When I chose to become a doctor all those years ago, I never imagined that my career would take this path: being a GP, but also spending a significant proportion of my working week immersed in medical management. It wasn’t on my list of ambitions to be a medical director. My early career was devoid of role models in medical management, and if I’m honest, I was naive to much of the responsibility that came with the role—that is, until I started doing the job. So, on the one hand, it’s curious that this is where my career path has taken me.

On the other hand, I’ve always passionately believed in building fair and compassionate workplaces for healthcare staff, recognising and valuing people for the work they do. It matters a lot to me that all healthcare staff are supported and developed, that their views are heard and given credence, and that they’re not just at the receiving end of decisions made at an organisational level that make no sense to them. So, perhaps my career has taken me to where I’m meant to be after all.

But it’s by no means an easy job. Just as our clinical work can feel like daily firefighting, it’s much the same in medical management. The current workforce crisis in particular leaves me with no shortage of problems, many of which I feel powerless to solve. Although I’m personally committed to creating a positive workplace culture and environment for my teams, I can’t help anyone thrive in the face of severe understaffing.

Workload pressures take their toll, patients don’t get the service they deserve, and this eats away at morale. The fallout from this is that staff leave or reduce their hours, leaving an even bigger problem to fix.

Add to this the pension debacle, whereby doctors can end up paying to go to work if they increase their NHS commitments to plug gaps, and it’s no wonder I’m not exactly inundated with offers of taking on extra paid NHS work from existing staff. And market forces have led to an exponential rise in locum rates—all factors which, in combination, have led to a situation where we’re disincetivising continued commitment to core NHS work, making it more attractive to work on a locum basis or leave the NHS altogether.

Watching this situation unfold and being caught in the crossfire as a medical manager is not a happy place to be. I want better for my teams and for their patients. Extra medical school places being petitioned by the royal colleges, among others, is welcome—but we need solutions that will make a difference now, not in 10 years’ time when the damage will most likely be irreversible. Solutions for the here and now are not within my gift to implement, but without them it feels as though the NHS and its staff are being set up to fail.

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The NHS and its staff are being set up to fail

I can’t help anyone thrive in the face of severe understaffing
England is still waiting for answers to social care crisis

While politicians offer futile “solutions” the real world suffers


Waiting for meaningful solutions in social care policy feels very similar, with little hope on the horizon. A quick historical timeline serves to emphasise the despair many of us feel, as keenly as Beckett’s protagonists.

The Sutherland royal commission’s *With Respect to Old Age* report, published in 1999, made a series of recommendations on adult social care funding and provision, with few fully implemented. In 2010 the health secretary, Andy Burnham, tried to convene cross party talks on sustainable solutions, which were boycotted by the Conservatives and briefed against as a “death tax.”

In 2011 the government commission chaired by Andrew Dilnot took extensive evidence, examined several options, and recommended a lifetime cap on care costs and a more generous means test. But after the 2015 general election the Conservatives reneged on the coalition pledge to enact it.

The well regarded Care Act 2014 set out a range of rights and responsibilities around care and support, which have never been accompanied by the resources or staffing to make good on the intentions. That same year a King’s Fund commission chaired by Kate Barker, economist and former member of the Bank of England’s Monetary Policy Committee, also set out a series of recommendations on funding and access that weren’t heeded by politicians.

Heavily rationed

Meanwhile, austerity policy under the 2010-15 coalition government and in the following parliament led to sustained cuts in local government budgets (and hence social care). The King’s Fund and the Nuffield Trust estimated in 2016 that 500 000 fewer people were in receipt of care by the middle of the last decade than at the start. Annual surveys by Carers UK show that most care is delivered unpaid by family members and that they, in turn, receive little statutory support.

Yes, there have been a series of in-year cash injections to social care, largely focused around supporting discharge from hospital and joint working between the NHS and social care, but they’ve never compensated for the cuts. In 2021, modelling by the Health Foundation suggested that by 2030 adult social care in England would need an annual uplift of £8.9bn just to maintain current levels of service and £14.4bn to restore access to historic levels. Social care access is already heavily rationed by strict eligibility thresholds and means testing.

During the 2017 general election campaign Theresa May, then prime minister, announced rather hastily a proposal to fund care from recipients’ estates, which was soon decried as a “dementia tax” and dropped. Then, right after his 2019 election victory, Boris Johnson pledged to “fix the crisis in

Prioritising the health of our children by reducing road traffic deaths

Last year, 27 450 people were killed or seriously injured on Britain’s roads. If these deaths or serious injury from road traffic crashes were a cancer, they’d represent the fifth leading new cancer diagnosis in the UK—with only prostate, lung, breast, and bowel cancer higher.

This is a public health matter, and health inequalities play a big part. Children in the most deprived 20% of areas are six times more likely to be injured than those in the least deprived 20%, and 16 children are killed or seriously injured in road crashes every week on their way to or from school.

We know how to prevent this: a combination of environmental and driver behavioural changes. The *Highway Code* changed in January to mandate safer driving behaviours around vulnerable road users, such as leaving at least 1.5 m (5 ft) when overtaking a cyclist, but 61% of drivers are unaware of the changes.

