For her first six months of work as a doctor in the small Ukrainian town of Sambir, Olena Parijchuk was paid precisely nothing. She and a small group of fellow physicians had an audacious plan—to transform a dilapidated tuberculosis sanitorium into a 30 bed hospice. They toiled and painted and sawed and heaved, doctors-turned-labourers. “Some of my colleagues in Kyiv told me I was mad,” Olena tells me, smiling broadly. “Maybe I was.”

That was six years ago. Today, the white walls of the Mother Theresa Hospice dazzle with refracted autumn sunshine. Olena is keen to take me inside, but first she shows off the hospice gardens, a field bisected by spindly fruit trees. “Look! When the war began, President Zelensky told us to grow fruit, to grow vegetables. This field has every species of fruit grown in Ukraine. It is . . . ” She stops, struggling to finish the sentence. “It is our victory garden.”

I came to Ukraine earlier this month alongside the renowned neurosurgeon Henry Marsh, who, until retiring two years ago, spent over three decades visiting the country to operate pro bono and train local surgeons. Even before Russia invaded, Ukraine’s GDP was a mere £4000 per capita, compared with the UK’s £32 000. Publicly funded healthcare is patchy, and palliative care scarcely exists at all. There are only 10 state hospices for a population of more than 40 million. Local doctors were eager for some support and training in palliative care, which I was only too delighted to provide.

But how do you live in the face of death? How do you muster the strength to go on? These questions frame every aspect of my work, yet for Olena—who strives to help people die with dignity, even as Putin aims to slaughter them—they are unimaginably pertinent.

Inside her hospice, I meet a woman who spent a month trapped at home alone after falling and fracturing her neck of femur, as both her daughters had gone to fight on the front line. Patients with end stage cancer have been transported hundreds of miles to this hospice from the horrors of Kharkiv and Mariupol because terminal cancer care was impossible there. Olena shows me a photo of a young man with a tracheostomy and a crater where half of his skull should be. Evacuated from Kharkiv, he died in Sambir under her care.

Olena, like every Ukrainian I met, is extraordinarily brave and resourceful. But she has no choice. Everyone here is fighting for their very life. Provision of tender palliative care is simultaneously an act of defiance, of resolve—and what it must cost her is vast. I can’t shake Samuel Beckett’s words from my head: “You must go on. I can’t go on. I’ll go on.”

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Provision of tender palliative care is an act of defiance, of resolve.
A return to austerity will further damage the public’s health
Brutal public spending cuts will lead to increases in health inequalities

Government policy has changed at such dizzying speed that any comment or prediction is likely to be out of date by the time it was written, let alone published.

In the days since this piece was written, Jeremy Hunt, then chancellor, made a budget announcement on 17 October. Then a few days later Liz Truss resigned as prime minister and Rishi Sunak was appointed. What happens next is anyone’s guess. But the economic challenges will remain, regardless of who is in power.

What we were promised from Hunt was not a new recognition of equity of health and wellbeing, but a return to austerity. If that means a return to the brutal cuts of the Cameron/Osborne government we can expect further damage to the public’s health, increases in health inequalities, and an NHS left in an even more parlous state.

Along with the chaos, there was more than a whiff of nostalgia about Truss’s approach. We were back in the 1980s, with Reagan-style “supply side” reforms. A more enlightened idea, that economic policy should be oriented to wellbeing and saving the planet rather than to GDP growth, was nowhere to be seen.

Consistent with this commitment to old fashioned debates is the rumour that a health disparities white paper, pledged for last spring, will not appear. It seems the government would rather trust its libertarian instincts than plan public health policy based on evidence, such as a sugar tax to combat obesity, or other interventions to encourage healthy behaviours.

Such libertarian antipathy to “nannying” is entirely predictable, but reduction of health inequalities requires more than changes in behaviours. It needs a whole government commitment to tackle social conditions that lead to the unfair distribution of health.

Past governments
Such commitment was not in evidence from Truss and has been sorely lacking in the UK for the past 12 years. When David Cameron was prime minister, a public health white paper recognised the importance of health inequalities and the wider determinants of health but, with austerity the priority, the government pursued policies that, predictably, made things worse. Theresa May declared that health inequality was a burning injustice, and expressed sympathy for the “just about managing,” but her premiership was eaten up by Brexit. Under Boris Johnson the main initiative was to change the language from inequalities to disparities. The levelling up white paper certainly had the potential to tackle the socioeconomic causes of health inequality, but the scale of investment has been tiny.

