

comment

“Compassion fatigue shows in our monkeypox policies and procedures” **ERIC KUTSCHER**

“Information is not the only reason for a visit to GP during pregnancy” **HELEN SALISBURY**

PLUS Implications of scan-first-ask-questions-later

CRITICAL THINKING Matt Morgan

The medical handover is broken

The most dangerous procedure in medicine doesn't involve scalpels, or lasers, or even touching the patient. It involves words, sounds, and pieces of paper: it is the medical handover.

Teams huddle together with folded lists or custom PowerPoint slides, leaning on tables or sometimes even sitting on the floor. As critical results are read aloud, all around the team phones are ringing, alarms are chiming, and interruptions fail to be noticed. This is the reality of clinical handovers between excellent staff who are caring for complex patients. Too often, however, what's said is not heard, what's heard is not understood, and what's understood is not done.

Despite safety alerts and published advice outlining evidence based strategies for medical handover, the quality of those handovers remains as variable as the information provided. Handover, like the ward round, is a critical item in a doctor's toolbox, but it's seldom formally taught—unlike, for example, the Krebs cycle. The new Medical Doctor Degree Apprenticeship for NHS organisations may be a golden opportunity to weld into doctors' training these core activities that could improve patient outcomes far more than expensive designer drugs. All too often the theory of medicine can trump the practical aspect of being a doctor.

However, what any emerging model must resist is creating a two tier system that divides us into those with the cognition for medicine and those who deliver it through service. Being advertised as a way to increase diversity in the medical workforce, the Medical Doctor Degree Apprenticeship must not reinforce the “gown and town” divide that already exists between state and independent schools,

between certain universities, and between people with different social backgrounds.

Instead, traditional medical education will need to become even more mindful of the practical demands of the job, pairing time dedicated to the Krebs cycle with training based on high quality evidence for the service of being a doctor.

Oscar Wilde and Stephen Fry are among those who have noted that “we are not nouns, we are verbs”—so let's train others to doctor, rather than just to “be” a doctor.

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OPINION Eric Kutscher

To end monkeypox, we must return power to our patients

The US's response to the virus fails to put people at its centre

As a primary care and addiction medicine physician, I have been dismayed by the number of patients I've treated over the past few weeks who've been infected with the vaccine preventable monkeypox virus.

Most have been in considerable pain and required strong analgesics, with some unable even to sit because of their skin lesions. Yet for many, the most agonising and scarring aspect of their infection is not their physical symptoms but the complete removal of their humanity by the medical response to monkeypox.

As a medical and public health community, we are exhausted after covid-19, and our compassion fatigue is showing in our policies and procedures for monkeypox. The spread of the virus to previously non-endemic countries was only recently declared a public health emergency of international concern by the World Health Organization. Cases have been reported in parts of Africa for decades, but outbreaks of the disease across Europe and the US over the past few months, and its detection particularly among gay,

bisexual, and other men who have sex with men (MSM), have caused alarm.

Unlike covid-19, this is not a novel virus—we have the appropriate diagnostic testing, treatment, and even vaccines that we need. Yet, just as we have failed to deploy these tools to assist in outbreaks in African nations, we are now also failing our patients from a sexual minority group—patients who are already underserved and justifiably mistrusting of a medical system that less than 50 years ago considered the idea of men having sex with men a psychiatric illness.

Emergency department

Many of the patients I've seen have had to come to the emergency department for testing, unable to get a simple swab performed in urgent care settings, at health department clinics, or with primary care doctors. They wait in isolation for hours for a special pathogen team to swab their sores and often don't receive the results for five to eight days. They are asked to isolate—often without a confirmed diagnosis—for an indefinite period of time until their lesions scab over and new skin



It's our job to help individuals make informed decisions about what they want to do with their bodies

forms, without being provided a place to isolate, a non-stigmatising medical reason or note to provide to their employers, or financial protections for work missed.

My patients attempting to avoid infection have been unable to obtain vaccines, rolled out in a mechanism that greatly favours those with medical literacy and privilege.