Some real examples show what’s possible. In Edinburgh a change to 20 mph limits has reduced road traffic casualities by 40%. So, let’s bring in 20 mph limits in all urban areas. Oslo and Helsinki have reportedly eliminated pedestrian deaths with Vision Zero—an initiative including car-free zones around schools. And all types of fatal collisions fell by 49% when San Francisco introduced segregated cycle lanes.

We should stop seeing the world through our windshield. The government’s economic analysis of its £27bn funding for major road traffic schemes focuses on a hypothetical reduction in traffic delays,
social care, once and for all with a plan.” The Queen’s speech, 657 days later, lacked any meaningful commitments to back this up.

When the “solution” was finally announced in 2021, it was no such thing. An additional £33bn over three years was to be raised by a “levy” in the form of national insurance increases on working adults. But most of the cash was to be given to the NHS, leaving only £1.7bn a year to social care—most of which would be swallowed up in protecting people whose assets exceeded the £86,000 cap from using all of them.

The national insurance rise (now reversed by the current leadership) was criticised from both right and left for being inequitable, placing an excessive burden on lower earners paid a higher proportion of their income as a flat national insurance rate. The health and social care secretary in the six week Truss government of 2022 was gone before she could offer a serious proposal of her own, beyond a short term winter cash injection of £530m—which has yet to be released to the system and focused entirely on supporting hospital discharge. Meanwhile, one in nine social care posts is vacant in a worsening workforce crisis, as the sector deals with poor funding, falling profit margins, points based immigration rules, the impact of Brexit, and competing sectors also short of labour. In his autumn statement the chancellor, Jeremy Hunt, unexpectedly announced an extra £7.5bn for social care over the next two years. But nearly half of this will come from postponing the new cap and other funding reforms, while almost a quarter will depend on all councils choosing to raise their council tax. Even assuming that every local authority employs this option, it’s no panacea. Much will depend on the local government financial settlement to be announced later.

Wages and energy costs
Local authorities rely heavily on central government grants for funding. These grants have been serially cut, and the Institute for Government found that cuts have hit deprived areas harder. Moreover, council tax is regressive and compounds the inverse care law: areas with the highest value properties and the highest proportions of homeowners (and the lowest need to provide public or subsidised housing) are the areas that can raise the most money, even though they’re less deprived.

In any case, it’s likely that much of the new money will be sucked into wage increases and energy costs rather than widening or preserving access to adult social care. And neither Hunt nor Steve Barclay, the new health secretary, has presented any meaningful solution to social care’s recruitment and retention crisis. With no workforce there can be no care, even if the money’s there.

Vladimir and Estragon—living in a dystopian no man’s land removed from reality, while the real world continues elsewhere—would recognise this exercise in futility. But their predicament lasts for only two hours (with an interval), not two decades.

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without acknowledging the increased road travel and resulting incidents created by expensive, new, widened roads.

When local residents petition for a zebra crossing by their school, their project joins a list of at least 79 others, and funding goes only to the top three lucky projects—but we need to prioritise making our roads safer.

Children make up 21% of the UK population. Only 76% of mothers with dependent children are in employment, compared with 92% of fathers. In a cost of living crisis, running a car is one of the biggest household expenses. But if children can cycle, walk, or scoot to school safely, the household may need only one car. Furthermore, walking or cycling has clear benefits for health by reducing sedentary lifestyles, as well as for the environment.

We’re in a vicious cycle where 34% of children are driven to school, 62% of UK adults say that it’s too dangerous to cycle, and 59% of car journeys are under two miles. Only 5% of walking journeys are over two miles, so a modal shift from cars requires better infrastructure for cyclists and pedestrians, with better public transport. Electric cycles allow older people and people with disabilities to

In Edinburgh a change to 20 mph limits has reduced road traffic casualties by 40%

cycle more easily, especially on hills and for longer distances.

We should harness the health benefits of reduced car travel. Pollution from road traffic contributes to many health conditions: 34% of men and 42% of women are not active enough for good health, and active travel can be one of the best ways of fitting exercise into a busy day.

Let’s prioritise our health by making roads safer. We can’t afford not to if we want to look after our planet and the coming generations.

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Looking into the abyss

Just at the moment, our GP surgery is in the happy position of having enough doctors. Our wait for routine appointments is comfortably under two weeks, which has a beneficial knock-on effect on our duty doctor days. Patients who are offered an appointment one week ahead usually feel able to wait, but if the waiting time expands to more than two weeks they often request a duty doctor call.

Our urgent calls have recently fallen from over 60 a day—which didn’t feel safe for one doctor to manage—to around 40, which is stressful but achievable. However, this good fortune is both rare and fragile. Many practices are just one retirement, maternity leave, or long term sickness away from collapse. And there are gaps on the horizon in our staffing, with not a single response to our advertisement, nor, it would seem, to those of all the other practices in our city looking for new doctors. We’ve reached a situation of all the other practices in our city looking for new doctors. We’ve reached a situation where any qualified and registered GP could approach almost any practice and be offered a job on the spot.

