DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Local Test & Trace – Playing catch-up with the giant players behind the 'NHS' mask

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Notice – In Memoriam

We regret to report the sad news, received just as we went to press, of the death of Dr David Player, who was a member of DFNHS for many years. He joined DFNHS in 1989 and was a good friend of the organisation. David made many lasting contributions to the opposition of health inequalities. A full obituary will follow in the next issue.

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[Cover satellite image – Halifax, Calderdale, West Yorkshire]

Medicine – it's personal

When people suffer an injury, or become seriously ill, their priority is to get expert help quickly, but once that initial assistance has been provided, the priority often shifts to that care being provided in a stable setting, by a stable team in whom confidence and mutual respect can develop.

How often have we heard people complain of large hospital departments, or large primary care settings, "You never see the same person twice"? The doctor-patient relationship takes time and effort. It can be complex, it is often hard work, it can be exasperating, and sometimes it can be heartbreaking, but it is an important part of the healing art.

It can also be tremendously fulfilling to the doctor involved, as they see trust developing, anxiety reducing and an appreciation of their patient as an individual, living a life with its own set of circumstances and challenges. It can make the difference between a day in which you feel you have achieved nothing and one in which you feel that you have made a real difference to another person's life. It can make all the difference between staying in the profession, and abandoning it. This newsletter includes two entries that were submitted for last year's DFNHS/BMJ essay prize, in which the title was 'Where have all the doctors gone, and why?' One is from Zimbabwe and one from the Philippines and they explore this question from a very different perspective from most of the other entrants, which might make us pause for thought.

It did not come as any surprise to me that discussions at this year's Annual General Meeting of Doctors for the NHS returned time and again to the importance of continuity of care and the way in which we are letting go of that concept, for a whole variety of reasons. Continuity of care unites the interests of clinicians and patients in a way that little else does and we must hold that common ground, confronting the factors that are eroding our ability to keep safe this vital component that makes medicine a profession, rather than a series of transactions, and, rightly or wrongly, grants us our standing in society. We must certainly not relinquish it for our own personal convenience – because it demands that our patients have easy access to our time, or for personal gain. We let it slip from our grasp at our peril.

The recent invitation from NHS England for applicants for APMS contracts, based on a 'digital first' model, makes no reference at all to any kind of continuity of care [1]. It plays to the idea that primary care is a series of unconnected events and clinicians can dip in and dip out, dealing with each contact in isolation. It completely misunderstands and undervalues the complex interactions between clinician and patient and have such an impact on the outcome of their care.

The rush to interact with patients along a wire, or across the ether, rather than in person may have attractions when trying to stop the spread of airborne viruses, but the concept of Digital First in access to clinical services was already being pushed vigorously before anyone had heard of Covid-19. After all, there are big commercial players involved – Cerner, IBM and many others. In 2018, Simon Stevens pronounced that outpatient clinics were obsolete [2] and Matt Hancock was advertising Babylon's GP at Hand app [3].

Certainly, there will be times when telephone or video-consultation is appropriate and convenient for patients, particularly in follow-up appointments of a patient with a clear diagnosis, who is well-known, has good verbal skills and with whom a good, trusting relationship has already developed. I am yet to be convinced that it is appropriate for

many initial assessments. Accurate diagnosis of a person and their clinical problems demands that we should make use of all sources of information that are available to us. Why on earth would we voluntarily confine ourselves to the words that come out of the patient's mouth, or the variability of what we can see on a screen? After all there is a limit to where you can stick an iPhone. Shouldn't we have the confidence of our professional standards and denounce Matt Hancock's prescription that all GP consultations should be remote by default [4]? It requires a much more nuanced approach.

Access to healthcare is one of the points on which we are judged, whether fairly or unfairly. The hurried rearrangement of Primary Care in response to Coronavirus seems to have been more successful in some places than others. John Hussey's and Kathryn Moore's account of the redesign of an inner city health centre and the services it provides, shows the amount of thought that goes into maintaining that access and giving the public the confidence that the service they value is still there in their hour of need. It is concerning that, in West Yorkshire at least, there has been a noticeable shift towards an increased proportion of cancers being referred at later stages, and a shift to more of these referrals coming through A&E. Prior to the pandemic, the relatively poor cancer survival rates in this country were attributable to delayed recognition of the possibility of cancer. The concern now is that there may be a perception that it is less easy to be seen in Primary Care, possibly combined with the limitations of telephone triage and consultation, making a bad situation worse. Of course, it needs to be done as safely as possible, but our patients need to be able to see that the NHS is open for business in all settings. We must do our best not to put barriers in their way.

Artificial Intelligence (AI) could be a valuable tool, serving a useful function in alerting the clinician to possibilities they had not considered. Digital systems and AI are useless unless the initial information that is entered is accurate, but how is that information gathered? It requires the human touch. It requires tried and tested methods: careful and sensitive questioning, observation of non-verbal cues and clinical examination, followed up by selection of appropriate investigation. How many times have I heard the salesman's pitch that their system will mean that the patient "only has to tell their story once"? But the story can change each time it is told, depending on the questioner: on appropriate prompts and questions, guided by clinical experience. I have heard referring clinicians say, "That's not the story they told me" on so many occasions when the diagnosis had changed radically, because taking a history is an interactive process and demands good clinical knowledge and understanding of human behaviour to know what questions to ask and which avenues to explore. So far, this is beyond the ability of AI systems, whatever the snake-oil merchants tell us, and we must not sell our humanity short, for the sake of our patients, and ourselves.

References

[1] NHS England (2020) *New Market Entry: Preliminary Engagement Pack* [online] Available at: https://bit.ly/3dsoHQQ

[2] Illman, J. (2018) 'NHS outpatients model obsolete, says Stevens' *Health Service Journal*, 13 June [online] Available at: https://bit.ly/2H0gN5p

[3] Syval, R. (2018) 'Matt Hancock accused of breaching code over GP app endorsement', *Guardian*, 30 November [online] Available at: https://bit.ly/3lH5Lko

[4] Walker, P. (2020) 'All GP consultations should be remote by default, says Matt Hancock', *Guardian*, 30 July [online] Available at: https://bit.ly/34TMohj

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In isolation, but not alone

A bright, fresh Sunday morning in early autumn in Halifax, West Yorkshire. Two retired doctors have received their orders for the day. As part of a team of 18 contact tracers assembled by Calderdale Council, they have been given a list of people who have tested positive for Coronavirus, that the national Test and Trace service has been unable to contact by telephone, after a period of a day or more.

There are 11 people on the list. The local team have tried, and been unsuccessful, in phoning them. There is no point in further delay. It is time to try and speak to them directly. Two people continue with phone calls, and two are on house visits.

The initial call of the day takes us to a tidy former council estate. A middle-aged woman answers the door, having first warned us that she is in isolation. We are kitted out in safety goggles and masks and explain that that is the reason that we are paying her a visit. Most people seek a PCR test because they are feeling unwell, so we ask how she is getting on, and whether she and her partner are experiencing any practical difficulties in isolating themselves from the rest of society. For people who are struggling to get food or medicines, or have large dogs that need walking, or need to provide care for others, we can put them in touch with local support services run from council volunteer hubs.

If people are struggling financially, we can try and help them to gain access to any financial support they are entitled to, but if they are facing serious hardship and have no other means, there are discretionary funds that can be unlocked. Everyone talks about 'Test and Trace', and certainly those are essential steps, but by themselves, they achieve a big fat zero. Making sure that people who pose a risk of transmitting infection are able to avoid contact with others, and are given the support and motivation to do so, is the bit that actually makes the difference. It is incredible how little funding has been put into ensuring that this happens, and how little effort into assessing peoples' compliance, when compared to the vast sums that have been spent on other elements of National Test and Trace.

Nevertheless, it would seem that the great majority of the people that we are speaking to are actually complying with the request to isolate the household. The overwhelming sense is that their brush with the virus has brought them up short. They are worried for themselves, their families and the people that they might, unwittingly, have infected. They welcome the opportunity to speak about their experience, to help our attempts to stem its spread, and to understand the way in which it is propagating through our communities. Hostility is vanishingly rare.

After 20 minutes' chat, we have the details of the people with whom she has had close contact in the couple of days before she began to feel ill, who will need to isolate for 14 days after they were last in her company, details of her workplace, the names of shops, restaurants, pubs, gyms, hairdressers that she had attended and who she might have met there. We then ask her to think back further – a week before the illness – to people she had met and places she had visited, or shared car trips, to try and get an idea of where she might have picked up the virus.