As healthcare professionals, our role should be to improve care, not impede it. We should be enhancing access and educational resources, not limiting them. We should be creating systems that allow individuals to make healthy decisions that protect themselves and other people and give them power over their bodies.

We must empower our patients if we are to end this monkeypox outbreak, and there are concrete steps we can take to do this.

OPINION Giles Maskell

Scan first, ask questions later?



Taking stock after two years of the pandemic, it comes as no surprise to discover that demand for medical imaging is higher than ever. Historical under-provision of imaging by the NHS has made this more or less inevitable, but changes in clinical practice have also contributed.

In the past, the process of medical diagnosis followed a clear formula. Taking a careful history was followed by the conduct of a full examination—these were the precise words we were taught to use—and then, if necessary, some “special tests” were carried out to confirm or refute the diagnosis suggested from the history and examination.

For better or for worse, things have changed. “Get a scan and then I'll see the patient” has become a familiar injunction. A variety of innovations in

practice designed to speed up diagnostic pathways, including the growth of remote consultations, mean that a diminishing proportion of the patients passing through the computed tomography scanner have benefited from the “careful history and full examination” preliminaries.

Up until now, guidelines for the appropriate use of medical imaging outside screening programmes have largely been based on the presence or absence of clinical findings. If a certain finding is present, the test is indicated; if not then it probably isn't. This has gradually been changing, particularly in conditions for which the clinical findings are notoriously unreliable or non-specific.

Although physicians still appear to value the contribution of examination to patient assessment, increasingly the



First, our vaccine rollout must be overhauled to include more distribution sites, greater privacy protections, and provisions for vaccines that prevent other diseases that MSM are at a higher risk of. We cannot continue to offer vaccines only through government health agencies but instead must provide them to federally qualified health centres and primary care providers who have built trust with the most vulnerable communities.

When people register for a monkeypox vaccine that requires certification of eligibility and the disclosure of sensitive information (sexuality and/or number of sexual partners), they should be informed of the protections in place to keep that information confidential. Individuals should be able to register for appointments without giving a name to allow those who are fearful of their sexuality being made public a way to access vaccination. All MSM who are being vaccinated against monkeypox should be offered other vaccines they might be

eligible for, including hepatitis B, HPV, and meningitis.

A patient centred approach

Second, monkeypox testing must be made available as a free, at-home swabbing kit in multiple languages. We should ensure that these swabs can be ordered online in the same way that covid-19 tests can be, with the ability to pick them up at public health clinics and community centres that are accessible to high risk populations. Given that intimate and sexual contact has been put forward as a common transmission route in the current outbreak, home swabs can be automatically dispensed with every prescription for pre-exposure prophylaxis (PrEP). Self-collected swabs could be mailed to public health labs free of charge, and trained healthcare professionals can contact each patient to discuss their results and review important prevention or treatment information. Anonymous contact tracing—which we’ve depended on so heavily for other infectious diseases—can empower those who test positive to help contacts obtain priority access to limited vaccinations.

For those who are positive, we must create a mechanism of paid sick leave that does not require individuals to disclose their diagnosis to their employer. With a stigmatised virus, we can’t ask patients to tell their employers about why they need time off. Individuals could be shamed, outed against their will, and lose the income necessary to keep their homes and access to food. Universal paid sick

leave could do this, but in the interim we need government guidance to employees and employers as to what their rights are and how to navigate isolation periods, maintaining financial stability without compromising patient confidentiality. Otherwise, individuals who are actively infectious may need to continue to work without isolating, inadvertently putting others at risk.

Patients similarly need access to places to isolate without putting those they live with at risk of contracting the virus: we turned hotels into isolation venues for patients with covid-19, so why not for monkeypox? We need to expand the meal delivery services and other essential goods provided to those isolating with covid-19 to those isolating with monkeypox.

And finally, we must recognise that the least stigmatising and least homophobic approach to this infectious disease is to provide individuals with information on how it spreads and what steps can mitigate their risk of disease. Our patients have the autonomy to figure out what’s best for them. As a healthcare community, it’s our job to help individuals make informed decisions about what they want to do with their bodies, providing empathetic care regardless of what that decision is.

