General practice is at a crossroads. The work is relentless, and the workforce is diminishing year on year. I see colleagues all around me, who were previously full of passion, now drained and disillusioned. The job itself should feel full of opportunity—yet more than a third of GPs plan to leave the profession within five years. Workload is partly to blame, but I also think the professional structure needs a serious overhaul.

Partnership has traditionally been viewed as the pinnacle of a GP’s career. It brings autonomy: a sense of control over how you run your practice, see your patients, and work with your colleagues. Many GPs also strongly believe partnership fosters a unique commitment to one’s population and provides one of the most cost effective models of primary care delivery.

But partnership also entails some unquestionable oddities. Overnight, GPs who mostly have no training beyond clinical medicine become owners of a small to medium sized business. They’re in charge of a budget, accountable for the safe running of a practice, and responsible for employing a range of staff, both clinical and non-clinical. It’s fair to say few of us are fully prepared for this, given that we’ve spent most of our working years learning the art and science of practising medicine, not running a business or learning about HR.

We see huge variation in how practices are run, from site maintenance and how professional the website looks to how technology is used and methods of recruiting and retaining staff. These usually reflect leadership that’s either sinking or swimming, in an ever changing and pressurised system.

Another difficulty with the partnership model is that it’s no longer financially viable to have an all partner model, which was how most practices traditionally operated. With successive years of underinvestment in general practice, the only way for partners to now make a profit is to have a lean management structure with a few profit sharing partners and many more salaried GPs, who have no financial stake in the practice.

How have we ended up with partners and salaried GPs pitted against each other, with the progression of one group not in the best interests of the other? I’m sure harmonious relationships exist in many places, but you only have to look at GP social media groups to get a sense of the tension this divide creates.

Partners, salaried GPs, and locums all have vested interests, which is partly why we’ve failed to campaign successfully for the change needed to make general practice a sustainable and enjoyable career again. Now more than ever we need a single unified voice, but I don’t believe we’ll achieve this without major reform that brings our profession together.

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The NHS is falling over. Not everywhere, but in some places and in some services the signs of extreme stress are manifest. These signs are the result of the irresistible force of rising demand for care meeting the immovable object of constrained capacity.

Something has to give. For an increasing number of patients, timely access to acceptable standards of care is no longer possible. For staff the challenge is to deal with unprecedented workloads when vacancy and sickness levels among their colleagues remain high. The psychological safety of staff is at risk, with consequences for themselves and the patients they treat.

Evidence of stress can be found in many places. University Hospitals Birmingham NHS Foundation Trust was recently downgraded by the Care Quality Commission, with standards of care in emergency departments a particular concern. At Brighton and Sussex University Hospitals NHS Trust surgeons and anaesthetists have expressed concerns about delays in the treatment of time-critical emergency and trauma cases. Nottingham University Hospitals NHS Trust has restricted the provision of chemotherapy services because of staff shortages and has been downgraded by the CQC, with emergency services and maternity services both being a concern.

General practices are also in the firing line. Despite carrying out record numbers of appointments, practices have been criticised for delays in seeing patients and not offering face-to-face appointments to all those requesting them. In response NHS England has published a plan for improving access and supporting practices, but attacks on general practices in the media and by ministers has accentuated the pressures that practices are under, even with the additional funding that has been announced.

The ambulance service is a signature example of the state of the NHS today. There are growing concerns at the length of time ambulances are required to wait to hand over patients at hospitals because of the volumes of patients attending emergency departments. Lengthening handover times put patients at risk and delay the ambulance service responding to other calls because its teams cannot be released to do so. The Royal College of Emergency Medicine and the College of Paramedics have warned that handover delays threaten patient safety.

Social care
Social care faces challenges that are equally significant and growing. Staff shortages resulting from Brexit and competition from the retail and hospitality industries have accentuated these challenges. Some care homes are having to cancel their registrations to provide nursing care, leaving residents to look for places in areas that are at or close to capacity. The CQC has rightly highlighted adult social care as a major concern in its new report on the state of health and social care.

One of the consequences of what is happening in social care is that hospitals are experiencing increasing difficulties in discharging patients who are medically optimised. This puts even more pressure on hospital beds and contributes to the growth of corridor care in emergency departments. The interdependency of health and social care underlines the need to find sustainable solutions for both, encompassing funding and staffing.

Where does covid fit into this picture? Around 8000 patients with covid are currently in acute hospitals and around 800 are in intensive care. While not trivial, these numbers are much lower than at the peak in January 2021, but they are nevertheless contributing to stress across the NHS.

The reason is simple. Core capacity, such as hospital beds and intensive care facilities, has been reduced over many years, leaving no buffer to deal with surges in demand. Relatively small changes in demand therefore have significant impacts of the kind that are now appearing.