Often people will have a pretty shrewd idea of how they might have caught the infection, because of acquaintances that have become ill and had the test. As time goes by, the same settings may be mentioned by cases that are otherwise unrelated – a warehouse, a factory, a pub, a salon, a part of the health service. If we recognise patterns, we can easily speak to the council's Public Health Officers and see whether additional work needs to be

done to make these settings as safe as possible.

This is one of many benefits of contact tracing being carried out by local teams. We live in these communities. We know the geography. When people are telling us about the places they have been and the things they have been doing, we can form a clear picture in our minds, which can guide further questioning. Unlike people working out of a remote switchboard, we have a vested interest in reducing the damage to lives and livelihoods in our home town, and the people we are speaking to recognise that. So far, they seem to find our attempts supportive, rather than intrusive.

The Serco/Sitel contact tracers phone from an 0300 number and, not surprisingly, many people are reluctant to accept such calls. We phone from local numbers, and often we get through. When we don't, it needn't take long before we are on the doorstep. Figures from last week showed that Calderdale had the highest proportion of cases contacted in the North-east and Yorkshire, through the combination of national and local efforts. And yet, the number of cases is rising across Calderdale, as they are across the country. Can we make improvements? Definitely.

> "From the outset, PHE would only give us access to the details of people that the Serco/Sitel service had been unable to contact....This must be limiting our ability to plot the virus's spread. "

To be effective, we should be identifying the contacts of infected people as quickly as possible. Time is also critical in providing support to people so that they can be supported to remove any barriers that would make it difficult to isolate themselves. The many interfaces in the clunky national system, mean that results are not being released quickly enough from the centralised laboratories to the Serco/Sitel contact tracing system. Only 60 per cent of results, sometimes fewer, are released within 24 hours of the sample being collected. Once they have made a few attempts at phoning the person, and the case has been passed onto local contact tracers, more time has passed. Today, the people that we are visiting had their tests between 4 and 8 days earlier. This is far too late in the day. If a few of Dido Harding's billions were allocated to local authorities to build up their contact tracing services, it could redress this country's woeful performance in controlling the pandemic. If a bit more were available to increase the capacity of local hospital and academic laboratories to perform PCR tests and link them to a much more direct line of communication with local Public Health Departments, we would have invested in a much more resilient system to tackle this pandemic, and the next one.

Later in the day, we visit a small terraced house in the town centre. We have been given details of two people at that address, who had tested positive a week ago. When the door is opened, we learn that there are seven members of the family living there. They have all tested positive, within a few days of each other, and the person who has answered the door does not look at all well – drawn and fatigued. Each of those people who had a positive test, will have been phoned to ask for the people that they have been in close contact with. Amongst their contacts, they will have named the other six members of the family. So each member of the family will have been phoned once as an index case and six times as a contact of each of the other people in the house. Forty-three phone calls will have been directed at this one family, purely because the information systems that are being used regard every test as a separate event: there seems to be no way of collating the data from an Excel spreadsheet, to bring it together by household. This is occurring

time and again, antagonising members of the public and wasting everybody's time. The system seems to have been designed to accumulate data centrally, with little thought given on how to extract it, to use in the control of this disease.

Calderdale has been under local restrictions since the end of July. Long before this, the Chief Executive of the Council was calling for a locally based service [1] but our local contact tracing service was not allowed to go live until the middle of August. From the outset, Public Health England would only give us access to the details of people that the Serco/Sitel service had been unable to contact, so we are only able to see part of the local picture. This must be limiting our ability to plot the virus's spread through our communities. We don't even know what proportion of local cases we are dealing with, to be able to understand what capacity would be required to expand our service to cope with all new cases. And then, once we have identified those people who have been in close or direct contact with the infected person, PHE won't permit us to speak to those contacts and support them to isolate, even if they are living in the same house we are visiting at that very moment. They insist we send those details back into the national system, with the further delay that entails. Because these contacts probably feel perfectly well, at least initially, they are likely to require much more convincing than someone who is sick and worried, to stay off work, avoid social contacts, and stay in their home. These are exactly the people that might be swayed by a conversation with local workers and the support services they can offer.

At the end of our shift, we have spoken to seven individuals, seen people affected to varying degrees by Covid-19, and identified several workplaces and social settings as potential settings for outbreaks. We have connected with families in terraced streets and leafy avenues lined with Victorian villas in central Halifax, in villages and in our market towns and people have given us detailed information about their personal lives. We have gathered a few more pieces of the jigsaw puzzle describing the complex web of interactions that go to make up our community, and across which this virus is spreading into yet more lives. And, hopefully, the people we have spoken to understand that they are not alone.

Reference

[1] Ham, C. and Tuddenham, R. (2020) 'Testing and contact tracing: a role for local leaders', *Health Service Journal,* 5 May [online]
Available at: https://bit.ly/33TrwHD

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Coping with Covid? A View from General Practice

Who We Are

We are an inner-city practice in Liverpool with a list size of 9000 patients. We have several patients in Nursing Homes, a large elderly population, and a high prevalence of long-term conditions. Since 2012 we have operated a total triage system for all GP and ANP appointments which enables 100% same day access.

Information in the early days

- Guidance and advice from DoH, NHSE and government seemed to change daily.
- Our local LMC were invaluable – sifting through the latest guidance and passing on relevant points to practices via daily early morning emails.
- Our lead GPs used the LMC guidance and formulated practice operating procedures, disseminating them to the practice team.
- Liverpool Network Alliance also circulated regular emails which were particularly useful as services began to resume.

In the early days of lockdown daily practice email updates ensured everyone knew how we were dealing with telephone calls, home visit requests etc. Procedures changed as guidance changed and as lockdown restrictions were lifted. This required a massive amount of flexibility and the embracing of a great deal of change. Whilst it was a stressful time, it was also incredible to see our entire team pull together and develop a quite different way of working in a noticeably short space of time.

Continuing Primary Care during the lockdown period of the pandemic

The challenge was, and is, to continue providing primary care whilst keeping patients and staff safe. Primary care was advised to move to a telephone triage system. As we were already operating this system this was not a huge challenge for us.

Staff

Staff who were shielding and anyone who could work from home were enabled to do so via laptops. Our Reception supervisor (shielded) worked via Skype connected to a laptop in reception so that she could see everyone.

Zoom, Skype and WhatsApp were used for team meetings, enabling those staff working from home to be included.

A WhatsApp Home team group was formed to try to avoid any sense of isolation amongst staff working from home.

There was a real sense of the team working together to ensure everyone felt safe and included, whether they were in the building or at home.

Patients

Accurx screening texts are sent to all patients before attending, asking if they have any symptoms, any recent travel or contact with C19 cases or if anyone in their household has symptoms.

One of the huge privileges of primary care is that we all come to know our patients and their families over several years, sometimes decades.

However, this privilege also makes it extremely distressing when something bad happens to them. In the early stages of the pandemic we had numerous deaths in a short period of time which was upsetting for many of us.

Whilst we have developed and accepted new ways of working, we must acknowledge that patients have also had to do the same. Our patients have been amazing, they have largely accepted the need to wait outside the surgery, wear face-coverings and so on. We have been humbled by the numerous expressions of gratitude, concerns for our safety, and thanks from patients.

Suspected Covid-19

Isolation rooms were identified, enabling separate access in and out of the surgery. Our reception and admin teams took charge of this, stripping two clinical rooms of everything but essential equipment in a very few hours. Protocols were developed for booking patients into the rooms and for deep cleaning of the room and any equipment used.

Hub working was initiated across our network. This ceased to be used after a short period of time, because only small numbers of patients were being booked into it and it was felt to be resource expensive. However, the model has been tested should Hub working need to be reinstated.

This was a particularly frightening time for many people, including clinicians who did not know how many suspected Covid-19 patients would need to be seen, or how ill patients would be, along with doubts about whether the PPE was sufficient to keep them safe. We encouraged an honest, open discussion about this. Some clinicians, whether it be due to personal issues or because of concerns about vulnerable relatives at home, felt particularly anxious about seeing possible Covid-19 patients. We agreed to try to keep those clinicians away from any high-risk patients. It was heartening to see the whole team agree about this and express genuine concern for each other.

Digital and Information Technology

Accurx has been invaluable, especially in the early days when we were inundated with phone calls from worried patients. We developed a library of texts about stay at home advice, guidance on shielding, and guidance for specific patient groups. Reception sent the texts, diverting these queries away from clinicians, thus freeing clinicians to deal with unwell patients.

Prescriptions: Reception were instrumental in encouraging all patients to nominate local pharmacies which enabled prescriptions to be sent electronically, reducing the need for patients to leave their homes.

Photographs: Patients sending photographs has been useful, but also required a new set of protocols, including when it is appropriate to request a photograph and consent to save photos into records. Asking the patient to send a photograph and then doing a telephone or video consultation has been useful, particularly when managing skin lesions or rashes.