It is likely the effect of this neglect was a marked slowing of improvement in life expectancy, an increase in social and regional health inequalities and, chillingly, a fall in life expectancy for the most deprived 10% of the population. The sheer brutality of austerity was “justified” to get the public finances in order—as if that somehow justified poor people dying before their time. What we are potentially facing now is more brutality by cuts in public spending, with public finances in disarray.

At the very least we would want two things from government: that its plans be likely to work; and that it be devoted to the common good. Neither looks likely.

First, as we have seen, Truss’s policy objectives did not succeed in their own terms. Tax cuts do not lead to growth in...
GDP. The idea of enlarging the pie to help everybody by making rich people richer has also been discredited. The IMF, previously a bastion of neoliberalism, in a 2015 research report concluded the way to economic growth is to expand the incomes of the poorest 60% of the population.

Second, it is not fanciful to assert that a government’s political complexion really can change health equity. We know health inequalities narrowed under New Labour, compared with what came before or after. In the US, counties that voted for the Democrats in presidential elections from 2000 to 2016 had greater declines in mortality than those that voted for the Republicans. What Americans call “liberal” policies are good for health.

It is not the presence or absence of a disparities white paper that should concern us. More worrying is the chaos in government disparities white paper that should concern “liberal” policies are good for health.

“mortality displacement.” Could some of the Big changes are possible, since 47% of over 65s do no exercise at all
Will GMC proposals prop up GPs?

Before 1979, being a GP required no postgraduate training. After completing medical school and a year of hospital experience, you could set up in practice. It’s worrying, in retrospect, to consider how little such newly qualified doctors knew at that stage in their careers and how unsupported they were when most practices were single handed.

Now, after the two foundation years, GP trainees must complete three further training years, two of which are in GP placements. They have weekly tutorials and close supervision, with debriefs after each surgery. To qualify, they must complete a portfolio to show their breadth of experience and pass written and practical exams.

The NHS is short of 11 000 doctors and would be in an even worse position without SAS (specialty and associate specialist) and LE (locally employed) doctors. These doctors are not on a training path to become consultants or GPs, but they often provide the core workforce in busy hospitals. Now the GMC is suggesting a change to the rules that would allow SAS and LE doctors to lend a hand where we’re most stretched.

The proposal has met with mixed reactions. It’s hard to see how shuffling doctors out of understaffed hospitals into the understaffed community sector—without adding to the pool—would solve anything. Many SAS doctors are highly skilled and experienced and would, with appropriate training, make excellent GPs. It would be great to welcome them onto formal training programmes, adjusted to take account of relevant experience. This would involve an expansion of GP training, which is clearly needed anyway.

However, this doesn’t seem to be what the GMC has in mind: its statement refers to SAS doctors “working alongside GPs in complementary primary care roles.” I don’t know what those roles might be, and I didn’t find the answer in the document. In my practice I see patients and try to help with their new and/or longstanding problems, covering a broad range of medicine, psychiatry, and preventive care.

We have established protocols for simpler problems that can be solved in a rule based fashion, and we’re grateful to our nurses and pharmacists for doing this work. So, what would these SAS doctors do?

Supervising learners—medical students, foundation year doctors, specialist trainees, and a growing tribe of additional staff—already cuts the time GPs have for patients. The concept of yet another group to oversee makes my heart sink. From the patient’s perspective, seeing a doctor who isn’t a GP may be better than no appointment at all, but where does this leave SAS and LE doctors to lend a hand where we’re most stretched?