To claim that the NHS is coping—as Sajid Javid, the secretary of state for health and social care, did recently—is stretching credulity to its limits. My experience as a non-executive director of an NHS foundation trust and chair of an integrated care system is that the NHS and its partners in social care are working tirelessly to respond to the needs of patients and service users, but staff face a Sisyphean task.

Tackling the backlogs that have built up during the pandemic will take time, added to which are the challenges of the coming winter and uncertainty over covid.

The service needs investment, with a fully funded and credible workforce plan the top priority.
ACUTE PERSPECTIVE David Oliver

Should single rooms be the default?

The national medical director for NHS England, Stephen Powis, recently told MPs on the health and social care committee that, after the pandemic, “single rooms should be the default” in NHS hospitals, to “improve infection control, privacy, dignity, and patient flow issues.” Most NHS wards have a mix of open bays and single or double side rooms. With the exception of some recent new builds, the beds in open bays still predominate.

Many of our hospitals are decades old and subject to a major maintenance backlog. Insufficient capital has been made available for new builds, upgrades, and redesign.

The solutions lie in continuing to protect the NHS to ensure that all patients receive timely care of a high standard. Protecting the NHS means, above all, taking care of staff, valuing their work, retaining staff by offering flexible contracts, and attracting back staff who wish to contribute.

It is hard to exaggerate the negative impact of the pandemic on the health and wellbeing of staff. Continuing service pressures have amplified this impact, as illustrated in the CQC’s reports, discussed earlier. An example was the report on Birmingham, which raised concerns about staff feeling under pressure to provide care in a way they felt was unsafe in response to workloads in emergency departments, highlighting the challenge of psychological safety in the workplace.

The government now needs to invest resources to build the resilience in health and social care that was lacking during the pandemic. Core capacity including staff, beds, and equipment must be expanded and paid for by an earmarked fund separate from the budget needed for existing services to ensure it is used for capacity building. The highest priority is a fully funded and credible plan to train and develop the workforce of the future, without whom there will be no NHS and social care.

There is still time to save the NHS, but time is running out. Ministers need to get out more and see for themselves the realities on the ground. They might then form a more realistic assessment of what is happening and what needs to be done.

Older patients can feel isolated, neglected, and lonely in side rooms.
Could it be covid?

Every year, as the weather turns colder, many patients present to their GP with symptoms of a respiratory virus. All GPs have a well rehearsed explanation about why this three day cough accompanied by a sore throat and runny nose is viral, rather than bacterial, and won’t be helped by antibiotics. The routine has been adjusted this year to include an extra question: “Have you done a covid test?” In most cases the answer is no, which is understandable but alarming.

The government’s coronavirus website still lists the main symptoms as a high temperature, a new continuous cough, and a loss or change in sense of taste or smell. If you have these symptoms you can order a PCR test for coronavirus. This list hasn’t been revised, even though we know that these aren’t the main symptoms of the delta variant. Headache, sore throat, and runny nose are the three most common symptoms in unvaccinated people, in data collected through the Zoe Covid Symptom study, which has 4.7 million people logging their symptoms daily. Fever and persistent cough are fourth and fifth, and in vaccinated people only one of the original symptoms—persistent cough—makes it into the top five (and only just), being less common than sneezing.

Patients should be forgiven for feeling certain that they don’t have covid (although some have been described as having Schrödinger’s cough—simultaneously severe enough to need antibiotics but not bad enough to be covid). There has been no public messaging stating that these common respiratory symptoms could be caused by coronavirus, despite a much wider range being published in WHO’s case definition nearly a year ago and numerous subsequent calls for a change in UK government guidance.

If we want to halt the spread of covid, we need to empower people to recognise when they may be infected and enable them to access accurate testing to find out. If they rely on information based on an outdated and inaccurate case definition, they risk infecting vulnerable people and perpetuating the pandemic by mixing freely at school or work and in public.

On a more personal note, patients are being encouraged by the press and politicians to demand to be seen face to face. This puts GPs and their teams at risk, as the screening questions used for covid are likely to miss many cases.

There’s a parallel here with the persisting prominence of handwashing in official messages about covid precautions (for example, on the UK Health Security Agency’s Twitter feed). Clean hands are a good idea, but fresh air is far more likely to prevent infection by an airborne virus. I really want to keep my patients safe, but it feels like an uphill struggle when so much information they receive from ostensibly trustworthy sources is misleading.

We need to empower people to recognise when they may be infected

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Mind the gender health gap

The latest episode of Sharp Scratch focuses on the gender health gap and whether the medical curriculum is doing enough to equip future health professionals with the skills to overcome it. Joining the team is Elinor Cleghorn, author of Unwell Women: A Journey through Medicine and Myth in a Manmade World, who charts the history of medical misdiagnosis of women:

“The gender health gap is something that we’ve come to understand over the past two decades or so, since sociologists in medical research have been trying to investigate why it is that women tend to experience disparities when navigating health and medical systems. But the origins of the gap are very long and, in my book, I put the gender health gap square at the feet of Greece. There are many different factors involved in why one’s gender affects the kind of healthcare you get. This ranges from social and cultural factors that exhibit deeply embedded ideas about how women and people of marginalised genders respond to their illnesses and pain. But medicine in general also just has less knowledge about some of the more complex health conditions that tend to affect women and people of marginalised genders disproportionately.”