Video: Again, Accurx were invaluable, quickly enabling video consultations by mobile phone, webcam and now by email. Video consultations have been useful for managing patients when physical examination is not thought to be needed and for reviewing patients with depression or anxiety. Video is often better than a phone call because we can see the patient or seeing these patients face-to-face because we are able to see some visual cues which can be hidden by facemasks.

Nursing Homes

In the early stages of the pandemic, managing Nursing Home patients was particularly harrowing. We found ourselves holding difficult and emotional conversations with patients, staff and relatives initially by telephone and later by video, something which has never been the norm and will probably never feel normal or acceptable to many of us. However, this may have provided some psychological support for Nursing Home staff who were dealing with exceedingly difficult and traumatic situations.

We will never forget a video consultation with one of our Nursing Homes during which the Nurse broke down in tears as she told me how many residents they had lost.

Access

Our doors have always been open and closing the doors to the public was a major and uncomfortable decision, however it was necessary to protect staff and patients. Although the doors closed, they were manned by a receptionist wearing PPE. The practice was very much open and operating, albeit behind closed doors.

Our receptionists announced that they had made plans to enable social distancing by coordinating the area outside the surgery and in the waiting room. They organised a rota for manning the doors whilst protecting vulnerable members of staff by keeping them at the back of reception away from the waiting area. We always knew we had an incredible team, and this was just one example of how they proved it!

Patients are encouraged to contact us by telephone or email, but we do have some patients without access to either, or who come to the surgery in person. These "walk- ins" are greeted by the receptionist manning the doors, complete a screening questionnaire before entering the building. We control the number of patients in the building in order to maintain social distancing. This means that sometimes patients may need to wait outside the surgery – patients are informed of this when booking appointments and are reminded to wear a face-covering.

Challenges

PPE: We never received any eye protection. Goggles were donated by a local school; face-visors were made by the husband of one of our doctors. We ran out of face masks on several occasions, needing to rely on masks made by staff and friends. The practice partners provided scrubs for all staff and we received donations of scrubs and scrub bags from local organisations and patients. Whilst it was disappointing and frustrating to feel that PPE provision was inadequate, we also felt a deep gratitude to the patients, friends and organisations who made donations.

Shielding: The shielding process has been fraught with confusion, lack of clarity and changes to the high-risk inclusion criteria.

Initial guidance advising people to shield for 12 weeks included pregnant women, diabetics and asthmatics. This depleted many primary care teams, of those with the conditions and of those living with affected people. Our home working team made welfare phone calls to shielding patients giving details of community support groups who help with shopping, collecting prescriptions, dog-walking etc.

Shielding patients were identified centrally and informed by NHSE. Primary care was asked to review the lists and contact any patients we believed had been inappropriately identified as high risk. It was often difficult to understand why some patients had been identified as high risk, eg we had one fit and well patient who was told to shield by the transplant service. He was a kidney donor, not a recipient and was as baffled as we were! Fortunately most of the patients we advised that we did not think they needed to shield were relieved and grateful to hear that they could at least go out for a walk.

The Future

Face-to-face consultations

We recommenced face-to-face consultations as soon as we received PPE. The wearing of PPE by the clinician and face masks by patients is a necessity but continues to feel unnatural and brings a new level of difficulty to consultations. Both PPE and facemasks hide some non-verbal cues and act as barriers between the patient and clinician. This is particularly difficult for patients with hearing loss who rely on a degree of lip reading and during consultations with patients who do not have English as their first language – telephone interpreters may struggle when both patient and clinician are speaking through masks.

On a personal level, being unable to even touch the hand of distressed patients has been upsetting and we will continue to struggle with this.

Workplace

Ensuring staff are socially distanced both when working and during breaks is a new requirement. Protecting staff by staggering break times and limiting the number of staff in rooms is challenging.

We must recognise that staff returning to work after shielding or maternity leave may feel anxious about working arrangements and we must support them as they return.

Some staff who can work from home may continue to do so.

IT

We needed to develop different ways of communicating and consulting with patients.

Video consultations, electronic prescribing, e-consultations and text messaging will continue. Remote monitoring such as home temperature checks, BPs, oximetry will be developed further.

Digital poverty

Whilst the increased use of IT has been welcomed, it also highlights the problem of digital poverty. Many of our patients do not have access to or are unable to use the technology required for video or e-consultations. This will be a bigger problem for practices in deprived areas and is another inequality which may need to be tackled at public health and social care level.

Summary

Maintaining a responsive General Practice during the period of Covid-19 lockdown has been a challenge to the system, practices, clinicians and patients. Teamwork, flexibility and mutual tolerance have been impressive and heart-warming in all areas. Primary care has probably changed forever with new digital tools likely to remain in use. However, it has been good to see that old values of GP such as care and respect between practice and patients has helped us all ride these uncertain waves.

John Hussey and Kathryn Moore
Liverpool GPs

This year's AGM was unique in being held online for the first time. It also marked the regrettable absence of a Conference this year, after it was decided that the technology, though good and improving, was still not quite good enough to grant speaker presentations a glitch-free time, or members the surety of a reliable enough internet connection for the duration of any Conference.

Despite these limitations, this year's unprecedented challenges and increasingly damaging attacks on the NHS gave members ample grounds for discussion, and future action to keep the NHS safe from further deliberate and malign damage, even as the pandemic continues.

AGM 2020

AGM Reports

Opening address: Colin Hutchinson, Chair

[Colin's full report was made available before the meeting and can be downloaded from https://bit.ly/3i5EWEd.]

Colin highlighted what we have been able to achieve over the past year and presented our plans for the future.

Alan Taman, our communications manager, has been doing some additional work with us this year which has given us more inreach into mainstream media to the extent that we were quoted on the same day in both the *Daily Mail* and *Daily Mirror* which was quite an achievement. We have links with the *Guardian*, *Morning Star* etc. We have placed ourselves as being a trusted source of comment and information particularly on the increasing degree of commercialisation in the NHS.

Colin felt we should be discussing what exactly is going on by referring to 'commercialisation', such as the detrimental impact of the private health centres on the NHS, the issue of subsidies paid to private hospital chains during the period of lockdown, the potential for the blurring of boundaries between what is treatment within the NHS and treatment within the private sector, and the coherence of the national response to coronavirus including the Test and Trace system.

We are trying to Increase collaboration with other organisations particularly our long-term ally KONP. Colin has a place on their steering group which he attends on behalf of DFNHS. Most changes that we seek can only be achieved through government action so we need to get our ideas heard by politicians both at local and national level which is not easy. We are collaborating with Our NHS Our Concern, which Arun Baksi has been instrumental in setting up, which seeks to build contacts with politicians in parliament.

Colin encouraged all members to forge links with their local MPs wherever possible. DFNHS depends on the enthusiasm of its members and he was particularly grateful to members of the EC who have helped take forward the work we are trying to do. We need new members especially those working in the NHS so that we have first-hand information from the front line. He welcomed ideas for attracting more members.

One of the major issues is that we went into the pandemic with NHS in a much weakened state. The waiting list in January had reached 4.6 million, and the A&E 4 hour target was at the worst level ever recorded. The health service had been undermined and rundown and fragmented.

There was much discussion about how we as a body should react to the government's response to the pandemic and it was felt in the early phases we should not be overly critical as we would be seen as being potentially divisive and meddlesome and that we should be gathering evidence and arguments for a future public inquiry. There has been little mention of an inquiry so how long we hold on to this approach has to be decided. We have been critical of certain aspects of the response (see Alan Taman's report on page 18).

The workforce crisis

There is the major problem in terms of getting services up and running in the way we would like it. Part of that is the problem of retaining doctors. We have made a submission to the House of Lords Public Services Committee Inquiry about the barriers that have been put in place to people feeling that they have a fulfilling role within the NHS and are able to properly contribute to the way that services are designed and delivered. There is a sense that professionalism is being eroded. It seems to have been replaced by a sense that they are just a cog in the wheel. We will continue to explore this area of reduced job satisfaction.

DFNHS Essay prize competition

This has become one of the highlights of our year. See Peter Trewby's report (page 16) for details. Three themes occurred repeatedly across the entries – the need for a fair and effective social care system, job satisfaction and staff retention, and thirdly, the corrosive effect of racism within the NHS, within public services and in broader society. As an organisation we should pay close attention to these concerns.

Virtual Meetings

This AGM was conducted online via 'Zoom'. The Executive Committee meetings have been on-line over the past few months and this has worked remarkably well with more meetings and greater attendance than before. Hopefully this format will increase the attractiveness of being on the EC, especially from outside England and for those who are still working.