As doctors, we must show the basic compassion that is missing in all of our policies for monkeypox.

Eric Kutscher, internal medicine and addiction medicine physician, New York City

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decision to perform imaging is made on the basis of other factors.

Wholesale adoption of the scan-first-ask-questions-later approach has a number of important implications. The first is a requirement for a huge increase in testing capacity.

No one involved in the care of NHS patients can fail to be aware that imaging services are unable to cope with current levels of demand. The recognition of this in the Richards report is welcome, but it will be years before the actions so far taken in response deliver the required expansion.

Second, while imaging remains a scarce resource in the NHS, the decision to image patients at low risk carries the opportunity cost of disadvantaging patients with other conditions whose need may be greater or more acute.

Imaging patients at low risk disadvantages patients whose need may be greater or more acute

There is only one place at the front of the queue—the promotion of any one group of patients can only mean others dropping further back. It is simply not credible to claim to be giving priority simultaneously to patients with stroke, with trauma, with heart disease, with suspected cancer and so on, without somebody losing out.

A third consequence is that a re-appraisal of the meaning of the test result is required. A positive result in a patient at low risk does not have the same meaning as a positive result in a high risk individual, and conversely, a negative result in a patient with relevant

symptoms and signs does not provide the same level of reassurance as it would in a patient with a very small chance of having the disease in question. The result of any diagnostic test must be interpreted in the light of the prevalence of the condition in the population undergoing testing.

This is not another lament for the loss of clinical skills, still less an attempt to turn back the clock on changes in practice that are surely irreversible. Departure from the traditional diagnostic paradigm—history, examination, tests—is now an established trend, the implications of which deserve further consideration.

Giles Maskell, consultant radiologist, Royal Cornwall Hospital, Truro, UK

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Losing general practice's specialness

Until last month I was able to offer shared care to antenatal patients and saw them regularly, taking turns with the midwife.

My role would begin with those careful, neutral questions in response to the news of pregnancy ("How do you feel about that?") and would carry on through to the final weeks. If problems arose specialists would become involved, but otherwise this was part of my job as a generalist.

There are good reasons for taking antenatal care away from GPs, and our part of the country is the last to give up this area of work. With fewer registrars spending any of their training in obstetric posts and a lack of ongoing training or updating, our local medical committee was advised by medical indemnity providers it would be increasingly difficult to defend GPs doing this work if anything went wrong. Indeed, they're likely to withdraw cover for GPs undertaking antenatal care in the near future.

So, I understand it's a sensible move. If GPs don't have the skills to care safely for pregnant patients, we should hand over to people who do. As we're clearly busy enough, very few GPs will complain about the loss. But a part of me mourns it. We may be less needed at the initial stage now that women can find the advice they need online before their first midwife appointment at 8-10 weeks—what vitamins to take and not to take, which foods to avoid, and how to quit smoking.

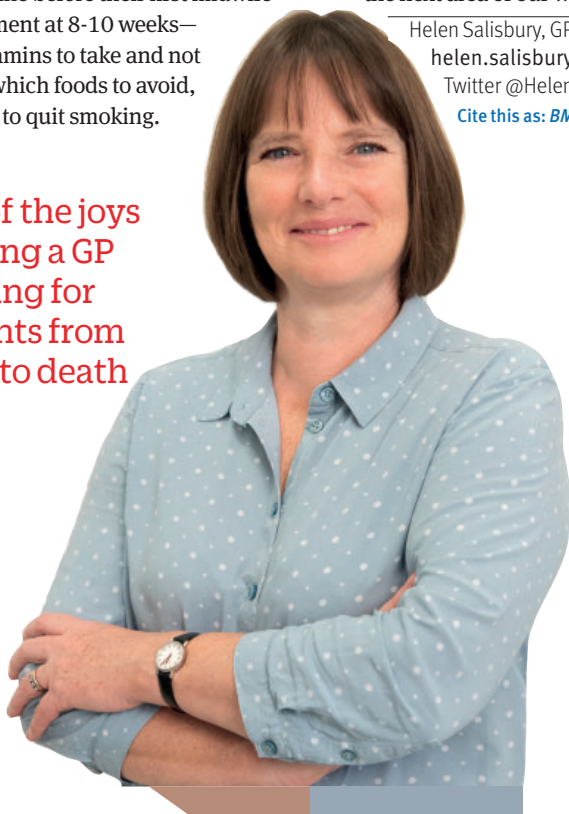
However, information is not the only—or even the main—reason a woman visits her GP when she learns she's pregnant. We're often the first person she tells, a neutral space in which to explore surprise, excitement, or ambivalence. It can be the start of a relationship between doctor and patient, and between doctor and family, that lasts for many years.