A QI approach to improving your wellbeing

In this podcast Pedro Delgado, vice president of the Institute for Healthcare Improvement, explains how he turned some of the QI methodology he’s been taught over the years on himself, and improved his wellbeing during the pandemic. He explains how traditional QI and improving your wellbeing both rely on shaping the changes you make to your own context:

“Improvement always has to be local. For us as individuals, that applies too: improvement is individual for us and has to be something that works for you in your reality.”

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Edited by Kelly Brendel, deputy digital content editor, The BMJ
The hidden pandemic

Inaccurate mortality data from under-reporting of covid-19 deaths impedes equitable responses to the pandemic, write Charles Whittaker and colleagues, suggesting ways forward.

Estimating mortality attributable to different diseases, risk factors, or events is pivotal to inform resource allocation and evaluate public health interventions. Information on death rates and burden also supports wider aims of societal governance, public accountability, and memorialisation. Recent examples of mortality estimation include the true toll of hurricane Maria in Puerto Rico, mortality during famine in Somalia, and the war in South Sudan.

Mortality data have also been essential in understanding the spread of covid-19. However, under-reporting in official death records has greatly obscured this understanding. We explore why under-reporting of deaths should have been expected, examine how use of alternative mortality sources can help advocate for a more equitable pandemic response, and highlight the crucial need for increased investment into civil registration and vital statistics systems before the next pandemic.

Importance of accurate covid-19 mortality data

Accurate understanding of the spread of covid-19 is crucial in navigating the trade-offs that underlie political decision making, including considerations of public health, economic growth, and civil liberties that must be integrated into pandemic responses at the national level. Internationally, it is equally crucial in justifying and framing decisions surrounding global allocation of limited resources such as vaccines and therapeutics. Using case data as a metric for appraising control measures and tracking local epidemics is challenging because the frequency of asymptomatic infections, non-specific symptoms of mild disease and limitations in testing capacity result in substantial underascertainment of cases. Mortality data on covid-19 are thought to be less susceptible to underascertainment than case numbers and have therefore been widely used to understand the dynamics of the pandemic and inform public health responses.

Underascertainment of mortality is common in infectious diseases

A recent global assessment of global health system capacity by the World Health Organization suggested that almost 40% of the world’s deaths (irrespective of cause, and in non-pandemic periods) are not registered. Understanding the true extent of mortality associated with infectious diseases is complex and challenging, most notably in resource poor settings where limited diagnostic capacity and access to healthcare mean many deaths are missed. For malaria, less than a quarter of estimated deaths appear in official national statistics; for yellow fever, less than 1% of the estimated 50 000 deaths a year across Africa are reported; for tuberculosis, both global estimates and hospital postmortem studies suggest large numbers of deaths are not correctly attributed to the disease.

All of this suggests that relying solely on official mortality statistics for any of these diseases would lead to an incomplete and deeply biased understanding of their impact. Is this any different for covid-19? The answer, we argue, is no. Accumulating evidence suggests officially reported covid-19 deaths provide an inadequate picture of the true dynamics of SARS-CoV-2 epidemics (table). This obscures our ability to understand the true burden of the pandemic, evaluate the complex trade-offs surrounding control of transmission, and advocate for a globally equitable and effective pandemic response.
11-68% of excess deaths. Analyses of city burials have been used in many settings in the absence of all-cause mortality data. Rapid mortality surveillance from Addis Ababa, Ethiopia, suggested only limited underascertainment, with covid deaths representing 82% of excess mortality in the third quarter of 2020. Before data on excess mortality were available, crematorium reports during the second wave in India (right) were the first source that indicated extensive underascertainment of deaths, with as few as 1% of covid-19 deaths reported in some places.

Global variation in underascertainment

Evidence for widespread underascertainment of covid-19 deaths comes from various sources. Excess death statistics (total mortality compared with baselines from previous years) have been widely used since the start of the pandemic. Although the proportion of excess deaths caused by covid-19 or indirect effects of the pandemic remains uncertain, excess mortality is often viewed as a more objective indicator of the pandemic death toll than officially reported deaths from covid-19.

Modelling of excess mortality trends suggests that at least half of covid-19 deaths have been missed globally and, at worst, 75%. This global estimate, however, masks wide variation between countries. Results from many European countries suggest at least 75% of covid-19 deaths feature in official reports, but in other settings this proportion is far lower. In Peru, re-analysis of death certificates and covid-19 case definitions resulted in a tripling of official covid death rates and closer alignment with excess mortality. Across South Africa, estimates of excess deaths have also reached more than three times the number of officially confirmed deaths, and estimation from many sources in India suggests only 10% of covid deaths have been officially reported. In Brazil, by contrast, surveillance of severe acute respiratory infections suggests roughly 80% of covid-19 deaths have been recorded.