In this context, it’s difficult to fathom the thinking around NHS Digital’s publication last week of practice level statistics on appointment types and waiting times. Predictably, there were newspaper headlines shouting “GPs to go on shame list over access,” but I don’t think that GPs have anything to be ashamed of. Plenty of them do feel bad, however, when they go home after a 13 hour day: they’re distressed that they had no time to touch base with the patient with a recent cancer diagnosis; they worry about the possibility of a clinical error in a too-busy day, or an important action overlooked in a letter they barely had time to read. Some are feeling guilty, not about work but about the family and friends they’ve neglected in order to make this job possible, and many are quietly reassessing their choices.

The stated aim of publishing these statistics on appointments and waiting times is to give patients the opportunity to switch to a practice with a better profile. Once upon a time, general practices were meant to be in competition, hoping to register more patients and thereby earn more and grow in size. If, like most surgeries, you don’t have enough doctors and you’re already bursting out of your premises, adding patients to your list will only make things worse. This is especially true when you consider that the patients with the greatest incentive to switch practices are not generally the young and fit ones, who rarely need to see a GP, but those with multiple needs that their current surgery may be struggling to meet.

Formally closing your list to new patients is rarely an option, but, if we want to remain in our current happy place, should we perhaps consider trying to fudge our statistics to make ourselves less attractive to potential switchers? A combination of pride and honesty will prevent this, but it does feel like the most logical thing to do.

If you don’t have enough doctors, adding patients will only make things worse

Everyone has an accent

Accents are influenced by different factors and can change depending on where we are or who we are with. This episode of the Sharp Scratch podcast explores how certain perceptions about accents have been constructed, and the various ways this can play out in medical training and healthcare. Guest Lisa Casey, an assistant principal at a secondary school in London who hosts a podcast about language and linguistics, shares some of the early research that the social psychologist Howard Giles carried out in the 1970s on this topic:

“Essentially, what he found was that received pronunciation [RP] rated highly for things like intelligence, competence, confidence, and level of education. Traditionally speaking, RP is a non-geographically specific accent. It doesn’t bear any markers of a particular place. Instead, it’s what linguists call a social accent. Other accents that were geographically located—and particularly urban accents like Liverpudlian, Brummie, Cockney—tended to rate much lower on things like intelligence and education and competence, but they tended to rate much more highly on things like friendliness or sincerity or compassion in a way that RP didn’t. So it’s now 50 years or so since the original study happened. And, by and large, our attitudes to accents are sort of the same.”

Casey discusses how “accent prejudice exists and it’s very real,” while also noting that accent is only one factor that shapes people’s perception of competence:

“There’s definitely lots of evidence to suggest that marking yourself out as a doctor comes from the way that you use your language. This is moving away from accent and into dialect. But if you are using words that are associated with medicine, then that idea of trust is more likely to be built.”

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Everyone has an accent
The association of housing with health was recorded scientifically over 170 years ago, and housing remains a wider determinant of health globally. The cost of housing also affects health as it determines what residual income remains for other needs such as food, transportation, and medical services. Reviews have identified that experiencing foreclosure and lack of housing stability are associated with worse physical and mental health.

Globally, environmental risk factors can contribute more than a third of the preventable disease burden in children. In parts of Africa, lack of facilities for simple exercise have contributed to a recent and disproportionately increased incidence of obesity in women. Also, recent studies indicate growing incidence of obesity among children and young people in African cities because of the absence of play spaces.

Housing as a pointer to urban health and equity

Poor housing conditions are a known mechanism through which social and environmental inequality translates into health inequality. The confluence of accelerating climate degradation and the SARS-CoV-2 pandemic has identified commonalities to both crises, including urbanisation, overcrowding, and environmental degradation. These problems led to rapid spread of the new zoonosis in the poorest communities—the people that have contributed least to the root causes of the crises but may experience the longest consequences. Proposed solutions relevant to housing include better support for the physical and social environment, reducing evictions, and learning from previous epidemics such as Ebola and HIV. Internationally, redesign of the built environment and attention to those in the most precarious accommodation is seen as essential to global recovery.

Even before the pandemic, the relationship between housing and the wider built environment was increasingly viewed as a measure of the quality of the city as a whole, addressing the sustainable development goals on health (SDG 3) and sustainable cities (SDG 11). By 2014, a third of the world’s urban population lived in slum conditions. Urban dwellers living insecurely have come up with local solutions to the problems. Some regions have made remarkable progress in securing better quality housing and overcoming the challenges of land ownership. Cities and financiers need to consider how they can promote rapid solutions to apparently insurmountable problems. In all settings, the role of the city government, land, and other asset owners versus individuals’ efforts to secure accommodation are relevant to the liveability of the city.