Proposals for the coming year as discussed already at EC

Disciplinary processes in the NHS and their unfair, opaque protracted nature: Malila Noone (MN) and Arun Baksi are taking the lead in developing ideas for a fresh approach to disciplinary processes. We are looking for other organisations to partner with to develop the process in a constructive way which is fair to medical practitioners as well as to those who are trying to manage services and maintaining standards while dealing with difficult staff.

Maggie Bassendine suggested collaboration with RSM. Their series 'In Conversation' included one with Dr Sellu. The RSM has a membership across specialities and is independent.

'A Rescue Plan for the NHS': a vision for a post-covid-19 NHS has been produced jointly by KONP and Health Campaigns Together and is an umbrella for campaigning on a large number of aspects of what have been found wanting in health and social care. [bit.ly/33xxUEb]

Reform of Social Care: Our NHS Our Concern jointly with us submitted a paper written on reform of social care to the House of Lords Public Services Inquiry.

The Trade Bill before the House of Lords: We have serious concerns that despite statements that the NHS is not on the table, there is no mechanism given to negotiators to take it off the table. Unless it is specifically excluded it will affect trade deals not just with the US but with any other country. It should be a matter for national government to decide on priorities and not for future courts to decide on how the service should be provided in the years to come. The campaigning group We Own It and the Trade Justice movement are campaigning for an amendment to that Bill to specifically exclude the NHS and to ask for parliament to have the right to scrutinise the draft agreement. We signed a joint letter with these groups. Many of our members

have been writing to members of the House of Lords to ask whether they would push for these amendments. If the amended Bill went back to the House of Commons the government will be forced to make a very clear statement of intent if they removed those amendments.

Whistle blowing: Front-line clinicians are ideally placed to raise concerns about the way services are being delivered and the impact on patient safety but there is a real fear of retaliatory action by employing authorities. It has been suggested that we could host a platform so that individual doctors could air such concerns. This would have to be moderated very carefully and evidence collated to ensure their concerns were well founded. This is for discussion at EC.

Migration and Healthcare: The group 'Stand up for our Health' was set up with Lancet Migration, Doctors for the World and the UK faculty of Public Health by Lucinda Hiam from the School of Hygiene and Tropical Medicine. She has authored some very influential papers on health inequality and the impact on death rates. The group is campaigning for universal access to health services for migrants and those with no recourse to public funds. We have agreed to partner them in that campaign which is due to be launched on 6 October.

Discussion

The discussion opened to the floor included the following.

Labour Party: There was some discussion about influencing the Labour party. It was agreed we need to be seen as independent of political parties. We should engage with politics at a local and national level and have good facts to present to all parties. However it was a concern that unless there was a strong opposition to current developments they would soon be set in stone and become irreversible.

Views from the front line and BAME staff: Samina Ishaq thought DFNHS had done fantastic work. She felt that the three themes in the essays do reflect exactly what is current in the minds of front-line workers. Lack of social care was very evident and a concern during the pandemic. Retention of staff is a serious current concern. A great wave of people was re-deployed the first time round but this may not be repeated. Staff are fatigued and dissatisfied with the lack of information and there is lack of trust in the information given. Reconfiguration of services has been occurring under the umbrella of covid-19 and following on a covid-19 led response. She was concerned about the issue of BAME staff in her own Trust. There was disparity of PPE distribution offered to front-line workers such as porters and cleaners, 70% of whom were from BAME community. Later antibody tests showed the extent of exposure and infection in that group.

Workforce Race Equality standards of 2015 had not been acted on so recently she and colleagues have looked at disparities including the disproportionate number of BAME staff facing disciplinary action.

There is some concern that some BAME staff avoid risk assessment because of a fear that information they provide will be used against them. They have to be reassured that the risk assessment is in their interest.

Samina agreed to liaise with MN about disciplinary procedures.

Continuity of care: David Zigmond spoke of his strong concerns about the erosion of personal continuity of care particularly serious in mental health services, in general practice and management of chronic diseases. The problems were made worse by the introduction of markets and indiscriminate attempts to industrialise our healthcare care or co-operatise it. It is not confined to a single political party. Peter Fisher felt that when

we look at developments such as digital medicine we should consider them around the need for continuity of care. Andrea Franks pointed out that the lack of beds leads to movement of patients between wards and between teams which in turn contributes to the disruption of continuity of care.

The NHS Logo: Maggie Bassendine strongly supported these points and added that commercialisation of the service has led to fragmentation of services. The public, including herself, are unable to identify what is public and what is private because of the use of the NHS logo. NHS Test and Trace and a rehabilitation hospital she was aware of are making huge profits for private owners but we cannot know who is making a huge profit because there is no transparency. She proposed that we campaign against the misuse of the NHS logo and suggested the privatised NHS use an amended logo so the public know which services are contracted out. Alan Taman spoke about branding and developing brand loyalty and trust. The use of the NHS logo was a form of deliberate deception used to persuade the public that the service is the NHS and to be trusted. This should be a campaign issue. Peter Fisher agreed this should be a key issue.

Treasurer's Report: Peter Trewby, Treasurer

Peter told the meeting that our financial position is steady at the moment.

Summary

Total Amount in feeder account on 23/9/20 = £10,038 607 + £3500 in our current account. Our principal outgoings have been £3000 to KONP, £1000 to NHS Support Federation, £1000 to the "Centre for Health and the Public Interest" (CHPI), £1000 to the film production of "Under the Knife", £1010 to We Own It, £1200 for publicity in the BMJ, £700 for Junior Doctors' essay prize and £11,000 to our Communication and Publicity manager.

Figures 1 and 2 show fluctuations in our deposit balance over the past 12 months and over the past 6 years.

Subscriptions

Since our last EC meeting we have lost 12 members (5 deaths, 4 persistent non-payment/no reply, 1 moved abroad, 2 retired/in nursing-home and could not be persuaded to remain). A further 21 are being actively pursued for non-payment. We have 12 new members including 5 trainees and 2 GPs. We currently have 643 members including 20 trainees and 36 GPs (including retired).

£700 Essay Prize

The *Journal of the Royal Society of Medicine* (JRSM) agreed to collaborate with us on this year's essay prize: "If I was Minister of Health…" . We received 51 quite excellent essays. Kamran Abbasi, editor-in-chief of JRSM, Colin Hutchinson and Peter Trewby were markers. Three prizewinners agreed plus eight distinctions and 40 "highly commended".

Several essays will be published in the JRSM and in this newsletter. Suggestions please for next year's essay title. One suggestion was 'Continuity of Care'.

Audited accounts for year ending 30 June 2020 can be viewed online (https://bit.ly/3i5EWEd).

In summary

No pressing financial problems apart from the usual plea for new members and for ideas for causes to support financially in line with our aims of supporting the NHS.

2020

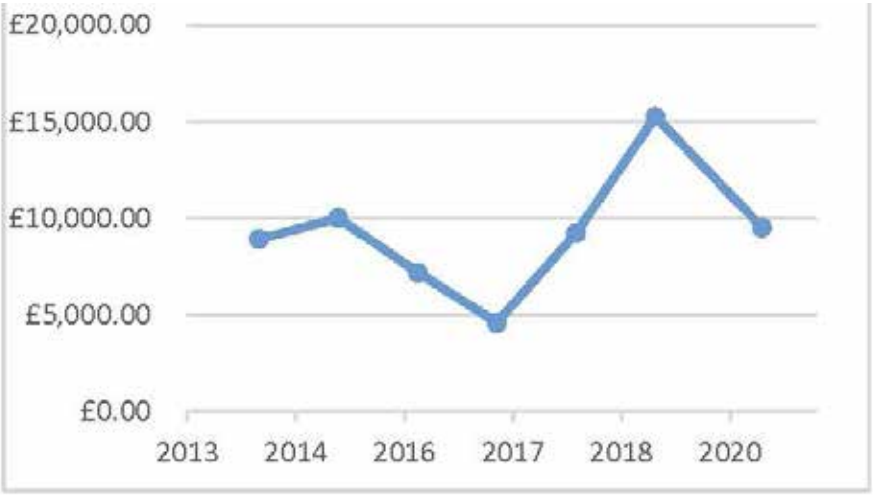

Figure 1 Historic balance in September, 2014-20

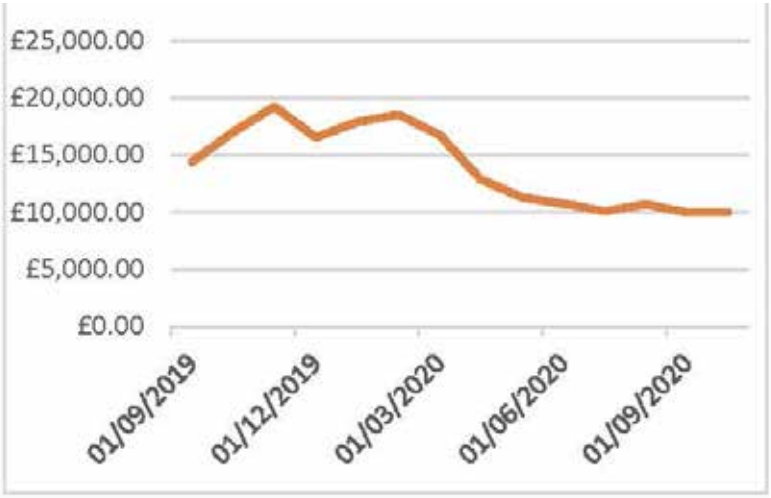

Figure 2 This year's balance, September 2019 - October 2020

Thank you to all those who pay their subscriptions promptly or reply immediately when reminded and to our auditor Robert McFadyen who again has brought light and clarity to my accounts.