National estimates are likely to mask further local variation—regional estimates of excess deaths across South Africa highlighted substantial variation among provinces, with covid-19 accounting for 11-68% of excess deaths. Covid mortality can be estimated from excess deaths only when reliable mortality data are routinely available. In many settings, estimates of unreported covid deaths must rely on alternative sources, including data from burials, cemeteries, and crematoriums as well as postmortem surveillance studies from hospital mortuaries (box 1). These unofficial sources confirm substantial variation in the under-reporting of covid-19 deaths across settings without routine collection of mortality data. In addition, these studies help identify the factors that lead to covid-19 deaths being undetected, such as lack of diagnostic testing or limited access to secondary healthcare (leading to deaths from covid-19 in the community).

Gaps in covid-19 surveillance are likely to be even more prevalent in countries affected by conflict. Recording and sharing information is often difficult in these settings, hindering accountability, accessibility, and transparency. These obstacles have motivated citizen science initiatives operated through social media to identify unreported covid-19 deaths. Such activities often reveal extensive under-reporting of covid-19 deaths (box 2). While unconfirmed covid-19 deaths ascertained from alternative sources should be treated with caution, these results highlight the extent to which covid-19 might have spread unobserved across many parts of the world where surveillance of community deaths is weak or absent, such as Yemen and Syria.

In other countries, hackers gained access to non-public datasets to reveal the true scale of mortality during the pandemic. In Belarus, the hacker group Cyberpartisans gained access to data showing that excess deaths for the city were more than double the official covid-19 death toll by February 2021.

Box 1 | Alternative sources of data on deaths

Burial patterns

In one study from Jakarta, Indonesia, officially reported covid deaths accounted for about 25% of recorded funerals of people who had had confirmed or probable covid-19. Other analyses showed there were 61% more burials in Jakarta from January to October 2020 compared with the same period in 2015-19.

Analyses of city burials have been used in many settings in the absence of all-cause mortality data. Rapid mortality surveillance from Addis Ababa, Ethiopia, suggested only limited underascertainment, with covid deaths representing 82% of excess mortality in the third quarter of 2020. Before data on excess mortality were available, crematorium reports during the second wave in India (right) were the first source that indicated extensive underascertainment of deaths, with as few as 1% of covid-19 deaths reported in some places.

Postmortem diagnosis

In Lusaka, Zambia (left), a postmortem survey in the country’s largest tertiary care hospital suggested that only about 10% of people whose deaths were recorded as related to covid had had a diagnostic test before death. Additionally, 73% of the covid deaths captured by the study had occurred in the community, where none of the deceased had had a test, highlighting how treatment seeking behaviour can lead to important gaps in surveillance.

Further analysis revealed that covid-19 mortality in Lusaka was highly skewed towards younger age groups compared with higher income countries. This shows how auxiliary data can provide a more complete picture of covid-19 morbidity and mortality than use of officially reported cases and deaths alone.

Box 2 | Citizen science initiatives

Citizen science initiatives have been relied on in some settings to shed light on the scale of the pandemic. These include drone footage of cemeteries in Aden, Yemen, which provided one of the first indications of under-reporting in the city and later prompted the use of satellite imagery to quantify burials.

Similarly, satellite imagery of mass graves in Damascus, Syria, hinted at higher covid death tolls than officially reported. The images prompted an investigation using obituary certificates uploaded by citizens to model the epidemic in Damascus.

The two studies suggested that as few as 1 in 80 covid deaths feature in officially reported mortality statistics in Damascus and Aden.

6 November 2021 [The BMJ]
Understanding the past, advocating for an equitable future

These realities paint a complex picture of the spread of covid around the world—one that is fundamentally different from many prevailing narratives.

Underascertainment of covid mortality obscures our understanding of the pandemic’s progression, the effectiveness of interventions, and the optimal allocation of resources. Modelling studies in Jakarta found that the effect of city-wide physical control measures is most clearly visible in data on excess funerals rather than official cases or deaths.¹⁹

Accurate mortality data also help track the pandemic’s maturity and assess the relative contributions of physical control measures and population level immunity in declining transmission. This in turn helps inform the most appropriate level of interventions and enables more accurate weighing of the benefits of maintaining social distancing against the societal costs of continued closure of schools or workplaces.⁴⁰

The accuracy of mortality data also has consequences for the distribution of vaccines.⁴¹ To date, vaccines have overwhelmingly been delivered to higher income countries,⁴² and initiatives supporting equitable distribution have been unable to ensure adequate population coverage elsewhere. This unequal distribution reflects stark global disparities in access to healthcare resources. A more accurate understanding of the global burden of covid would not wave away the non-technical, structural, and political reasons that have seen many poorer countries excluded from access to vaccinations and other resources. But the situation has not been helped by narratives based on inaccurate official mortality statistics suggesting some countries have been largely “spared” the worst effects of the pandemic. These inaccurate data obscure the true picture, both by hiding deaths and by underestimating the effectiveness of interventions in settings that successfully limited transmission through timely implementation of control measures. This perpetuated the myth that public health and social measures were not critical to pandemic control, contributing to the collapse of many health systems during epidemic waves.