**KEY MESSAGES**

- Housing is a wider determinant of health, environmental degradation, and health inequality globally
- Rapid urbanisation and migration to cities has often outpaced city administrations’ ability to provide housing
- Land ownership, administrative and sectoral fragmentation, and rigid enforcement of building standards have added to the challenge
- Engaging vulnerable groups in the development process can create innovative local solutions
- In high income cities, greater allocations of social housing and alternative financing solutions to support home ownership for those on low incomes are urgently required
New solutions for lower income cities

The proportion of the population living in urban areas in the global south has grown rapidly from just 35% in 1990 to about 52% in 2020 and is projected to reach 66% in 2050. Rapid urbanisation and population growth in developing cities have resulted in higher land and housing prices, putting many households out of the housing market and forcing tenants into cheap accommodation. Owners of land on the fringes of areas of employment stand to profit from extortion of the poorest people, preventing much needed improvements.

For this reason, much urban growth in Africa, Asia, and South America is informal, and the rate of growth often outpaces city administrations’ ability to provide basic infrastructure. Laws and regulations that should guarantee accessibility are poorly enforced and exclude large numbers from the planning process. Most people have poor knowledge of tenancy rights. This led the World Health Organization to recommend that local government and civil society, backed by national government, establish local participatory governance mechanisms that enable communities and local government to partner in building healthier and safer cities. However, the opposite often happens: deliberate measures by some city authorities deny services and infrastructure to areas of the city, triggering a constant threat of forceful evictions and demolitions. This undermines people’s willingness and ability to invest in household improvements and sanitation that would benefit whole communities.

A critical element in resolving accommodation in cities is the valuation of unregistered land. This is also fundamental to achieving the sustainable development goals on food security, poverty, urban development, housing, and displacement. In many developing countries, only 30% of land rights are registered. The UN Human Settlements Programme (UN-Habitat) has worked with countries to support the valuation of unregistered land occupied by the poorest communities. After valuation, communities need forms of finance, and potential models are emerging. In 107 cities across 13 Asian countries, community development funds have been established through seed funding from city or national government and community savings schemes at very low contributions, providing finance platforms for 25,000 savings groups. Community leaders have hailed this as building a financial system for the future to change the lives of the poorest people.

Experience in Central America also shows that technical assistance for self-help construction, when combined with sound inclusive financial methods, can open new opportunities to make land, shelter, and services affordable to low income city dwellers. Loans set at affordable repayment even to those on low incomes have accompanied these schemes. UN-Habitat complements such developments by providing technical assistance for upgrading urban slums, including, as a priority, provision of water and sanitation, electricity, and paved streets for all households regardless of ability to pay.

Alongside formal support, families and communities have taken action to improve their living standards. Substantial transformation was seen in urban and rural sub-Saharan Africa between 2000 and 2015, with improved water and sanitation and the proportion of housing with sufficient living area and durable construction doubling from 11% to 23%. Nonetheless, nearly half of Africa’s urban population still lives in unimproved conditions, partly explained by widespread inadequate sanitation. Beyond financial assistance, cost effective housing policies and interventions in poorer households, such as Piso Firme, a scheme in Mexican cities to replace dirt floors with cement, have also yielded better health outcomes, especially for children.

High income countries require a different approach

In high income countries, poor housing quality, insecure tenure, and crowding in cities are a measure of wider poverty and multiple health disadvantages. Across the European Union, 45.8% of single parent households were at risk of poverty or social exclusion in 2018. About 15.7% of people lived in overcrowded dwellings, rising to 26.5% in the population at risk of poverty. The proportion of people living in private rental accommodation (which can cost up to 40% of income for poor households) has risen from 10% to 15% in the past 20 years, as states have moved away from providing social housing. The inability of the market to solve the housing problems of people on low incomes was most visible in the events surrounding the US house price crash, caused by irresponsible lending practices, that contributed to the global financial crisis in the late 2000s. The WHO Commission on the Social Determinants of Health recommends that national and local government, in collaboration with civil society, manage urban development to ensure greater availability of affordable quality housing. However, progress has been hindered, particularly since the 2009 financial crisis, by major changes in property ownership. The trend is part of a longer-term transfer of assets to environments that create wealth and international investments in “safe” returns such as properties that reliably increase in value.

A more integrated relationship between city planners, those who lead building standards, landlords, tenants, and health leaders at the city level is required to meet the urgent needs of those on the margins of accommodation. City administrations need to face the fact that more social housing or alternative solutions that create affordable housing are needed. City administrations and local government have a particular responsibility to support the most disadvantaged households with safe and secure homes.

Some examples of progressive planning do exist. A series of commissioned multisectoral policy research papers in England set out...
Housing situations in (from far left): Kibera, Kenya; Addis Ababa, Ethiopia; laying cement floors in Mexico; mould in Tower Hamlets, east London

the purpose of social housing, optimal communication with residents, assisted living, local community asset transfers, and how housing providers can support healthier living.\textsuperscript{38}

A memorandum of understanding in England between the public, charitable, and business sectors recognises the shared responsibility for housing with joint working, shared principles, cross sector partnerships, and shared success criteria to guide best practice.\textsuperscript{39}

Another example is the community led housing efforts in England. These built a network of organisations, including cooperatives, community land trusts, and co-housing organisations, to garner support for local groups and develop local projects nationally.\textsuperscript{40}

Across the US, permanent supported housing programmes provide access to affordable community housing along with flexible support services. By 2013, nearly 240 000 permanent supported housing units had been created, with an average of 12 000 units annually since 2006.\textsuperscript{41} Community groups in some cities have moved to solutions that operate outside traditional market based approaches to accommodation.\textsuperscript{42} Imaginative solutions with local leadership to develop vacant properties have been investigated. One example is escalator ownership, where young people rent a home at a reduced rate allowing them to save to buy a percentage of the home from a housing association.\textsuperscript{43}

The pressures on accommodation in wealthy cities will not reduce. Greater allocations of social housing and alternative financing to help those on low incomes to own homes are urgently required.