Discussion

David Zigmond suggested producing a compendium of the essays depending on copyright issues.

Distribution of funds: It was agreed that decisions will be left to the EC. One suggestion was research into details of government spending on private suppliers as there is no transparency. CHPI have a team who would look into this. We could link our contribution to CHPI specifically to research into this subject and a publication.

Communication Manager's Report: Alan Taman

[Alan's full report was made available before the meeting and can be downloaded from https://bit.ly/3i5EWEd.]

Alan told the meeting that this year has seen unprecedented events, and unique demands and opportunities for the group.

Members in the nations of Scotland, Wales and Northern Ireland were all contacted individually in the months prior to the pandemic, and asked for their views on what DFNHS meant for them. Only a few replies were received, but these indicated that members were generally satisfied with the work DFNHS was doing to protect the NHS from privatisation and under-funding. Members were then also contacted by specialty and asked the same questions, which again indicated that members were satisfied.

Once the pandemic began and national lockdown was declared, it soon became apparent that a great deal of work needed to be done in unique circumstances, and that this was changing rapidly and unpredictably.

Time was devoted to framing the best strategic response, carefully avoiding any 'knee-jerk' responses which could have proven counterproductive or harmful to DFNHS's reputation. The government's campaign to make the NHS the central focus of public action was weighed up very carefully. The consensus (shared by AT and also by EC) was that the drive to 'protect the NHS' was a short-term tactic aimed at preventing the service from being overwhelmed by Covid-19 cases. It did not reflect a change in government ideology towards the NHS, nor its long-term strategy of continued under-funding and privatisation. It was decided not to challenge the government's stance during this phase of the pandemic, as this was a unique situation of great difficulty and doing so could easily cast DFNHS in a bad light, as 'unpatriotic'. However, public comments were made early on about the woefully inadequate PPE provision, which attracted national media attention. Other groups, such as the BMA and Doctors' Association UK, commented from a more 'front-line' perspective.

As the testing and tracing 'Lighthouse Lab' system was set up, it was clear that this was being done in a privatised, 'business model' by large corporations with little to no expertise in public health. It also became clear that local authority expertise was being largely marginalised. This was therefore privatisation largely for the sake of it, which was shown not to be working, and which ignored the wealth of expertise in public health available via LAs. DFNHS has commented publicly on this several times, and again national press has taken an interest. We have also worked with other groups (We Own It, Keep Our NHS Public, Health Campaigns Together) to try to make the public aware of these shortcomings.

DFNHS also commented on the way private

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hospital facilities were being used in the pandemic, with details of funding remaining obscure and the relationship between the NHS and the private organisations remaining unclear.

An alarming picture is now emerging, with regard to the ongoing way test & trace is being funded and developed, private facilities engaged, and existing NHS services either put on hold or withdrawn using the pandemic as a blanket explanation with little to no accountability. A coherent, clear and present danger to the NHS is becoming apparent, under the guise of the continuing pandemic. This is driven by ideology that is hostile to NHS principles of universal, free healthcare. DFNHS will continue to oppose this and continue to work with other groups to do so.

The Essay Competition drew very good responses this year, following the leafleting of every Postgraduate Research Centre in major trusts in the UK.

Procedurally, our social media streams continue to grow – we recently exceeded 2,000 followers on Twitter for the first time. This will continue to be developed. National media continue to regard us as reliable, and contact us for advice and comment.

The next 12 months remain unpredictable. However, the focus will continue to be on developing social media, commenting where appropriate, liaising with other campaigning groups for concerted action against the looming threat to the NHS, and reaching trainees to encourage them to join.

Discussion

David Zigmond praised Alan for being an anchor point for the organisation. He felt there were good articles in the Newsletter which could be published. Maggie Bassendine felt publications particularly as e-books would be especially useful for students. AT agreed to look into these suggestions.

Plans for the Future

Members discussed the following key points and EC will consider how best to action these at the next EC meeting.

Campaigns and affiliations with other organisations

- Keep Our NHS Public, Health Campaigns Together and we give our support to their campaigns on Social care and The NHS Rescue Plan.
- Lancet Migration, Doctors for the World and the Faculty of Public Health in support of the migrant health campaign Hands Up for Our health launching on 6th October.
- Our NHS Our Concern.
- We Own It in support of their Trade Bill campaign.

'Evidence based' interventions

Last year 17 were adopted by commissioners resulting in restriction of access to certain treatments. 31 interventions have now been added and more are likely. The exclusions are presented as a way of 'protecting patients and saving the NHS money'. More restrictions will be imposed in the future. The programme is said to be openly democratic but The Patients' Association made some negative comments about the consultation saying they were not really involved despite the NHSE website stating they were.

The programme is coordinated and promoted by the Academy of medical Royal Colleges but RCP did not fully endorse them nor did NICE but individual Colleges cannot be relied on to make public statements in opposition to NHSE.

The link to funding may lead to their adoption even if doctors disagree.

Evidence from Royal Colleges is a professional/ medical view and does not reflect views from the patient/social side. Public consultation cannot be said to have taken place.

The whole concept of exclusions brings NHS healthcare into line with an insurance based system. Exclusions within the NHS may push patients into the private sector. It claims to be making the NHS more efficient but the focus should not be on reducing NHS activity but improving care and outcomes for patients. It ignores the fact that the referral to the specialist constitutes the referral of a problem which may or may not require an intervention.

The restriction of certain interventions interferes with the interaction between the individual patient and their doctor, gets in the way of personal choice. It interferes with professional judgement. We are being asked to deal with health care as a commodity rather than a 'living organism'. The acceptance of evidence based medicine as a general concept should not interfere with the management of an individual case and personalised medicine. Letting doctors do their job and decide what is in the best interest of the patient based on their clinical condition is the essence of evidence-based medicine.

Discussion

There was agreement that restricting interventions was a direct attack on professionalism. John Puntis felt health professionals such as from DFNHS could comment on treatments and access healthcare in general as the consultation period was now over. He felt the best way forward was to look at what the local CCG is doing.

Patient held records

Maggie Bassendine reported that legally, hospitals can destroy medical record after 8 years. Patients in other countries and maternity patients are trusted to hold their own records so this could be universal. Alternatively they could be offered to patients before they are destroyed. It would indicate the value placed on the patient experience and it links to our statement 'doctors for patients not profit'.

With the new digital system we don't know exactly what is recorded and we seem to have no control. Digital data provide useful information for commercial marketing organisations. With individual ownership of records, companies would be required to seek permission for access from each individual patient.

Voice activated records are being promoted but outsourcing them to companies abroad has not been not satisfactory.

Samina Ishaq reported that technology is advancing so current trainees are growing up with it although it can be more difficult for those unused to it. One advantage is that access to GP records from hospital and vice versa can be very useful.

There could be a problem if the computer system crashes and finds it is not fully supported or backed up. It was agreed there could be a campaign on patient ownership of their records.

Quality of laboratory services

MN spoke to this. Her local laboratory had moved off site and she has been pursuing them with FOI queries regarding blood cultures: 'what percentage of blood cultures achieving the recommended turnaround time (TAT) of 4 hours from collection to loading onto the automated reader'.

Delay in culture leads to loss of pathogens and an inaccurate or negative result but her local lab did not know and would not set up an audit.

MN will be taking this up with the Royal College of Pathologists who did not take a public stand against laboratory centralisation. Eric Watts is also taking up the issue of quality standards with the RCPath.

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Other issues

Other issues to be addressed next year include:

- Public Health
- Tackling the backlog and other covid-19 related issues
- NHS workforce issues
- Racism in the NHS
- Training: generalist vs specialist skills

Please e-mail Alan (healthjournos@gmail.com) or Colin (colinh759@gmail.com) if you have any thoughts on what you would like to see DFNHS act on.