Inaccurate data obscure the true picture, both by hiding deaths and by underestimating the effectiveness of interventions

What can and should be done?

Collection and analysis of accurate population mortality data should be urgently scaled up in settings lacking reliable death registration systems. This will prevent existing global inequities in surveillance from conspiring further with parallel inequities in access to treatments and wider determinants of health. Rapid, retrospective, or prospective collection of mortality data is possible and, although not as accurate as estimates of excess mortality, can provide useful, timely, and actionable information in crisis settings. Examples include rapid household surveys,⁴³⁴⁴ records from burial sites⁴⁵ or their remote analysis through satellite imagery,⁴⁶ key informant studies and capture-recapture analysis of lists of deaths,⁴⁶ and verbal autopsy surveys.⁴⁷ Social media or other civil society sources can also be used to reconstruct mortality trends in the absence of complete mortality data.⁵⁵

The most suitable method will vary between settings—for example, civilians or social media groups may only collect lists of deaths in response to conflict or in the context of religious practices. Satellite imagery will be effective only in locations with geolocated and regularly used cemeteries, while postmortem surveys are unlikely to be representative if people dying in the community are not routinely brought to mortuaries.

Such data gathering exercises should be seen as short term solutions and not as a substitute for long term investment in civil registration and vital statistics systems. Better death registration and certification should be a cornerstone of future pandemic preparedness plans and is essential for achieving sustainable development goals to “leave no-one behind.”⁴⁸ This will require improvement to existing registration systems, the establishment of global standards for defining and reporting pandemic deaths, and the creation of robust governance frameworks that mitigate political interference.

Recent efforts by WHO, including its technical advisory group on covid-19 mortality assessment and the report on global health systems capacity,⁷ are encouraging. Comprehensive descriptions of the status quo are a good start but must be accompanied by investment to improve civil registration, targeted implementation of technological innovation, and tailored solutions to overcome the economic, political, and sociostructural barriers in each setting.⁴⁹

Equally important is establishing robust safeguards to avoid distortion of official statistics for political motives. Politicisation of covid death reporting is common and influences whether they feature in official statistics.⁵⁰ Improvements to registration systems alone are therefore unlikely to resolve the many remaining problems with death ascertainment. A robust governance framework is therefore equally critical and must accompany any future improvements to system capacity.

Without these improvements, biases in surveillance that cause the greatest underestimation of cases and deaths where access to care is lowest will continue to obscure understanding of this pandemic and hinder efforts to prepare more equitably for the next.
Evaluating drugs and vaccines in pregnancy
Routine exclusion is no longer an option

Inconsistent messaging from authorities, driven by lack of trial data, has increased covid-19 vaccine hesitancy among pregnant women. This, coupled with the increased transmissibility of new variants and relaxing of social distancing restrictions, contributed to the surge in hospital admissions seen in successive waves. Concerns around the longer term effect of covid-19 post partum, including long covid, cardiovascular complications of covid-19, and widening socioeconomic disparities are also mounting. Despite a desperate need for treatments, pregnant women continue to be left behind.

In the long shadow of the thalidomide and diethylstilboestrol tragedies, only one drug designed for use in pregnancy, atosiban, has been licensed in four decades and only five prescription medicines (amoxicillin, labetalol, dexametidine injection, doxylamine with pyridoxine, sodium feredetate) are licensed for non-obstetric use in pregnancy in the UK.7

Covid-19 vaccination is currently recommended in pregnancy, based on developmental and reproductive toxicology studies in animals, a positive risk-benefit profile in women of childbearing age, and post-marketing data from vaccinated pregnant women and their infants, rather than clinical trials.11 But despite cumulative data from over 200 000 pregnant women showing the effectiveness of vaccination,12,13 low public confidence remains. The effect of vaccine hesitancy may, worryingly, cross over to other vaccinations such as influenza.

Off label
It is essential to eradicate endemic off-label prescribing in pregnancy, which excludes women and their babies from the protections afforded by the rigours of the licensing process and creates unacceptable ethical and legal dilemmas for clinicians.

Off label prescribing in pregnancy includes prioritisation of developmental and reproductive toxicology studies at the start of drug development, consideration of physiologically based pharmacokinetic modelling, and ensuring pregnancy experts are involved in clinical trial development and in trial steering and monitoring committees.