Some women bloom in pregnancy, but for others it's a time of anxiety, relationship difficulties, and physical discomfort. I hope we'll be successful in sharing care with our local midwives who will now build these relationships, handing over any worries to us after delivery. I worry that I'll still see pregnant women when they come with apparently unconnected symptoms, and I'll gradually become less skilled at knowing when to reassure about a pregnancy and when to be concerned.

I can imagine colleagues of a generation ago bemoaning the demise of GP home deliveries—something we'd regard as unacceptably risky today—and I realise we must all adapt. However, one of the joys of being a GP is caring for patients from birth to death, and at all points between. We're not just there for when things go wrong but also to keep them going right. Our final role is to care for patients as they are dying. I can't help wondering if this will be the next area of our work to disappear.

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One of the joys of being a GP is caring for patients from birth to death



LATEST PODCAST



Continuity of care

For many, continuity of care is one of the defining features of general practice, but its benefits aren't always well understood by politicians and policy makers. In this episode of the *Deep Breath In* podcast, Martin Marshall, chair of the Royal College of General Practitioners, talks about the evidence base for continuity of care:

"If I see a patient who I know and who I trust and they trust me, then the evidence is that that patient is more likely to be satisfied with a consultation. They're more likely to agree with or adhere to any advice that I give them. They're more likely to have better health outcomes. They're less likely to go to emergency departments. And then, of course, for the healthcare system as a whole, we know that care is more efficient if you deliver it through relationships. The evidence actually is really convincing. Our challenge is getting policy makers to understand this."

The team also hear from Emma Gladwinfield, a GP in Rossendale, Lancashire, who's taken a creative approach to providing continuity of care to her patients:

"As a GP, I've been working really closely with headteachers in the area. There are so many similarities between GPs and headteachers: we're both trusted in the community and we both go to bed at night worrying about the same families. Speaking to lots of headteachers, they are generally really worried about obesity. In Rossendale, almost a quarter of 11 year olds leave primary school obese. We can't wait for them to come into our surgery age 25, we need to act now. What I've been doing is connecting with schools, churches, and community centres, and taking the primary healthcare team out, doing workshops and blood pressure checks, physical activity sessions, nutritional sessions, lots of different things with different organisations."



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

Harms of alcohol in different age groups

Concern should be focused on older drinkers

“Our message is simple: young people should not drink, but older people may benefit from drinking small amounts,”¹ was the eye catching conclusion of a recent study from the Global Burden of Disease project.² These results seem to have important implications for clinical practice: should we be advocating abstinence in the under 40s while encouraging older teetotalers to take up drinking for health reasons?

The study estimated how the risks of harm, measured in disability adjusted life years, vary with alcohol consumption, age, sex, and country, and estimated the level of alcohol consumption at which drinkers face the same risks as non-drinkers. The authors find that, in many parts of the world, including western Europe, younger drinkers face increased risks of harm with any alcohol consumption. In contrast, older drinkers see their risks of harm fall at low levels of drinking before rising at higher levels of consumption.

These differences arise because of the different profiles of risk faced by each age group. A much greater proportion of overall harm among under 40s comes from injuries, and any alcohol consumption will exacerbate this risk. Adults over 40, however, have a much higher prevalence of cardiovascular disease, and low levels of alcohol may reduce this risk.

Oversimplification

On the surface, these findings seem to support a greater focus on the drinking habits of younger people, but important additional factors should be considered before changing clinical practice, advice, or guidance.