Digital technology in healthcare

Alan Taman outlined what he saw as the three principal areas of concern for DFNHS, in protecting the NHS as digital healthcare advanced.

Digital healthcare was potentially of great benefit both to patients and the NHS and should be welcomed per se. However, there were grounds for concern, which DFNHS should consider:

Remote consultation: intended to replace or supplement face-to-face clinical work (eg GP at Hand). This was gaining in popularity, especially because of the pandemic, but there were concerns around effectiveness, exclusion, privacy, confidentiality, dealing with clinical complexity, and continuity of care. Several members also raised the prospect of patient records, related to this, and whether patients should gain the right to own their own record.

Health app development for the public: these were becoming more popular and sophisticated (see for example *New Scientist* reports on the Apple Watch: bit.ly/3IffC0M and bit.ly/3jyMS2j). They were huge business. But again there were concerns over inequality, integration with healthcare, and effectiveness.

Policy development: use of digital data on a large scale, such as data scoring, was very powerful and potentially effective but is subject to imposition of ethical values which could risk increasing 'blaming' and deservedness or similar sinister policy developments.

Data ownership and empowerment were suggested as the best way of ensuring the benefits of digital healthcare continued to outweigh the drawbacks and the NHS was not threatened.

Each of the above areas threatens the NHS and patients. DFNHS should look into these areas given that one of our aims is to protect the NHS.

Responses invited by email to Alan (healthjournos@gmail.com) who will collate them.

Election of Executive Committee

Two members of the 2019-20 executive committee – Jacky Davis and David Wrigley – felt they could not continue to serve on the committee owing to other commitments and wished to stand down.

EC thanked them for their efforts.

Helen Fernandes was accepted on to EC.

Keep Our NHS Public Report

[This is an abridged version of the full report, which can be downloaded from https://bit.ly/3i5EWEd.]

John Puntis summarised this for the meeting. KONP have continued to make a significant and positive impact.

DFNHS (as NHSCA) was instrumental in setting up KONP and provides a significant financial contribution which is essential for the organisation.

Over the last year KONP have grown in prominence with increased media presence over the past year. There are 70 affiliated local

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campaigning groups, 52k followers on Twitter and 26k on Facebook.

KONP launch their campaign National Care and Support Service on 10th October.

Alliances are at the heart of their work and they seek to build new alliances on issues key to campaigning such as We Own It, Docs Not Cops, Medact, Trade Justice Movement, Global Justice network, Peoples' Assembly and also with trade unions and the TUC through Health Campaigns Together.

The membership has almost doubled over the past 18 months and increased to about 1000. The NHS Staff Voices group established in February puts KONP in close touch with issues important to NHS staff. Some active medical students have joined recently and they may establish KONP groups in medical schools.

We have a few people from outside KONP with backgrounds in marketing and advertising who will help develop campaigning strategy.

The film *Under the Knife* was shown on line at a film festival recently and given to KONP. Some of it has been used in two campaigning videos. KONP is trying to raise money to increase office staff which is essential to increase effectiveness.

John Lister's document *A Rescue Plan for the NHS* is being used as a basis for campaigning together with Health Campaigns Together. It is a comprehensive document identifying problems and suggesting solutions.

Further discussion

Provision of Social Care: The KONP campaign for a National Care and Support Service supported by the Socialist Health Association and disabled rights activists is calling for free social care funded at the right level with seven demands. The point of difference with some organisations and some campaigners has been over organisational integration of Health and Social care, or whether they should remain separate. The thrust of the KONP campaign is that the services should remain separate but work closely together. Currently, the two services have different funding models which sometimes lead to disputes over who is responsible in a particular case. Arun Baksi felt that changes imposed by succeeding governments have hindered the key demand for continuity of care. The document from Our NHS Our Concern to which DFNHS contributed, shares common ground but favours integration of hospital care, social care and primary care under one umbrella funded by general taxation and administered locally.

Arun Baksi spoke at The National Pensioners' Convention and a vote showed that 97% supported a national care service. However he whole heartedly supported the KONP proposals. The centralised remotely bureaucratic model of the NHS in England is seen as a barrier to integration. In Scotland the services are able to move towards more integration. The demographics of those needing social care is changing with the number of dependent young adults increasing and it is important that all users are given a voice about this issue.

The KONP campaign launches on 10th October. Registration is via KONP website (www.keepournhspublic.com).

NHS Support Federation Report

Alan Taman reported that the NHS Support Federation had continued to produce many documents detailing continued threats to the NHS.

The production of 'The Lowdon' electronic newsletter in association with Health Campaigns Together had been a notable achievement.

'Where Have All the Doctors Gone – And Why?' International perspectives from 2019

This year's essay competition drew some inspiring entries, and the winning essay will appear in a future issue of this newsletter. Last year's runners-up included two essays offering an internationl view to the question posed, which from a post-pandemic perspective shed a different light on the problem of under-staffing

"Doctor Mugawuri – it's casualty. We have an ambulance which has just arrived with a patient who is vomiting blood. He is in shock. Please come as soon as possible".

Before the phone is dropped another call gets through and a different voice pleads "Doctor – it's Grey Ward burns unit. We have an emergency. The 60% burns patient's blood pressure is crashing and the cannula is out. Please come and help". In the middle of a long corridor to Grey Ward to save the burns patient, the junior doctor has a troubled mind, battling on his own whether he should change his mind and attend the one with upper gastrointestinal tract bleeding. But why is he alone? Where have all the doctors gone – and why?

Sometime in 2012 I made a lifetime commitment. A decision based on passion which up to today I seem to question, but never regret – stepping into the medical field. My name is Prime Mugawuri and I am a junior resident Medical Officer at United Bulawayo Hospitals, Zimbabwe. Ever since I earned the title "Dr", it has been a nightmare for me. Instead of enjoying the long-awaited destiny I am finding that destiny to be full of lemons. I often ask myself the question, "But why?". Don't get me wrong: medicine was, and is still, what I always breathe. Often when I switch on my television and watch documentaries, such as the untold stories of the ER, life as a doctor seem to be perfectly smooth. I have never set foot in the developed world, but with the austerity measures and resource-limited setting, being a doctor in a developing country such as mine is never easy. Often when one gets out for a 10 minutes break with colleagues it's all about "Dr X are you ready for your Plab 2?", "Dr Y are your travelling documents all set for the new and real life in Europe?".

It is really sad to see that in a class of 50 who graduated with a bachelor's degree in medicine (MBChB) only a quarter of them practise in this country, but "Where have all the doctors gone and why?". In my setting there are many factors that contribute to such a catastrophe. Firstly, a dangerous working environment. Often doctors work with inadequate medical kit. Sterile procedures are conducted in an environment that a fellow colleague in Europe can get goose bumps of fear – fear for both the needy and the caregiver. No gloves, no swabs, not even enough linen. Another reason is that when most of the doctors finish work they go home to find out that a salary of 1200 rtgs dollars (equivalent of 50 US dollars) has been credited for that month in their accounts – a balance not enough to pay for basic commodities, fees for children, rent and transport to work. Poor doctors. They are labelled greedy when they dump the profession and look for greener pastures. Also, as is my case, junior

doctors are left alone without supervision and assistance from seniors who will, in our setting, be doing private work to supplement their pockets. This has a huge bearing on the final outcome of the management of patients. Most of these doctors leave for a better working environment. Furthermore people want better education and this is why it is not astonishing that my former colleagues left for a better life and postgraduate specialist programmes abroad; a term often described as "Brain drain". Statistically the doctor to patient ratio in my setting is 1:200,000 – oh yes, 200,000. There is only one medical school in the country with a population of 15 million and, passionate or not, any doctor working with such a burden eventually will become overwhelmed, slowly depreciating into one who is reluctant to serve well in accordance with the Hippocratic oath. No wonder I have two classmates of mine quitting the profession and opting for farming.

I may not know the reasons why my colleagues in the developed world have left the profession. I have always viewed them as having better health facilities, adequate medicines and sundries and better remuneration than in developing countries. Maybe they leave because of early retirement, investing into other non-medical businesses or maybe it's due to lack of commitment or even fear of losing their licences after being sued. However I do know that in my country, a poor healthcare system, lack of adequate medicines and sundries and poor remuneration among other factors have sapped the desire of my brothers and sisters to continue in the profession they love.

As one author once said, "Life affords no greater responsibility, no greater privilege, than the raising of the next generation". I believe it is my responsibility to carry on with this marvelous job of saving lives and preserve this profession for the next generation, for in their future lie answers to the cure of HIV and AIDS, the cure of multiple sclerosis, lupus and other chronic diseases.

Prime Mugawuri
Pindula, Zimbabwe

To answer this question, we need to ask another – why did one choose to be a doctor in the first place?