Housing and health research has not kept pace with needs

Cities represent complex systems, and within these housing and health depend on many interactions that are often non-linear.\textsuperscript{44} This has not been reflected in decades of research on the topic, and even when research travels beyond academic environments, it doesn’t tell policy makers what immediate actions are required.\textsuperscript{45} Furthermore, those responsible for policy in housing use a variety of evidence and often value less empirical ways of decision making, including local acceptability and deliverability.\textsuperscript{46} Globally, WHO says research is required into how collaboration at various levels of governance in a city affects housing and health, noting that the long term social value of these interventions is rarely understood.\textsuperscript{47}

The European Network for Housing Research suggests that we need a much broader conception of “residential context,” including housing and health, that moves beyond a narrow biomedical model.\textsuperscript{48} Taking a transdisciplinary approach, particularly in examining the solutions coming from people without adequate housing in cities, may better address the wider dimensions of health.\textsuperscript{49} We can learn from how transdisciplinary researchers have approached other complex social challenges such as domestic and partner violence.\textsuperscript{50}

Relatively little primary research has been done in developing countries, where socioeconomic and cultural characteristics are generally different and more flexible solutions for accommodation and improvements have already emerged. Better progress towards effective action on urban health will be made through local experimentation in a range of projects, supported by assessment of these practices and decision making.\textsuperscript{51} This action research is more likely to shift emphasis towards adaptation of workable solutions to a wider area.\textsuperscript{52}

What city administrations can do

Cities in the global south, and to some extent those in the global north, are still evolving and are confronted with the consequences of globalisation and the erosion of the welfare state. In the south, city planners and managers need to view housing as an evolving entity where development starts small and grows rather than the present model whereby housing must be delivered with all its accepted attributes (including services). If this perspective of evolution of housing is accepted, then at each stage the safety and health of occupants will be more important than the material state of housing, the current focus of city planners and managers. City administrations can support participatory governance by including local people in partnerships working on development. Tackling housing inclusively can also allow people on the margins of society to access local employment services and engage in wider civil society,\textsuperscript{53} which benefits the whole city.\textsuperscript{54} In the global north, where city administrations are well established, there is a need to shift focus to halt the decline in secure housing for the poorest city residents. Leaders may need to rethink what city governance delivers for its most vulnerable citizens.

The 2020 pandemic is a wakeup call for city guardians everywhere. Poor planning for the accommodation needs of all inhabitants and inattention to the wider dimensions of health in urban settings at the expense of commercial drivers exacerbated the challenges of controlling community spread of infection.\textsuperscript{55,56} The social response to covid-19 has elicited behavioural and societal changes that may persist long after the pandemic.\textsuperscript{57} Already recommendations for healthy, safe, sustainable, and energy efficient housing in the light of recent experience are coming forward.\textsuperscript{58,59} Better housing policies can contribute to healthier and more sustainable societies everywhere.\textsuperscript{60,61}
Healthy, happy lives require affordable homes

The UK’s housing crisis is robbing people of the foundations necessary for wellbeing.

The recent turmoil in UK politics has done little to ease the anxiety felt by many people who are struggling financially as the cost of living crisis tightens its grip. The disastrous consequences of being unable to make mortgage and rent payments are all too real for many people right now. At ACORN, we’re hearing from people whose home is at stake as the government is distracted by leadership contests, political reshuffles, and policy U turns.

Jamie Rodney is an ACORN organiser working in Bradford. Every day he knocks on doors in the city, talking to people about the problems they and their communities are facing. “I recently spoke to someone who has had to take a third job. He barely sees his kids, and often goes a couple of days without sleeping more than a few hours because of a combination of stress and work,” Rodney says. “Then there’s a bigger category of people who are ‘just about’ pushing through, but for whom a new, sudden expense will tip them over the edge.”

Housing crisis

ACORN is committed to supporting tenants and campaigning for better rights, conditions, and laws in the social and private rented sector. While the “cost of living crisis” is a phrase that entered news bulletins this year, the “housing crisis” is something we have been acutely aware of for much longer. It’s a term that encompasses the many problems faced by renters in the UK: poor quality, overcrowded, and unsafe homes; insecure tenancies; and increasingly unaffordable rents.

With UK house prices getting further out of reach and social housing stock dwindling over the past few decades, renting has been the only option for millions of people, with the private rented sector growing from two million households in 2000 to 4.43 million in 2021. This has meant more people competing for the same houses, and some landlords have taken advantage of this situation to increase their yields. In a survey of tenants we carried out in July half of respondents’ rent had risen over the past year. The average rise was 10%, but some people experienced increases as high as 67%. Around 15% of respondents had been encouraged to bid over the asking price to secure a home, and 10% were asked to pay several months’ rent in advance. And this was before the massive rise in inflation we have seen in recent months.