The concept of yet another group to oversee makes my heart sink.
The covid-19 pandemic has exacerbated extensive backlogs in the diagnostic and treatment pathways for patients with cancer in the UK. Nationally, only 65% of patients receive treatment within two months of a primary care referral for a suspected cancer (the target is that at least 85% of patients are treated within this timeframe), with substantial regional variation.1

In its report on NHS cancer services, the House of Commons Health and Social Care Committee acknowledged that the ongoing disruption of cancer treatment resulting from the covid-19 pandemic is likely to result in substantial loss of life years.2 3 Although the target to clear the cancer backlog has been moved back by a year to March 2023,4 even this timeframe seems optimistic5 given that 57% of hospital trusts failed to meet the two month wait time target in 2016.6

Providing timely cancer diagnosis and treatment is challenging. The diagnostic pathway is complex, requiring specialist procedures for diagnosis and often multiple staging investigations to define the extent of disease and determine an appropriate management strategy. Most patients also need an array of specialised treatments such as surgery, radiotherapy, and systemic anti-cancer therapy, sequentially or in combination (multimodal therapy), and provided by one or more hospitals, requiring coordination over extended periods. For patients and their families, the concern is that delays in diagnosis and treatment will result in disease progression and an overall worse prognosis.2 Although long term commitments have been made to expand the NHS workforce as well as diagnostic and treatment capacity,7 short term solutions are urgently needed that use existing NHS capacity more efficiently.

One of the government’s responses to managing the NHS treatment backlog, announced by the health secretary in March 2022, includes giving patients the opportunity to “shop around” for their care, so that they are able to choose to have treatment at hospitals with the shortest waiting lists.8 This My Planned Care service will formally start in December 2022 and initially be available to patients with very long waits for elective treatment before being extended to all patients. For patients needing to travel, free transport and accommodation are expected to be provided.

We argue that the use of patient choice as a vehicle for managing the NHS cancer backlogs is naive because it does not consider the complexity of patient choice or disparities in quality of cancer care across England, let alone the challenges in coordinating diagnosis and treatment. Instead, evidence suggests that unless there is universal improvement in the quality of cancer care, patient choice could worsen waiting times, widen inequalities, and burden cancer patients with extra decisions regarding their treatment without improving outcomes.
Patient choice has not driven improvement

Patients in the English NHS, a publicly funded health system, have been able to choose where they go to hospital since 2006.\textsuperscript{9} Reimbursement for services was fixed according to a nationally agreed tariff, and information about the quality of care delivered at individual hospitals was made publicly available. Patients were expected to act as healthcare consumers, choosing not to be treated at their nearest hospital if other hospitals seemed to provide better quality care. In theory at least, competition between hospitals should stimulate improvements in quality.\textsuperscript{10,11}

Three analyses suggest that patients with cancer are highly responsive to choice policies.\textsuperscript{12-14} The proportion of patients selecting alternative hospitals is well above the 5\textendash{}10\% considered necessary to stimulate improvements in outcomes through market competition.\textsuperscript{13} For example, one in three patients, mainly from higher socioeconomic groups, having radical prostatectomy for prostate cancer moved beyond their nearest centre during 2010\textendash{}14 (figure).\textsuperscript{12,15} Similarly, nearly 30\% of patients with bowel cancer were not treated at their local surgical centre between 2016 and 2018.\textsuperscript{15,16} There is no clear evidence, however, that policies enabling patients to select a cancer treatment provider of their choice has led to better health outcomes or driven quality improvements.\textsuperscript{15-17}

In European and North American countries with active patient choice policies, 25\textendash{}75\% of patients do not use their nearest treatment provider for secondary care services.\textsuperscript{18,19} However, evidence from five European countries and the US, each of which has different incentive structures to support patient choice and provider competition, has not consistently shown improvements in patient outcomes from these policies.\textsuperscript{19,20} In 2019 the NHS moved away from competition (turning instead to collaboration and integration of care)\textsuperscript{21} given the lack of evidence that it improved quality as well as concerns that it could also exacerbate inequalities. However, patients’ ability to choose where they have treatment within the NHS remained enshrined in the NHS constitution.\textsuperscript{22} The launch of My Planned Care in the English NHS\textsuperscript{23} effectively rebrands patient choice but this time as a mechanism for managing current diagnostic and treatment backlogs by enabling patients to choose hospitals with shorter waiting times using information available on the My Planned Care website.