Consulting women and organisations representing their interests and those of their babies is key to ensuring pregnancy is not routinely used to exclude people from trials without clear scientific grounds. These measures would encourage medicine developers to include pregnant women from the start of the process.

Radical change
The covid-19 pandemic is radically changing the clinical trials landscape, catalysing collaborative drug development between academics, industry, and regulators, and accelerating implementation of research findings. Equity and inclusion are essential to scientific advancement, and the benefits of innovation and drug discovery should safely reach everyone.

We urge regulators and governments to implement these strategies for pregnant women and their babies, who for so long have been left behind in medicines and vaccines development. An urgent shift in policy and investment is required to ensure inclusion becomes the norm in development plans, unless otherwise fully justified. This will help counter vaccine hesitancy and improve confidence in the use of new treatments, leading to better health outcomes for women and their babies.

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Find the full version with references at http://dx.doi.org/10.1136/bmj.n2377
Government still doesn’t understand the NHS

Many clinicians will be concerned that a retired general is to lead a major review of England’s NHS to “strengthen leadership” and “drive efficiency” (News Analysis, 9 October). A cynic might ask if Gordon Messenger will be using the Ministry of Defence’s esteemed model of efficiency or whether a clinician might be sent on exchange to review the Ministry of Defence’s problems. This government remains unable to understand the NHS, why it is in such trouble, and why leaders from the armed forces or business, however eminent in their own field, can’t just transfer their experience to health.

When almost every NHS trust is in financial difficulty, the problem is the financial framework rather than individual competence. Although some trust chairs and chief executive officers are better than others, the Department of Health and Social Care and NHS England have at least a say in all the appointments, so the general might need to look first at these bodies.

Training people how to lead is relatively easy, but deciding where they lead is another matter; too often they lead in perverse directions chosen by politicians who still seek to privatise the NHS, perhaps covertly using this review. Of course we need good leadership and sensible efficiency, but they won’t solve the staff shortages that are crippling primary and secondary care or the epidemic of chronic disease overwhelming services.

The priority is for a national debate on what sort of NHS we now need and whether we continue entrusting our health service to any single political party and the electoral cycle. Health is always political, but we need better ways of bringing politics and services together.

I doubt that we’ll have to wait long to find out what’s truly behind the government’s new review.

David Levine, retired consultant physician, Sennen

Cite this as: BMJ 2021;375:n2632

Why doesn’t the NHS employ its own managers?

Bruch and colleagues perpetuate the belief that management consulting is a racket while failing to ask why the use of management consultants is so prevalent in the NHS (Editorial, 25 September).

I’ve proposed that their use is a consequence of the service’s lack of management capacity. Not many people seem to agree, but much of what consultants do for the NHS should be routine work in any organisation with sufficient management capacity.

Although the NHS was severely undermanaged before its decimation by Andrew Lansley, it has added about 30% more doctors since Lansley started as health secretary but still has fewer managers. Ian Kirkpatrick, who provided the key evidence that consultants often don’t add value to hospital trusts, has new unpublished data showing that hospitals with more managers are less likely to use consultants.

Perhaps we should be asking why the NHS is so reluctant to employ its own managers.

Stephanie Black, data scientist, Biggleswade

Cite this as: BMJ 2021;375:n2545

Effectiveness of consultancy is unclear in New Zealand

Our research on the use of consultants and contractors in the New Zealand healthcare system has yielded similar conclusions to those of Bruch and colleagues on the use of private management consultants in public health.

In New Zealand, dependence on consultants has been rising steadily for seven years. It now well exceeds public funds allocated to health research (although it is hard to be exact as there remains a lack of clarity around the sums allocated to consultancies). Yet, there has been little progress towards better monitoring or the development of effective measures to capture the benefits of consultant expenditure. Consequently, the effectiveness of consultancy services remains uncertain.

We agree that more rigorous evaluation of the value imparted by external consultants is urgently needed. Further, the outcomes of private sector expertise paid for by public funds should be held to the same levels of transparency as the public system.

Adeel Akmal, research fellow; Robin Gauld, dean and pro-vice chancellor; Erin Penno, lecturer, University of Otago, New Zealand

Cite this as: BMJ 2021;375:n2556

Overprescribing in primary care

We’ve known the solution since 1995

A government review estimates that 10% of items dispensed in primary care are inappropriate (This Week, 2 October). The solution to this problem—full integration of pharmacy into the primary care team—was published in The BMJ in 1995 in an editorial written by my colleague and me.

There is a long established waste of intellectual horsepower, money, and time in the separation of prescribing and dispensing in primary care. The improvements in quality of service, prescribing optimisation, professional liaison, and financial savings are vast. Scores of billions of pounds have been wasted since 1995, and who knows how much morbidity and mortality might have been avoided.

Complete integration of pharmacy into primary care is so self-evidently the right thing to do that failing to do so makes even less sense than Brexit. Presumably the answer lies, as ever, in the answer to the question: who benefits?