This competitive rental market is making it harder and harder for people with smaller disposable incomes to find anywhere suitable to live. Indeed, one in five respondents to our survey said they had moved to a new town in the past year because they couldn’t afford the going rents. The outcome of this isn’t just the upheaval that comes with moving, but children being uprooted from school, the loss of support networks, and the fragmentation of communities—the loss, essentially, of basic foundations that are part of building a happy life.

This housing crisis isn’t only breaking down the bedrock of a happy life, but also of a healthy life. Losing your home and having your life turned upside down from eviction can have a major impact on people’s mental health. Even the prospect of these outcomes, or the realisation of being unable to afford a suitable home, can lead to stress and anxiety.

Finally, there’s the physical effects that living in damp, cold, and crowded housing can have, putting people at greater risk of respiratory infections and cardiovascular conditions. It is sometimes hard to believe that we are living in Britain in 2022.

The need for reform

Yet change is possible. In 2019, the government announced the introduction of the Renters Reform Bill. ACORN, along with other organisations making up the Renters Reform Coalition, have been campaigning to make sure this bill delivers the change that renters need. A draft of the bill released in June looks promising and, if introduced in its current form, will drive up standards, improve security, and give tenants better recourse to justice.

However, as long as we have a shortage of affordable homes, any progress made by these reforms will be limited. We cannot expect landlords or letting agents to do this for us; they have invested to make a profit, and while some landlords will choose not to raise rents, people shouldn’t have to rely on the goodwill of others to keep a roof over their heads. We have already seen massive rent rises and some agents encouraging landlords that this is a great time to increase rents.

This is an emergency, and we need the government to act accordingly. Measures should be brought in to make sure the cost of rent is within reach of everyone. To start with, this should take the form of a cap on rent rises as we have seen in Scotland. Nobody should lose their home or be forced onto the streets this winter owing to the cost of living crisis.

Looking ahead, the government needs to reverse the decline in social homes and to deliver thousands of high quality, green, social homes, to ensure that our dependence on an insecure and unsafe housing market for the most basic of human needs does not continue.

Ultimately, if we are to build a better, more equal society in which everyone can lead happy, healthy lives and our communities can thrive, we need to make sure that everyone has access to a safe, decent, and affordable home.
LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Objective testing can support PPI deprescribing

Proton pump inhibitors (PPIs) are overused. Farrell and colleagues have outlined useful ways to approach deprescribing (Practice, 5 November).

Putative gastro-oesophageal reflux disease probably accounts for a large proportion of long term PPI prescribing. The clinical diagnosis of gastro-oesophageal reflux disease is notoriously unreliable, and upper gastrointestinal endoscopy yields normal results in at least 50% of patients with pathological reflux—more if they are taking a PPI at the time of endoscopy. The so-called PPI challenge, although simple in practice, has poor sensitivity (78%) and specificity (54%) for gastro-oesophageal reflux disease. Many patients without gastro-oesophageal reflux disease are therefore taking PPIs.

Despite PPI treatment, 30–45% of patients with a presumptive diagnosis of gastro-oesophageal reflux disease continue to have symptoms, and, although this usually leads to increased doses of PPIs and even the addition of other acid suppressive drugs, the reality is that uncontrolled acid reflux accounts only for the minority (10%) of PPI resistant reflux symptoms, and a substantial proportion of patients with symptoms of oesophageal reflux do not actually have gastro-oesophageal reflux disease. Functional heartburn and reflux hypersensitivity are common diagnoses in this context. Many patients are therefore taking PPIs unnecessarily and without benefit.

The strategies outlined can be useful in withdrawing unnecessary PPI use, but more objective testing can be helpful. Prolonged wireless capsule pH monitoring accurately predicts the ability to discontinue PPIs in patients with reflux symptoms. An acid exposure time of less than 4.0% is the optimal predictor of successful PPI withdrawal. Although not required in every case, objective oesophageal pH monitoring should be considered in patients with poorly responsive or non-responsive reflux symptoms and those with normal results on endoscopy and PPI responsive symptoms requiring long term maintenance.

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OBSTETRIC HISTORY AND RISK OF STROKE

Engage people with experience of pregnancy loss

Liang and colleagues report on increased risk of ischaemic or haemorrhagic stroke in women with a history of infertility, miscarriages, and stillbirths (Research, 25 June). Media coverage of the study has led to distress and anxiety for some women at risk. The article also promotes a stigmatising and victim blaming view of pregnancy loss.

The authors indicate that no “patients” (or members of the stillbirth or pregnancy loss community) were involved in the research, which is disappointing given its sensitive nature. Bereaved parents and families offer unique and valuable insights as research is prioritised, conducted, and translated, helping to ensure research quality and relevance. The evidence is also growing around the benefits of co-creation of research with patient involvement.

Engaging people with lived experience of pregnancy loss would have led to more sensitive communication of these results, with greater attention to the context in which the messages would be received.