Factors influencing patient choice are complex

Patient choice in hospitals and cancer treatment providers is driven by many interlinked context, culture, and person specific factors.\textsuperscript{23} Population based observational studies and patient surveys show that patients are attracted to hospitals that deliver better outcomes according to official ratings, perform a higher volume of procedures, offer more advanced technologies (eg, robotic surgery), or have a better reputation according to local and national media.\textsuperscript{15,25}

An analysis of the characteristics of NHS prostate cancer centres that treated high numbers of patients from outside their catchment area, patients seemed to respond to the availability of more advanced surgical technology and the perceived reputation of the hospitals or surgeons.\textsuperscript{12,15}

For choice policies to be effective, patients are expected to review online information or report cards about hospital quality and waiting times to inform their decisions. However, a 2010 study found that only 4\% of 1033 patients offered a choice used an NHS website that provided information on quality of care when deciding where they wanted to be treated.\textsuperscript{26} Similarly, in the US, which has a longer history of patient choice policies, a review found that only 6\textendash{}17\% of patients across the studies consulted online hospital rankings or report cards when making decisions regarding their healthcare provider.\textsuperscript{27} In addition, indicators of quality for many treatments are not publicly available to inform patient choices as they take considerable time and resource to develop. Instead, qualitative data suggest that most men with prostate cancer rely on advice from their family and friends, previous experience, and their primary care physician to choose a cancer provider.\textsuperscript{28}

Paradoxically, this could mean that patients prefer care at hospitals that have longer waiting lists because those that are perceived to perform better are likely to attract more patients from outside their local area.\textsuperscript{29} An unpublished national observational study in the UK of 69 153 patients with breast cancer diagnosed between 2016 and 2018 found that patients were more likely to travel for their breast cancer surgery to centres with the longest waiting times.

Yet, underpinning the UK’s new cancer care initiative is the belief that patients will decide where they want to receive their care based on waiting times. While patients in some studies chose a hospital or cancer treatment provider because it had shorter waiting times,\textsuperscript{29} the evidence is inconsistent\textsuperscript{11,32} and has almost exclusively been from patients seeking care for less complex conditions (eg, hip and knee surgery) or regional NHS pilots.

Another reason patient choice is unlikely to reduce waiting times for cancer treatment is that the quality of cancer care is not the
same across the NHS. National audits of multiple cancer services in England and Wales have shown significant variation in the structure, processes, and outcomes of care. For diseases in which quality of treatment has implications for mortality and long term morbidity, patients are likely to give waiting time priority only if they are confident that their care will not be compromised and that they will also receive the appropriate aftercare at their local centres. Patients may prefer to wait longer for treatment at centres that may provide better quality care while accepting a potentially increased risk of cancer progression. A more nuanced approach is therefore required to reduce waiting times.\