First, this study compares risk only within age groups—that is, whether 30 year olds who drink face greater risks than 30 year olds who abstain.



It is people in their 60s who face the highest rates of alcohol attributable harm

The authors do not compare risks between age groups. Nor do they look at absolute levels of risk. Without knowing the absolute magnitude of alcohol related risks in different age groups we cannot compare them with the myriad other risks we all face and accept from everyday behaviours such as driving a car or boiling a kettle. Recent reviews of drinking guidelines in the UK³ and Australia⁴ have focused on an “acceptable risk” approach, setting guidelines that maintain absolute risk at levels comparable with those from other everyday activities.

On this basis, the risks faced by younger people are substantially lower than those faced by older people. The Global Burden of Disease project’s analysis shows that globally, it is people in their 60s who face the highest rates of alcohol attributable harm, far higher than the rates faced by those under 40.⁵ It therefore seems excessively paternalistic to suggest that people under 40 should not drink at all on health grounds, given the low absolute risks faced by young people who drink moderately.

Second, the conclusions of the paper do not acknowledge the substantial remaining uncertainty around the existence, or otherwise, of a protective effect of low levels of alcohol consumption on cardiovascular risk. Many observational studies report protective

effects, and plausible biological mechanisms might explain them, but this research is limited by consistent methodological problems.^{6,7} Several studies using alternative approaches have found no evidence to support protective effects.^{8,9} The suggestion that we might encourage older people to consume small amounts of alcohol for the benefit of their health seems premature, potentially even unethical, since the apparent benefits may be illusory.¹⁰

Drinking in pregnancy

Third, the study’s authors find little difference in risk between men and women at similar levels of alcohol consumption and conclude there is little justification for separate guidelines for men and women. This may be true, but it is important to acknowledge the potential risks associated with drinking in pregnancy (such as fetal alcohol spectrum disorders) and provide appropriate information and guidance.

Finally, any linking of alcohol consumption with potential health benefits for older adults should be done with particular caution in settings where older drinkers are heavier drinkers. In the UK, for example, adults aged 55-74 are more likely than other adults to drink alcohol, and those who do, drink more alcohol on average than any other age group.¹¹

Overall, this new study provides some interesting new insights into the risks associated with drinking but finds little to warrant a change in practice. There may be good reasons to tackle problematic drinking among younger people, but if we want to reduce the substantial burden of societal harm caused by alcohol, our attention may be better directed at older drinkers.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Government's gaslighting has left vulnerable patients feeling forgotten



McLellan and Abbasi say that we must “face the fact that the nation’s attempt to ‘live with covid’ is the straw that is breaking the NHS’s back” (Editorial, 23 July). The government’s unwillingness to confront the current reality of covid is also directly impacting some of the most vulnerable patients. Some are developing social whiplash—we have instructed them to pivot from shielding, returning to normalcy, and then returning to shielding with no real guidance to support them re-joining society thereafter, beyond vague hand waving and a deferral to clinical judgment. It is concerning that the government appears to have slipped out the back, leaving patients wondering what they should be doing next.

Since the beginning of the pandemic, doctors have convinced the most vulnerable patients to retreat to their homes and shield, which has sometimes resulted in greatly increased anxiety as they live restricted lives in constant fear of infection. We have earnestly led them to this situation using the best available science, and by expending our personal and social capital in our efforts to protect them. I increasingly encounter fearful and fretful patients who continue to shield but are bewildered by the return to business as usual promoted by the government. When—if—a “safe” time to return to a normal life is more apparent from the data, I fear there is no roadmap in place to support these people who have been coiled like springs for several years.

Between the lack of clarity from the government and the juxtaposition of increasing infections and a return to normal, many of the most vulnerable patients have been left feeling frustrated, unsupported, and forgotten.

Eoin D O’Sullivan, renal fellow, Edinburgh

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MY PERSONAL PANDEMIC EXPERIENCE IS JUST ONE OF MANY

Oliver’s quiet heroism is a call to arms

Oliver’s recollections of “his” pandemic are sober, sage, and saddening (David Oliver, 23 July). He articulates the heroism of so many patient facing professionals struggling against the absence of information, candour, and resources.

