at the centre.

But research opportunities in Worcester were limited. The opening of the better resourced medical school in Nottingham, where he became special professor of gastroenterology, and the advent of fibreoptic endoscopy enabled Atkinson and other pathfinders to bring gastroenterology into the medical mainstream. Until this time it had been largely restricted to diarrhoea and ulcers, which it had erroneously attributed to excess acid.

In Nottingham, Atkinson shifted his major research interests to the oesophagus, focusing on motility disorders and management of swallowing. His consultant colleague and one time next door neighbour, Peter Toghill, said, "This was the most productive part of his career." It included the development of the Atkinson tube, later versions of which are still in use.

Publishing extensively, Atkinson taught and travelled the world, albeit never flamboyantly. Toghill said, "He was one of the old fashioned clinical investigators—a breed that has almost gone. He was heavily involved in the British Society of Gastroenterology. Many of us felt he should have been made president."

The Atkinsons retired to Witherslack, Cumbria, in the Lake District. He was a keen gardener and a passionate walker, and took a history degree at the University of Lancaster. A man renowned for a remarkable retentive memory, he developed dementia when he was approaching 90. Iris died in 2011. Atkinson leaves his four daughters and eight grandchildren.

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