**Implications for health inequalities**\n
Unfortunately, policies based on patient choice, both in the English NHS and elsewhere, have been found to widen inequalities in access. As Sajid Javid said when health secretary in 2022: “Disparities in health are exacerbated by the fact that it’s middle-class people in leafy suburbs that are better able to push the system to work for them.” Patients choosing to travel to hospitals further away are typically younger, fitter, and more affluent, even more so if the choice of provider includes private sector provision. To put it simply, marginalised patient groups are less likely to travel beyond their nearest hospital for care and therefore less likely to access or benefit from hospitals reporting shorter waiting times or better quality care.\n
Other structural factors can further widen inequalities, including unequal access to accurate information and user friendly tools to shop around as well as geographical variation in the availability of services, necessitating longer—or impossible—travel times for some patients. Even if travel costs are covered, it is difficult to see how patients who need to continue to work or have caretaking responsibilities would be able to access quicker treatment if it required travelling for 2-3 hours a day for six weeks for radiotherapy without paid time off.\n
**Alternative approach to reducing backlogs**\n
A policy based on allowing patients to shop around for their cancer treatment is thus not a sustainable solution for the backlogs in cancer diagnosis and treatment. Instead, we propose that the NHS builds on the opportunities provided by existing models of cancer care delivery to manage the cancer backlog and support meaningful patient choice.\n
We need to identify spare capacity, assure its quality, and coordinate its best possible use based on the complexity of the needs of individual patients. This requires an understanding of the configuration of healthcare provision in each region as well as data about the current patient flows between hospitals for each tumour specific treatment. To achieve this, the 21 cancer alliances (NHS structures in England that are responsible for managing and coordinating cancer care pathways regionally), should consider using routinely collected administrative and clinical datasets such as Hospital Episode Statistics and the national cancer registry, also including waiting times for cancer care to establish how existing capacity is being used.\n
Capacity of available services then needs to be managed and allocated equitably based on the need of individual patients. In the English NHS, as in many other countries, specialist multidisciplinary teams are already responsible for defining pathways of care and delivery of cancer treatments within a defined region for each newly diagnosed patient. The typical hub and spoke structure consists of one or more specialist treatment centres coordinating services for the referring local cancer units. Currently, specialist multidisciplinary teams do not allocate patients to specific hospitals as there may only be a single surgical or radiotherapy treatment provider within the specialist multidisciplinary team region.\n
However, with better access to information about waiting times and available capacity at other hospitals within or outside their region, the specialist multidisciplinary teams are well placed to recommend where patients should be treated according to severity of the cancer and the technical complexity of any indicated procedures. This would offer a ready made and low cost solution that would also be sensitive to the patients’ individual needs. It does require coordination across the existing cancer alliances and would benefit from designated pathway coordinators to liaise between specialist multidisciplinary teams.\n
Pathways of referral and care may need to be restructured to facilitate the coordination of care for patients based on complexity of their cancer. This could mean that more technically complex surgical procedures such as rectal cancer surgery are centralised to fewer, high volume hospitals to assure quality. The resulting spare capacity in hospitals no longer performing rectal cancer surgery could then be used for less complex but high volume procedures (eg, colon cancer surgery). This type of restructuring has been occurring during the pandemic.\n
Greater partnership between primary and secondary care could also deliver a more patient centred approach to managing diagnostic and treatment backlogs. In the English NHS, for example, the decision about where a patient with suspected cancer is referred is critical. A redesign of referral pathways from primary to secondary care provides an opportunity to develop a much more nuanced system of referral, encouraging shared referral decisions that explicitly consider waiting times, care quality, proximity, and other morbidities. This approach could be further strengthened with the planned opening of more than 100 new community diagnostic centres across England, although this remains an untested organisational change.\n
Simply giving patients information on waiting times through the NHS website My Planned Care is unlikely to solve the problem of treatment backlogs and risks making care more inequitable. A more effective, low cost solution is likely to come from enhanced use of routinely collected data about cancer care to enable existing regional multidisciplinary cancer teams to advise not only on what treatments newly diagnosed patients should receive but also where they should receive it, and a restructure of cancer referral pathways across the health system.

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**We need to identify spare capacity, assure its quality, and coordinate its best possible use based on the complexity of needs of individual patients**

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China’s Personal Information Protection Law

Privacy aims must be reconciled with the need for medical research in the public interest

China’s first privacy law, the Personal Information Protection Law, went into effect on 1 November 2021.1 The law shares some of the principles and concepts in the EU’s General Data Protection Regulation (GDPR), although stated in broader terms. Like GDPR, the Chinese law aims to empower individuals by giving them control over their data. Personal data are defined as “information related to an identified or identifiable natural person recorded electronically or by other means, but do not include anonymised information.”2 Health data, classified as sensitive, must be processed through a rigorously regulated pathway, with clear justifications for the proposed use and unambiguous consent. Importantly, while the new law does not cover fully anonymised data, it does apply to data that have been “de-identified” since such data can be reattributed to a particular person through other sources of information.

Unlike GDPR, the Chinese law provides no exceptions to the need for specific consent for using personal data in scientific research. Processors of personal data must therefore obtain specific consent from individuals for each research project.

Efforts to protect people’s privacy are laudable—the challenge is around implementation. Digitisation was accompanied by the rapid accumulation of health data in China, and innovation in technologies and analytics now provide powerful tools to answer complex questions through exploration of associations within very large datasets generated from China’s population of 1.4 billion.

Medical researchers need clear guidance on how to use and process health data in full compliance with the law. Otherwise, responsibility for deciding whether data handling is lawful rests on individual institutions.

Clinicians need training in how to discuss the use of health data with patients

This is particularly important for research that links different sources of data, such as genomic studies. To avoid legal pitfalls, some research teams or institutions may stall or decline all data sharing requests until a clear code of conduct has been agreed by the scientific community and approved by China’s National Health Commission and Cyberspace Administration.