Steven Ford, retired GP, Haydon Bridge

Cite this as: BMJ 2021;375:n2627
OBITUARIES

John Thurston
Consultant emergency physician (b 1937; q Guy’s Hospital, London, 1961; FRCP, FCEM, FIFEM), died after a short illness on 7 July 2021
John Thurston was born in London and went to Haileybury School in Hertford. Early appointments in cardiology at Westminster were followed by a consultant post in the A&E department at Queen Mary’s Hospital, Roehampton. Similar appointments followed until his final appointment at Darent Valley Hospital in Dartford. From the late 1980s he was involved in developing a training pathway for A&E doctors and growing the specialty. The British Association for Accident and Emergency Medicine established a future strategies group, with John as its secretary. As a result the Intercollegiate Faculty of Accident and Emergency Medicine was inaugurated in November 1993, with John as its first registrar. With his third wife, Stephanie, he retired to the West Country. He leaves Stephanie, five children, a stepson, and seven grandchildren.

David Yates
Cite this as: BMJ 2021;374:n2007

Kenneth Roland Kidd
Family doctor and educator (b 1927; q Bristol 1950; MRCGP, DObst RCOG), died from sepsis on 7 April 2021
Kenneth Roland Kidd (“Ro”) was in his own modest way a leading light in the development of primary care on the Isle of Wight. From 1956 to 1974 he worked to provide holistic care to his patients and was recognised for the innovations in healthcare delivery that he led. Ro then moved to Saudi Arabia, initially to the military hospital in Khams Mushayt. He became chief of primary care and emergency services at the military hospital in Jeddah. He established a highly integrated model of primary and secondary care, before moving to Riyadh as a tutor in primary care. Ro leaves June, his wife 39 years; his first wife, Joan, and their three sons; grandchildren and great grandchildren; and many friends from around the world.

Paul Barker
Cite this as: BMJ 2021;374:n2002

Gwen Douglas
Child psychiatrist and psychoanalyst (b 1920; q St Andrews 1944; FRCPsyCh), died from ischaemic heart disease on 22 June 2021
Gwenth Jean Elizabeth Douglas (“Gwen”) was born in New Zealand and came to England when she was 15. She later moved to Malta with her husband and they had a son. On returning to the UK in 1949 Gwen trained in psychiatry and also qualified as a psychoanalyst in 1956. She published a short but influential paper on giving psychotherapy to six mothers with puerperal psychosis. Gwen became consultant child psychiatrist at Sutton Child Guidance Clinic in 1963 and worked there until 1986. She later worked as a clinical assistant in psychiatry in the obstetric department of University College Hospital. She retired from the NHS in 1991 and continued to practise privately as a psychoanalyst until the age of 86. She was predeceased by her husband and son.

Peter Shoenberg
Cite this as: BMJ 2021;374:n2000

Allan C Prentice
Lead physician and responsible officer International SOS (Medical Services) UK Limited (b 1960; q Dundee 1982; CH, FFOM), died suddenly and unexpectedly from a cardiac event on 20 May 2021
Allan C Prentice joined Offshore Medical Support (OMS) in Aberdeen in August 1988. He worked through the many iterations of OMS and worked in all areas of occupational medicine but had most involvement in the offshore services, remaining active in both on-call rotas throughout his professional career. Allan also provided medical advisory services to many of the North Sea operators, as well as to the local councils, the University of Aberdeen, and the local paper industry. Allan had just made plans to reduce his work commitment to 60% from 1 June and had planned a long and active retirement. He leaves his wife, Susan, and two children.

Stuart Scott
Cite this as: BMJ 2021;374:n2004

Tom Duncan
Consultant general and endocrine surgeon South Tees District General Hospital (b 1931; q St Andrews 1953; FRCS (Ed)), died from linitis plastica on 13 April 2021
Tom Duncan was born in Perth and educated initially in Paris. He subsequently trained in London and thereafter at Aberdeen Royal Infirmary as a registrar and then senior registrar before being appointed to his consultant post. During his time in Aberdeen Tom spent a sabbatical year as a Medical Research Council research fellow. He had a particular interest in thyroid and parathyroid surgery. He was a superb teacher, an excellent surgeon, and a very supportive mentor to his junior colleagues, earning their lasting gratitude for his kindness and friendship. Aside from surgery he had an extraordinary knowledge of English literature and enjoyed travelling, skiing, golf, and listening to classical music. He leaves a sister in Tasmania.