Most would answer financial security. This is actually the mentality of the masses here in the Philippines – that all doctors are wealthy. And once a doctor, one will be rich. Indeed, a doctor will surely be wealthy, and there are numerous ways to achieve it, thus correlating with the primary question. On the flip side, others would respond with the desire to give service to the community and country in general, as clichéd as the phrase may seem.

The next factor to consider would be another question. What does one do next? After passing the licensure exam, most neophytes would not know how to proceed. Those determined to trek the path would settle for a residency training programme which by itself is a struggle given the limited time to apply. This implicitly gives one a sense of extension as they contemplate what to do next.

The unique clinical exposure stemming from the periods of clerkship and internship opens one's eyes to the stark reality of the country's health care system. One is made aware of the hard truth that what happens within the four walls of the hospital, along the hallways, in emergency rooms and in critical areas are a pale comparison to the theories and ideologies learned during medical school (save for some state-of-the-art hospitals this country boasts where one could not help but wonder whether the structure is truly a medical facility or a five-star hotel). This realization inevitably aids one in their future decisions. Then come gruelling months and years of residency and fellowship training, should one opt for them, which either fortifies or abolishes one's chosen path. Along this line of constant questioning of one's direction in life, a good portion of doctors choose to be

general practitioners. By itself, this may deliver the objective of becoming a doctor to gain financial security. Otherwise, the experience is a prelude for residency training, a pursuing for a deeper learning. By way of contrast, a select few doctors would go on to provide their services to underserved and underprivileged communities: a remarkable and noble feat against the backdrop of society's obsession with fame, money and power.

The last and arguably the most determining factor is still a question,'Where do I go now?'. This is mainly determined by the answer to our primary question. Most doctors relate this next step to the search for financial stability and career objectives. The most plausible answer, then, is to go abroad and reap the highest rewards, to practise in the most ideal setting, and to be the doctor that one has envisioned in the first instance. This, in turn, worsens the country's plight of a "shortage of doctors".

In the Philippines, there are about 130,000 licensed physicians, while only 70,000 are actively practising. Annually, approximately 2,800 doctors are licensed, but the national doctor-to-patient ratio is a measly 3.5 doctors per 10,000 population. The situation worsens in far-flung areas where the average ratio plummets to 3 per 100,000! We partake in this pandemic; at the same time, we have become one of the "solutions" to other countries' problem of scarcity of health workers. Migrating to other countries – it makes sense. Migrating to urban areas (from rural places) in our own country – that makes even more sense. In fact, it would make no sense for the doctor to choose to stay and serve in our own country.

I personally believe that there is a maldistribution of doctors, instead of an actual shortage. This concentrated medical pool tends to flourish in the urbanized areas, for the reason that the hospitals and centres there are better equipped to effectively manage patients. This reality magnifies the issue of 'doctor-shortage'. I agree that most doctors would desire to reap monetary compensation for all the years lost and expenses dealt during their time in medical school. Naturally, return of investments is

expected, often in double or triple-fold. Lastly, the bare and often contrasting health care scene in the country has led me to believe that the government is not particularly keen on finding solutions to address the burgeoning heath workforce crisis. Nevertheless, the government holds a couple of golden keys at their disposal. Developing strategies to entice doctors to work in the underprivileged areas, or better yet, make them stay in the country, is one; promoting funds to aid in the costly medical education is another. Lastly, as a compatible lock, doctors should be made to feel that their services are in dire need in the country. These solutions might not be achievable in the short term and could seem vague for some, but it is imperative that we, as doctors and professionals, recognize that we hold the greater part of the solution. It will be difficult to start, admittedly, but we have to start somewhere. We are caught in this maelstrom of our time, brought about by societal notions and economic pressures that compels one to believe that the road to fulfillment lies somewhere else, beyond the shores of this country. We can either drift to safety in passing, or brave the tides of stereotypy.

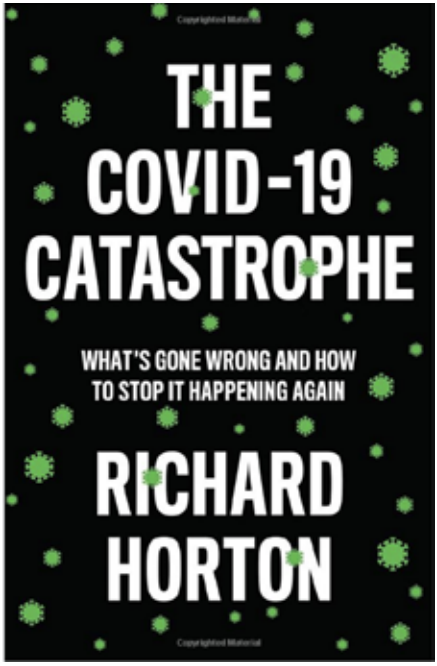
Marlon Reiland Suarez
Cebu City, Cebu, Philippines

Book Review

The Covid-19 Catastrophe
Richard Horton. Polity Press, Cambridge, 133pp. (£9.99, Amazon, paperback)

Richard Horton is Editor-in-Chief of the prestigious medical journal the *Lancet*, first published in 1823. In the preface to issue one, the founding editor Thomas Wakley served notice on the medical profession's pursuit of ignorance, prejudice, and patronage and on the self-interest of its leaders.

In his writings on the pandemic, Horton shows himself a worthy successor to Wakley. The book's subtitle is: 'What's gone wrong and to how to stop it happening again'. Horton has plenty of insights into what has gone wrong and provides important suggestions on how further disasters might be averted. In this review, I quote freely from his words.



China learned the right lessons from bitter experience

A key event in the historical time line is the 2002-3 Severe Acute Respiratory Syndrome outbreak caused by a coronavirus (SARS-CoV-1) that infected 8,096 people and caused 774 deaths across 37 countries. Although the Chinese government was heavily criticised at the time for its handling of the outbreak, ultimately, the rapid containment of SARS worldwide was recognised by the US Institute of Medicine as a global success. It warned, however, that a recurrence would put health systems worldwide under extreme pressure and that continued vigilance was vital. This outbreak was both an international wake-up call and the reason why the Chinese government was determined to do much better when COVID-19 (SARS-CoV-2) appeared.

Horton sets out by stating: "Chinese scientists and health workers deserve our gratitude . . . they worked tirelessly to understand the nature of this pandemic. They made it their duty to inform the WHO when they were sure there was reason to signal global alarm . . . I have observed nothing less than an extraordinary commitment to collaborate openly and unconditionally to defeat this disease."

The *Lancet* is at the cutting edge of international developments in medical science and published the landmark first clinical description of COVID-19 on 24th January, 2020 [1]. The Chinese made it clear that national health systems should be urgently scaling up intensive care facilities, building stocks of personal protective equipment (PPE), and preparing for potentially high mortality.

Government inertia

Given these clear warnings, Horton considers the delayed response to COVID-19 in the UK as "the greatest science policy failure for a generation". He attributes the complacency of our political leaders to the fact that they could not believe a virus originating in an unheard of Chinese city could have such calamitous effects in their own communities. This "appalling lack of political vigilance" was compounded by a decade of austerity, unprecedented decline in the growth of the NHS budget despite rising demand, and a public health system subjected to £1 billion of cuts since 2015. In the US, the spectacular unpreparedness for SARS-CoV-2 was also directly related to cuts in public health and epidemic prevention planning, reflecting a broader antipathy to international interdependence, solidarity and cooperation between nations. This resulted in more people dying in the US from COVID-19 in a 3 month period than during the entire Vietnam war. As for the US president cutting funding to the WHO in the middle of a pandemic, Horton does not mince his words: "By attacking and weakening WHO while the agency was doing all it could to protect peoples in some of the most vulnerable countries in the world, President Trump has, in my view met the criteria for the act of violence the international community calls a crime against humanity".

We in the UK were unprepared – fact

In the UK in 2016, Exercise Cygnus [2] had confirmed that pandemic influenza was top of the government's National Risk Register and that preparedness was 'currently not sufficient to cope with extreme demands of a severe epidemic'. As one of those involved later remarked: "We learnt what would help, but did not necessarily implement those lessons". Jeremy Hunt, then Secretary of State for Health, has attempted to absolve himself of any responsibility, but clearly there were many (like Hunt) who knew what might come but then 'chose third party rather than fully comprehensive insurance' presumably on grounds of cost.

Why was it that if took the government 7 weeks from the last week in January to accept the seriousness of COVID-19 and then wasted the whole of February and March? Horton's answers include preoccupation with Brexit, but he also notes that in early March, the prime minster had both recognised COVID-19 as a significant challenge and contradicted the conclusion of Exercise Cygnus by claiming that the UK was well prepared. While Johnson demonstrated he did not understand the capability of his country to address the most severe civil emergency risk on the risk register, he advised 'taking it on the chin and letting it move through the population', advocating hand washing and boasting about still shaking hands with everyone he met.