A further concern is that the law does not allow broad consent for research purposes, so researchers must renew consent each time use of participant data diverges from the original purpose of collection, unless data are fully anonymised. This is likely to delay or even prevent clinically important research using very large datasets. It limits use of data from biobanks or electronic health records, for example.

Deceased patients

Obtaining consent to use data from deceased patients is particularly difficult as some communities may see contacting relatives to request permission as offensive. But abandoning such data is wasteful and introduces bias. This issue is particularly problematic for use of data collected decades ago.

The law’s laudable privacy aims must be reconciled with reasonable use of personal data for medical research in the public interest.

First, regulations must be developed to specify the principles, requirements, standards, codes of conduct, and monitoring required for the legal use of health data for medical research purposes (including genomic data), along with clarity and practical guidance on health data processing. Such regulations should consider the use of datasets collected a long time ago as well as more recent and ongoing data collection. During this process, medical researchers should work with policy makers, lawyers, ethicists, engineers, computer scientists, and patients to manage competing interests, clarify technical standards required for safe data processing, and draft a step-by-step guide for data processors. These health sector regulations and codes of conduct should be approved by the National Health Commission and Cyberspace Administration, and regularly reviewed and updated.

Second, broad consent for reuse of health data in medical research should be legitimised in the public interest. A standardised consent form should be developed to avoid unstructured and entirely open ended consent. Patients should be given adequate information on the types of research that their data could be used for, what kind of information will be shared, who might have access to their personal data, and the right to freely opt out.

Third, clinicians need training in how to discuss these issues with patients, building trust while minimising disruption to healthcare. China’s hospitals and healthcare providers should develop and implement appropriate programmes as a priority.

China must now build on its privacy protection law and extend efforts to reconcile the need for privacy with the need for medical research that translates health data into important health benefits for China’s patients and population.

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LETTERS
Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Collecting data to prove the value of health visiting

Wilkinson’s article highlights the challenges of proving the value of health visiting (Feature, 1 October). This is partly because of health visiting’s wide remit, which aims to improve child health through health promotion, parenting support, and screening and immunisation programmes. Another challenge is generating meaningful evidence about the impact of variation in the delivery of health visiting services across the UK.

Publicly available aggregate data from the Office for Health Improvement and Disparities are currently our best source of information on health visiting services, yet these are known to have data quality problems. They are limited in describing outcomes for children and service variation for different subgroups of families (such as adolescent mothers or children with disabilities). The Community Services Data Set held by NHS Digital contains rich, individual level data on health visiting activity, which has the potential to transform what we know about the impact of health visiting. The completeness of this resource depends, however, on compatibility of local data systems with national data collection, meaning that it does not yet remain essential for evidencing service impact. More needs to be done to ensure that data collected can be used for research.

However important, quantitative data alone cannot offer the full picture of the impact that health visitors have on families and should be complemented by qualitative data. Such mixed method studies are currently ongoing in England and Scotland. These can inform policy makers and local leaders on how best to develop and commission services to meet the needs of their children and families in the context of the health visitor shortages so devastatingly described in this article.

Amanda Clery, doctoral student; Katie Harron, professor of statistics; Jenny Woodman, associate professor in child and family policy; Helen Bedford, professor of children’s health, London; Sally Kendall, professor of community nursing and public health, Canterbury
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LONG COVID UPDATE FOR PRIMARY CARE

We must acknowledge functional symptoms

Writing about long covid must be a fraught task. Greenhalgh and colleagues don’t mention a functional element to long covid (Practice Pointer, 1 October), which seems to be a huge omission. Many of the complaints we see in primary care are of a functional nature, and there is often a large functional component to physical illnesses like chronic obstructive pulmonary disease, asthma, and heart disease. How can we help people with functional symptoms if there is a taboo about mentioning it?

People with functional symptoms are suffering in the same way as those with physical symptoms, and if we are to destigmatising this area of medicine then authors as important and respected as Greenhalgh and colleagues should acknowledge their existence. It would be extraordinary if many people suffering long covid did not have a functional element to their presentations. Concentrating on physical tests and bodily mechanisms wholly risks missing this component.