Paula Quigley, chair of board, International Stillbirth Alliance; on behalf of the International Stillbirth Alliance, Red Nose, and the Pink Elephants Support Network

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Authors’ reply

We acknowledge the concerns raised by Quigley. This was written as a scientific paper with findings primarily aimed at other researchers and health professionals. It uses existing studies with historical data from women over decades to advance evidence on their risk of stroke.

The term “patient,” as used in the title and elsewhere, refers to “patient data,” such as from hospital records. The point is to establish the specific source of the medical data and their accuracy, as distinct from using a survey with self-reporting stroke events. Otherwise, we refer to those in the study as participants or as women.

The next stage of our work in this area has new data collection and interviews with women on their experiences, with extensive involvement in the project of those with lived experience, including members of the stillbirth or pregnancy loss community and of organisations representing those with stroke and cardiovascular disease.

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DOCTORS WORKING FROM HOME

Moral, physical, and clinical support are lacking

The “new normal” of doctors working from home has clear benefits, but Best’s enthusiastic portrayal does not consider some of the unforeseen consequences (Cover Story, 5 November).

People working in the acute setting share a spirit of comradeship and devotion to a purpose that they believe in. This “esprit de corps” is not possible if you are not present on the ward or physically not available.

Some juniors need help with putting a difficult cannula in. The presence of consultants on the wards allows moral, physical, and clinical support for juniors, nurses, and allied healthcare professionals. This camaraderie is essential to the wellbeing of the staff in the NHS. It’s what got us through the pandemic in the first place.

What we need most of all from senior doctors in this post-pandemic era is compassionate leadership. We struggle to believe that this can be achieved when working from home.

David S Sanders, NHS consultant, Sheffield; Suneeil A Raju, gastroenterology clinical fellow, Sheffield; Iman A F Azmy, consultant oncoplastic breast surgeon, Chesterfield

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Paul Wilkinson

Environmental epidemiologist at the forefront of research into the health benefits of climate change action

Paul Daryll Wilkinson (b 1959; q Oxford, 1985; MFPHM, FRCP), died from a pulmonary thromboembolism on 11 September 2022

If excess winter deaths are linked to colder temperatures, why do so many more die in England than in colder places such as Scandinavia? In 2001, epidemiologist Paul Wilkinson gave the answer: his groundbreaking paper “Cold Comfort” showed it’s the temperature inside the home that is crucial. Draughty, cold housing is inimical to health.

Wilkinson repeatedly found that what is good for the planet (reducing carbon emissions, cycling and walking, energy efficient housing) is also good for human health. In 1989 he became a research fellow and honorary registrar at the National Heart and Lung Institute. He had decided to make researching the health benefits of climate change mitigation strategies his life’s work and in 1993 joined the London School of Hygiene and Tropical Medicine as a lecturer. He worked there for nearly 30 years, becoming professor of environmental epidemiology and head of the environmental epidemiology unit from 2003 to 2007.

Wilkinson, who became director of the National Institute for Health and Care Research health protection research unit in environmental change and health, repeatedly urged his colleagues to “think big.” There was no time to waste, and he was hugely energetic. During his career, he led or was the co-investigator on over 70 research projects, covering subjects ranging from energy efficient buildings and air and noise pollution to the impact of flooding on health, and speed restrictions on road injuries.

Global expert on health and climate change

As a member of the UK Committee on the Medical Effects of Air Pollutants, Wilkinson was able to influence government policy on air pollution and his work on temperature and ventilation informed building regulations. On the global stage, he advised the World Health Organization and he was the scientific director of the ambitious Complex Urban Systems for Sustainability and Health programme funded by the Wellcome Trust. In this role, he travelled to the six cities in the study, offering scientific evidence on health and environmental matters. In Kisumu in Kenya, for example, he advised on a project to manage the vast rubbish dumps and blocked drains blighting the environment and the inhabitants’ health.

A gifted speaker, Wilkinson was much appreciated for his authoritative mastery of the facts and clear delivery—as a lecturer, on government committees, and when giving evidence in environmental health cases, including that of 9 year old Ella Adoo Kissi-Debrah, who died with air pollution exposure as one of the causes. He also enjoyed teaching epidemiology to international students at summer schools held in Prague and Krakow, where he was popular and frequently invited by the students to join in with the closing celebrations.

Early life

Paul Daryll Wilkinson was born in Yeovil, Somerset. He went to the local grammar school but then won a scholarship to board at King’s College Taunton. In 1978 he went up to the University of Oxford to study physics. He swopped to medicine after a term but remained interested in physics, and it informed his later work: he wrote models to show how air circulates in buildings, for example. Many academics as they become more eminent do less modelling and data analysis, but Wilkinson kept up with new statistical methods throughout his career.

After qualifying Wilkinson found the research element the most satisfying part of his junior clinical jobs at the Royal Marsden and St George’s Chest Hospital in London, which led him to embark on his career in epidemiology. His clinical background was important to him, as it gave him knowledge of the way body systems are affected by environmental factors. He could also never be just an academic number cruncher; he was always aware that behind the statistics are real people struggling with health problems.