Scientists too get it wrong

Meanwhile, scientists advising ministers seemed to believe the new virus was much the same as influenza. One of them (Graham Medley) called for 'a nice big epidemic', explaining spread through the population would have the beneficial effect of generating herd immunity. This was echoed by Sir Patrick Vallance, the government's chief scientific officer, who suggested that the goal was to infect 60% of the UK's population. With a known death rate in China of 1% among those infected, this would have meant around 400,000 deaths – a figure that should not have been too challenging for top brains to work out. The mistaken belief in the similarity between influenza and SARS-CoV-2 allowed a key government committee to endorse Public Health England's assessment of the virus as presenting only a 'moderate risk'. This was a whole 3 weeks after the WHO's declaration of a Public Health Emergency of International Concern (the most extraordinary power that a director-general of WHO possesses). Underestimation of risk was instrumental in delay in preparing the NHS for the coming wave of infection, with inadequate supplies

of PPE and insufficient numbers of intensive care beds and equipment.

England's deputy chief medical officer's description of the UK's state of preparedness as 'an international exemplar' caused astonishment. The truth, as Horton observes, was that: "The UK's response had been slow, complacent and flat footed. The country was glaringly unprepared". He also cites other examples of government misinformation including a denial that a policy of herd immunity was ever pursued; claiming that testing was always a priority; that older people in care homes had a protective ring thrown around them; that risk was not underestimated and lockdown was not delayed. During the ensuing chaos, frequent use of war metaphors ('We are at war with an invisible killer') by Matt Hancock [3] and others created an atmosphere where dissent and criticism of government policy was discouraged, and even branded as a kind of betrayal, just as scepticism of the ludicrous operation Moonshot (10 million tests a day) is now being portrayed as disloyal and unpatriotic [4].

"The UK missed opportunities to learn from the experiences of other countries. Horton suggests this was because the regime of science policy making was corrupt."

The UK failed to learn lessons

The UK missed opportunities to learn from the experiences of other countries. Horton suggests this was because the regime of science policy making was corrupted, as evidenced by its failure to act on clear and unambiguous signals from China and then from the WHO. Failing to contact colleagues in China and Hong Kong to obtain first-hand testimony and not discussing with the WHO simply constitutes an abuse of entrusted power. In addition, there was unforgiveable collusion between scientists and politicians in order to protect the government and convey the illusion the UK was prepared and made all the right decisions at the right time. "Advisors became the public relations wing of a government that had failed its people".

The government's 'Special Advisory Group for Emergencies' (SAGE) quickly became known for excessive secrecy and deference to ministers, prompting Sir David King, a former Chief Scientific Advisor, to set up an independent group of scientists. Deliberations by 'Independent SAGE' were based on the premise that scientific advice will only be trusted by the public if the scientists are seen to be independent of government. The first meeting set a new standard for scientific policy making, characterised by openness, enthusiasm and a desire to engage with the people. Examples from which government might have learned important lessons but chose to ignore included the rapid building of 'shelter hospitals' providing isolation facilities for less ill patients in China; the importance of early aggressive testing and isolation of contacts (Hong Kong); widespread mask wearing; strict border controls; screening travellers entering the country (Taiwan); the importance of coordinated effort and transparency (South Korea); local management of test and trace (Germany); early escalation of risk (New Zealand).

The health service as a line of defence

Horton defines a health service as representing commitments to the empathy and responsibility we feel to one another, and standing in opposition to principles of individualism and competition. Willingness to act on behalf of others is a second

feature of a health system, manifested by a belief in our interdependence, reciprocal responsibility and collective action. The whole basis of our society rests on these two principles, now sorely challenged by COVID-19. This disease must teach us to re-imagine our security as being about people and communities, about our survival, our livelihoods and our dignity. An effective health service is the most important defence we have to protect that security.

Protecting the vulnerable

Horton regards one of the lasting legacies of COVID-19 as being the silent human destruction wreaked on the most unprotected members of society, with devastation in the social care system taking place without any politician seemingly knowing or understanding what was happening. Members of the BAME community were four times more likely to die than their white counterparts, strongly related to socio-economic disadvantage. Almost two thirds of health workers who died were from an ethnic minority. Despite the very best efforts of health workers and contrary to what the government would like us to believe, the NHS did not cope. The true death toll in the population at large will also include those with symptoms of life threatening illness who did not receive the emergency care they needed. Health and care workers were left unprotected through lack of PPE while government ministers insisted on a daily basis that deliveries were being made to wherever needed. According to Horton, these statements turned out at best to be overpromises and at worst bare-faced lies, and demonstrated the hypocrisy of officials joining in with the weekly 'clapping for our carers'.

Why did the Royal Colleges and other bodies representing the medical profession not make more noise? The reasons are unclear, but Horton considers that the leadership of medicine in the UK and many other western nations has let down those they were supposed to protect: "It

was a grubby betrayal, a stain on the leadership of a profession whose frontline workers had given so much". Another reason might be that College presidents do not like to rock the boat and often have one eye on their future knighthoods or equivalent rewards for service. As for politicians, he goes on to add that: "The message of gross incompetence is not welcome in Western political, medical or even media circles. It conflicts with a geopolitical narrative that casts China as a negative and destructive influence in international affairs . . . But to blame China and WHO for the global pandemic is to rewrite the history of COVID-19 and to marginalise the failings of Western nations".

'The Ghost of Christmas yet to come'

Horton is clear that the pandemic of SARS-CoV-2 will be neither the last nor the worst global health crisis of the present century, and that it is more than a crisis about health – it is a crisis about life itself. He sets out a challenge: "our task is to uncover the biographies of those who have lived and died with COVID-19 …to insist on a social and political critique . . . to . . . use understanding not only to change our perspective of the world but also change the world itself". The risks we face are not just from new virus infections but the regime of science policy making. In addition, COVID-19 has seen a rebirth of the state which will: "assume an ever greater role, from reconstructing state-sector economies to expanding social protection, from creating resilient health systems . . . to

investing even more generously in science".

His view is that the virus that caused COVID-19 isn't going away and that the best we can hope for is peaceful coexistence, while on a positive note, disasters can be catalysts for social and political change. Let us hear from a wider array of voices assessing and judging risks transparently and more critically; health systems will be constructed to be better prepared for coping with a new disease; a redistribution of esteem will recognise and reward key workers; governments will tackle inequality with energy and commitment; countries will work together to strengthen the WHO and for global health security; the determinants of a stable and sustainable society will become matters of utmost importance; policy makers will pay attention to strengthening social capital.

Once we have got on top of this pandemic he asks, "can we redefine our values and goals together, can we give priority to our wellbeing over our wealth?" . . . We have to use this time for solidarity, for mutual respect and mutual concern. My health depends on your health. Your health depends on my health . . . . The post-COVID-19 age will usher in a new era of social and political relations".

Conclusion

Horton has written an impassioned and lucid account to help us understand what has gone wrong and what may be put right. There are important lessons to be learned. If the pandemic is indeed a portal from an old world to a new one, this gives us as campaigners for our NHS a new challenge – how to frame the narrative around a movement to rebuild [5] the NHS in a way that will energise and mobilise the mass of people who have experienced the pandemic at first hand and had their minds opened up to new possibilities. The situation is pressing – forward to a better world or backwards towards barbarism?

Let us contribute to the fight by creating an inspiring and inclusive vision in order to ensure that simply because "All changed, changed utterly: A terrible beauty is born." [6]

References

[1] Wang, C., et al. (2020) 'A novel coronavirus outbreak of global health concern', *Lancet*, 395, 470-73 [online] Available at: https://bit.ly/2HIP5QH

[2] Pegg, D. (2020) 'What was Exercise Cygnus and what did it find?', *Guardian*, 7 May [online] Available at: https://bit.ly/33M2Csi

[3] Sheridan, D. (2020) 'Matt Hancock tells Britons we are fighting a war against an 'invisible killer' as social distancing measures introduced', *Telegraph*, 16 March [online]
Available at: https://bit.ly/3cqwM8s [paywall]

[4] BBC News (2020) 'Coronavirus: Concerns over Boris Johnson's 'moonshot' testing plans', BBC News, 10 September [online]
Available at: https://bbc.in/33KZywp

[5] Health Campaigns Together and Keep Our NHS Public (2020) *A Rescue Plan for the NHS* [online] Available at: https://bit.ly/2Ellgxp

[6] Yeats, W. B. (1916) 'Easter, 1916' [online} Available at: https://bit.ly/3kCrwkM

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