Peter W Ward, GP, Gateshead
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Authors’ reply

The terms “organic” and “functional” are misleading. They imply a clear split between illnesses of the body and those of the mind. Long covid is associated with various structural abnormalities in different organs. Like any other medical condition, long covid also includes an element of mental processing of symptoms and emotional and psychological reaction to the illness and the limitations it confers. We did not ignore these aspects of long covid; we included them as key elements of a whole person condition that requires whole person management.

The patient’s symptoms may be many, varied, and fluctuating; no single biomarker exists to confirm or exclude long covid. Rather than label this pattern as “functional,” we need to listen carefully to the patient’s story, do a physical examination and relevant investigations, exclude alternative diagnoses, make and record the diagnosis of long covid, and direct the patient to self-management resources, support groups, and professionals with appropriate expertise.

Trisha Greenhalgh, professor of primary care health sciences, Oxford; Manoj Sivan, associate professor in rehabilitation medicine, Leeds; Brendan Delaney, professor of medical informatics and decision making, London; Rachael Evans, associate professor in respiratory medicine, Leicester; Ruairidh Milne, person with long covid and emeritus professor of public health, Southampton
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There is no health without mental health

Behavioural health conditions—including mental health conditions and substance use disorders, which often co-occur—have been among the most visible and widespread of covid-19’s effects. Greenhalgh and colleagues specifically note “mental health and wellbeing” as a key component of primary care for patients with long covid. Screening for and identifying potential substance use disorders are also important.

The US Department of Health and Human Services renewed its public health emergency declaration for the opioid crisis in January 2020, one week before the country’s first declaration of emergency for covid-19. In August 2022, the federal government published two reports on long covid, noting the importance of behavioural health in supporting those with long term complications of covid-19. Ensuring well funded, sustainable, and adequately staffed behavioural health services at all levels of government and in the private and philanthropic sectors is among the most essential lessons we can learn from covid-19.

Mitchell Berger, public health adviser, Rockville, Maryland
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OBITUARIES

Joyce Cohen Lashof

Former dean of UC Berkeley School of Public Health who brought social justice to public health

Joyce Cohen Lashof (b 1926; q Woman’s Medical College of Pennsylvania, 1950), died from heart failure on 4 June 2022

There were many reasons Joyce Cohen Lashof was an improbable choice for the deanship of the School of Public Health at the University of California at Berkeley back in 1981. The first was her sex. Meredith Minkler, now professor emerita at the school and then a junior faculty member, remembers that during the faculty meeting to discuss desirable attributes of a new dean, the men on the search committee kept saying things like, “He should have . . .” or, “He should be . . .” Minkler and the only other woman in the room, noted geneticist Mary-Claire King, now at the University of Washington, kept saying “She should have . . .” and “She should be . . .” to the blank stares of the men.

Lashof didn’t have a big footprint in the scientific literature, although by that point in her career she had been an author or co-author of high level government reports on public health. In addition, she was a physician applying for a job that traditionally went to those with doctorates.

Lashof eventually got the job at Berkeley and became the first female dean of a public health school in the US. She went on to redefine public health education in the US with her interest in health equity and social justice.

Background and early challenges

Lashof came from a Jewish family, the daughter of an accountant and a homemaker with roots in Ukraine. She was one of the first public health leaders to appreciate how intertwined politics and public health are. She and her husband, Richard Lashof, a theoretical mathematician, carried their beliefs everywhere.

She faced challenges from the very start of her career. When she applied to medical school, Lashof was told that she had little chance of being accepted as most medical schools wouldn’t accept women or Jews. She was also competing against priority admissions programmes for men returning from the second world war.

She graduated from what was then the Woman’s (sic) Medical College of Pennsylvania in 1950, and did her residency at Montefiore Medical Center in New York City. Afterwards she joined the junior faculty at the University of Chicago. According to the New York Times, the chairman of her department told her he couldn’t put her into a tenure track position “because she undoubtedly would follow her husband wherever he would go.” Her response? “C’est la vie.”

Lashof moved on to the University of Illinois College of Medicine, where she directed a study of health needs in poor communities. In 1967 she created the second community health centre in the US and in 1973 she became the first woman in the US to head a state health department.