While at Oxford, Wilkinson met Kay MacLarnon, a fellow medical student. They married in 1986 and had a son, Guy, in 2005. Their family home was in Northampton, and Wilkinson, like his father, got satisfaction from doing practical DIY jobs around the house. Before covid-19, he lived in London during much of the week and regularly cycled to the London School of Hygiene and Tropical Medicine. Although work took up much of his time, he savoured time with his family, including driving his son to tennis lessons.

On 11 September 2022 Wilkinson died suddenly from a pulmonary thromboembolism. He leaves his wife, Kay; his son; and his brother.
Gerald Keen

Pioneering cardiothoracic surgeon

Gerald Keen (b 1926; q London 1950; FRCS Eng, MS), died from cardiac and respiratory causes on 11 August 2022

Cardiothoracic surgeon Gerald Keen worked at Bristol Royal Infirmary, the Bristol Royal Hospital for Sick Children, and Frenchay Hospital from 1964 until 1991. His practice was originally thoracic and cardiac, both adult and paediatric, but over the years he concentrated increasingly on adult cardiac surgery, predominantly valve replacement and coronary artery bypass surgery.

Years after he had retired, Bristol Royal Infirmary was engulfed in scandal, with landmark inquiries into the deaths of children who had heart surgery there during the 1980s and 1990s which brought disgrace for two cardiac surgeons with whom Keen had worked—James Wisheart and Janardan Dhasmana.

Life and career

Born in London to parents who ran a greengrocers, Keen studied at King’s College London and the Westminster Hospital on an entrance scholarship in anatomy and physiology. After qualifying he served in the jungles of what was then known as Malaya as part of his national service, which he considered a “maturing experience,” says friends.

He trained with Russell Brock at the Brompton Hospital and with Charles Drew and Price Thomas at the Westminster Hospital. “While working under Drew’s direction he developed the technique of profound hypothermia and circulatory arrest which was one of the methods which permitted open heart surgery to begin,” says Wisheart.

Profound hypothermia was used in open heart surgery in infants, when cooling to low temperatures allowed the surgeon prolonged periods of total circulatory arrest for operating on the stationary open heart. Keen and Drew published a paper on the technique, and Keen a thesis, for which he was awarded recognition by the University of London.

Keen spent a year in San Francisco working with Frank Gerbode, the noted American heart surgeon who contributed to the training of several British heart surgeons in the new specialty of open heart surgery, which in the UK was largely focused on London. When he joined Bristol Royal Infirmary in 1964 Keen was the only full time cardiac surgeon in the south west of England, serving a population of over three million people.

Antony Baker, a retired consultant vascular surgeon who worked in Bristol at Frenchay Hospital and Southmead Hospital, says conditions in the 1950s and 60s for specialist cardiac practice were rudimentary and poorly equipped by today’s standard. Cardiac surgeons of that era were “groundbreaking pioneers” operating on patients who were desperately sick and had very poor prospects otherwise. “We wouldn’t have cardiac surgery like we have now if it wasn’t for the risks these people took,” he told The BMJ.

Keen would develop a strong interest in chest injuries and was a pioneer in the treatment of traumatic rupture of the thoracic aorta. He held the Hunterian professorship awarded by the Royal College of Surgeons, wrote a textbook on chest injuries, and edited another on operative surgery and management. He helped to expand the regional cardiac unit at Bristol Royal Infirmary into a major centre, showing “considerable determination in the face of some resistance,” says Wisheart.

In retirement, Keen maintained a medicolegal practice for many years.

Bristol heart surgery scandal

Keen had retired before the Bristol Royal Infirmary inquiry—one of the NHS’s biggest ever investigations—was set up in 1998 to examine the deaths of 29 babies undergoing heart surgery in the late 1980s and early 1990s. But he contributed evidence in a written statement in 1999.

Wisheart, who was also the trust’s medical director, was struck off and Dhasmana suspended from carrying out paediatric cardiac surgery for three years. They were found to have lacked insight and failed to recognise their performance lagged other units. The inquiry highlighted unsafe care, lax oversight, a secretive “club culture” among doctors, poor leadership and teamwork, and no systematic mechanism for monitoring clinical performance. It called for a revolution in openness, stating “there was enough information to cause questions about mortality to be raised had the mindset to do so existed.” The inquiry also found the physical setup was “dangerous,” with surgeons on one site—at the Royal Infirmary—and paediatric cardiologists several hundred metres away at the children’s hospital.

In Keen’s written evidence statement, he said that he was not associated with open heart surgery on children at Bristol Royal Infirmary from 1978 onwards and played no part in either the management or referral of Wisheart’s patients. He stated both Wisheart and Dhasmana were well qualified to undertake open heart surgery on children. He also stated it was clear with hindsight that having paediatric open heart surgery split between two sites could have adversely affected children’s care, but the model was “the best available at the time.”

Wisheart stayed close friends with Keen, with whom he worked for over a decade and shared an office, and gave a eulogy for him at his funeral.

In 2016, Keen’s wife, Marian, to whom he was married for 61 years, predeceased him. He leaves their two sons—David, a dentist, and Richard, an industrialist.

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