Michael Walker, John Duthie
Cite this as: BMJ 2021;374:n2001

Malcolm Yorston
Consultant anaesthetist Southampton General Hospital (b 1924; q Aberdeen 1953; FFRACs), died from frailty of old age on 23 May 2021
Malcolm Yorston studied engineering at Bristol university, but this came to an abrupt end when he accepted the invitation of his father to help run the oil refinery at Avonmouth. He completed basic artillery training and volunteered to be seconded to the Indian Army. On returning to Bristol, he was rejected by the university as he was considered too weakened by recurrent bouts of dysentery, and parasitic infections, to survive the course. Instead, he went to study medicine in Aberdeen and subsequently trained in anaesthesis. At medical school Malcolm met Jessie Millar, one of the few female medical students in Aberdeen at that time. They were married in 1954 and were together until Jessie’s death in 2018. Malcolm leaves two children, four grandchildren, and one great grandchild.

David Yorston
Cite this as: BMJ 2021;374:n2009

Michael Walker, John Duthie
Cite this as: BMJ 2021;374:n2001

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OBITUARIES

Nigel Hawkes
Medical journalist and director of Straight Statistics

Nigel Hawkes (b 1943), died from a heart attack on 6 October 2021

In June 2010 the medical journalist Nigel Hawkes, who has died from a heart attack at the age of 78, ran into one of Health Secretary Andrew Lansley’s advisers whom he knew well and whom he greeted warmly since they were old friends. “You’re a troublemaker,” she hissed, “always writing those ghastly articles in The BMJ.” And she turned away.

This story, recounted in one of Hawke’s columns, demonstrates one of his great strengths as a journalist. He was well known for being politically right of centre in his private life, but he never allowed party preferences, personal prejudice, or pettiness to cloud his judgment when it came to writing.

He was also unique in being able to take an impenetrable statistical conundrum and not only explain it to you clearly but delight you with his explanation. He made statistics fun and sweetened even the most labyrinthine complexities of NHS organisation.

Fiona Godlee, editor in chief of The BMJ, described him thus: “He was such a pillar of strength and wisdom and wit. We relied on him and only the other day were wishing he was able to investigate something methodological for us.

“We talked about “who is the new Nigel Hawkes?” and couldn’t think of anyone quite like him. I always loved our encounters and chats, and felt great comfort as editor in chief in knowing that it was Nigel who had taken on reporting or commenting on a tricky matter. You knew it would always be good and often surprising.”

Early life and career

Nigel Hawkes was born in Fulmer, Buckinghamshire. He went to school at Sedbergh, Cumbria, followed by St Catherine’s College, Oxford, where he studied metallurgy.

His first job was at IPC’s Science Journal, which closed shortly after he joined. From there he moved to Nature magazine, where he became news editor. In 1972 he joined the Observer as science correspondent, but changed direction somewhat 10 years later by taking on the role of the paper’s foreign editor, and then diplomatic correspondent.

In 1990 he moved to the Times, first as science editor and then health editor. The BMJ recruited him as a columnnist in 2007, a year before he retired from his Times job. He not only wrote an Observations column once a month for the journal, but also filed numerous news and feature articles.

Graeme Catto, former president and chair of the General Medical Council, remembers him covering the complicated machinations of the council at a time when it was tackling reform. “With the public, politicians, and the profession itself losing confidence in the council, not many believed that reform was possible.

“Into this maelstrom stepped Nigel Hawkes. A seasoned reporter formerly with the Times he was now writing a column for The BMJ and determined as ever to report accurately on complex matters. As that entailed attending a seemingly endless number of mind numbing events, our paths crossed frequently.

“Nigel’s reports were always fair, usually amusing, and often far more enjoyable than the events themselves. He was a consummate reporter.”

Hawkes made statistics fun and sweetened even the most labyrinthine complexities of NHS organisation

As well as an impressive journalistic career, Hawkes enjoyed a full and happy family life. In 1971 he married the journalist Jo Beresford at Chelsea Register Office, and they had three children and nine grandchildren.

The family home was in Kent, but while at the Times he bought a house in south London to make commuting to work easier. He used to joke that the house was in a Georgian terrace, omitting to mention that the George in question was King George V (the house was built in the 1930s) rather than one of the 18th century Georges.

While working on the Times, he was a colleague of Jeremy Laurance, who later became health editor at the Independent. Laurance cannot praise him highly enough: “He was such a fine writer—the most accurate, most intelligent, and most sane. Above all he was the most elegant, which made him a pleasure to read.

“In person he was always civil, kind, and helpful. Entertainingly he was also given to sudden outbursts of spluttering disbelief over the latest bit of idiocy—from the government or more often the news desk. He only had one vice to my knowledge—a secret passion for motor mowers. He owned a whole collection at his home in Kent.”

Straight Statistics

After retiring from the Times in 2008, Hawkes became director of a pressure group, Straight Statistics, whose aim was to detect and expose the distortion and misuse of statistical information and identify those responsible.

He wrote numerous books and was appointed CBE in 1999 for services to the newspaper industry and science, and was the Medical Journalists Association health writer of the year in 2007.

He leaves Jo, three children, and nine grandchildren.

Annabel Ferriman, London
ferriman@btinternet.com

Cite this as: BMJ 2021;375:n2579