Then it was on to the 10 year deanship at Berkeley, where she was credited with diversifying the faculty, working with local communities, and instilling the students with a sense of responsibility for delivering equity and social justice through public health.

Nancy Krieger, now a professor of social epidemiology at the T H Chan Harvard School of Public Health, remembers marching into Lashof’s office early in her deanship. “I was an outraged, incensed, politicised little graduate student who was trying to figure out where public health could have its voice,” says Krieger. “Joyce wanted to hear, and wanted to know what I was willing to do.”

In 1988 the two published a case study in the American Journal of Public Health about the value of public health schools doing policy analysis. They concluded: “Schools of public health have a public responsibility, based on the best knowledge available, to educate not only their students but also the electorate on the major public health issues of the day . . . public health in its broadest sense is public welfare, and its foundations lie in social justice.”

Lashof was president of the Association of Schools of Public Health, and after leaving Berkeley she headed the American Public Health Association for a year. She also headed the Presidential Advisory Committee on Gulf War Veterans’ Illnesses and the Institute of Medicine Committee on Technologies for the Early Detection of Breast Cancer. In 1995 she received the Sedgwick Memorial Medal for Distinguished Service in Public Health from the American Public Health Association.

Advocacy and activism

There were things Lashof didn’t achieve—she was a strong advocate for national health insurance, which still hasn’t come to be in the US. “Her ideals always exceeded the achievable reality,” says Lashof’s daughter, Carol. And she headed a scientific committee collecting evidence on the health effects of Agent Orange on Vietnam war veterans. The committee was unable to make a connection. “That just broke her heart,” says Minkler, and earnt Lashof the disapproval of progressive friends in the public health community. Eventually, further studies showed a connection, and recently the US government announced it would be supporting those veterans. “I think this decision—doing the right thing by vets—would have made her incredibly happy,” says Minkler.

Predeceased by her husband in 2010 and one of her daughters in 2018, Lashof leaves two children, six grandchildren, and two great grandchildren.

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Deborah Turbitt

Eminent public health specialist and spokesperson

Hand knitted cardigans hung from the altar rails at the packed east London funeral of Deborah Turbitt. Her family invited mourners to take one in memory of the public health specialist, who has died aged 59.

Knitting was relaxation during a public health career that spanned the 2005 London bombings in which 52 people died; the poisoning of Alexander Litvinenko, the former KGB officer, with polonium the following year; and the attacks on London Bridge and Fishmongers’ Hall. After the Ebola outbreak in West Africa in 2014, Turbitt oversaw a surveillance and testing system, and only three cases had to be treated in England.

In 2012 she led the public health preparations for the London Olympics, starting with overseeing the decontamination of the designated site and going on to monitor the wellbeing of the 14 700 competitors and 11 million spectators. No major public health incidents occurred.

In 2017 she found herself the butt of public anger when she decided to attend meetings of local people after the Grenfell fire in which 71 people died. She felt an obligation to be there, answering concerns about air quality and asbestos.

“She was always enormously supportive in a modest, tactful way,” said Yvonne Young, acting deputy director Health Protection London, UK Health Security Agency, who knew her for 20 years. “She was extremely knowledgeable, widely respected, and never flamboyant. She was someone you would listen to.”

She was also a ready spokesperson for public health, enlightening the media on topics from norovirus and baby food poisoning to false widow spiders and oak processory moth caterpillars.

Yvonne Doyle, NHS England medical director for public health, said, “Deborah not only had an amazing casebook, enabling her to solve most problems, but also great reserves of tact. She was sensitive to the restaurant owner forced to close because of an outbreak [of food poisoning], as well as acknowledging the importance of protecting the public.”

Diagnosed with oesophageal cancer in 2021, Turbitt leaves her husband, Mat, and four children.

Deborah was a socialist—pink to the core,” said Mat Wilson, her husband of 34 years. “It was the old fashioned socialism of the north, with its memory of the Jarrow march and straightforward tenets that people should be able to earn enough to live decently and that the poor and defenceless should be supported.”

When she returned to her home in Hackney during the covid pandemic it was not unusual for her to be clapped down their street, he added.