Covid relentlessly probed the many inadequacies and sticking plaster solutions in health and social care—chronically neglected and under-resourced for decades. Pretending that all is well is a defence mechanism, as is hurling oneself, like Sisyphus, at the mountains of urgent and “priority” tasks. Those who could, like Oliver, remain grounded and focused, yet compassionately caring, are the best of the NHS.

Many in the NHS have been thanked for their hard work and sacrifices by being compelled to take a substantial wage cut. This is now a broken system, dealt a further fearful blow by covid because of a near complete lack of institutional and financial resilience and robust forward planning.

Carrying on like this is a clear demonstration of leadership failure in the NHS and government. Oliver’s quiet heroism should be a call to arms for those interested in grown up debate and solution focused approaches.

David Goldsmith, retired physician, London

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NHS’s faultlines exposed

Oliver’s account is sobering. Covid has revealed the fault lines in the workings of the NHS. It has affected society at large and hasn’t spared healthcare professionals. The mismatch between demand and resources, both in personnel and capability, can no longer be wished away. Leaders must lead: come down to where care happens, gain a better understanding, and inform the public of the realities and challenges of delivering healthcare in the 21st century.

I am not confident that this will happen. Such introspection would reveal the solutions to be too long term to be given priority. I worry it will be politics as usual unless a fundamental change in perspective and honest debate happens.

Olu Akintade, consultant physician, North West Anglia NHS Foundation Trust

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HEALTH POLICY PRIORITIES FOR THE NEXT PRIME MINISTER

It’s time for Labour to step up

As Alderwick says, the health system is in flux (Editorial, 23 July). The NHS crisis has long been evident to staff and is now becoming appreciated by the public. That Conservative politicians seem oblivious is a reminder of their antipathy to spending on public services. Also missing is a robust response from the Labour party, spelling out what has gone wrong and setting out a coherent plan to put health and social care back on track.

Vigorous opposition would enable the public to clearly see the Conservative government’s undermining of the fundamental principles of the NHS; restore hope to those demoralised by years of austerity; counter the fear that there is no



alternative to current government policies; and help minimise the ongoing effects of covid. Johnson’s legacy for the NHS has been disastrous, and those contending to replace him are offering more of the same—it is crucial for Labour to step up.

John Puntis, retired consultant paediatrician, Leeds

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COMMERCIAL DETERMINANTS OF HEALTH

Public health teams in local councils are starting to pull levers to limit industries' influence

Many people feel unable to influence the commercial determinants of health (Helen Salisbury, 16 July), but public health based in local councils is starting to pull the available levers—limiting hot food takeaways, creating smoke-free places, alcohol licensing, combating industry sponsored educational material, regulating vending and branding in community venues.

Communicating the message is also important. We can work across council departments, such as planning and commercial services, as well as with politicians and elected members to influence decision making. We can expose industry tactics through community engagement and regional communication campaigns. We can change the narrative and language we use, reframing health away from the NHS response and towards the system and the structural and environmental antecedents of health, then embedding this in faculty and specialist training, as well as undergraduate medical curriculums.

The scale and power of industry seems overwhelmingly huge sometimes, but collectively we can fight back.

Amanda Pickard, public health practitioner, Sheffield City Council

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Effects on mental health are less widely recognised

Commercial agencies can cause mental as well as physical ill health. Perhaps the starkest example is the estimated 400 deaths from suicide attributed to gambling in England each year.

The effects of the commercial determinants of health on mental wellbeing are less widely acknowledged than those on physical health. The burden of cancer attributed to unhealthy diets and alcohol and tobacco use, for example, is well characterised. But each additional case brings with it the psychological distress associated with diagnosis, symptoms, treatment, and negative

outcomes experienced by patients and their families.

The UK is experiencing a mental health crisis, with services struggling to cope. Marketeers and manufacturers have sought to divert blame from upstream causes of ill health to people apparently making bad choices. If the commercial determinants of health are not tackled robustly, opportunities will be missed to improve public mental health, lessen health inequalities, and reduce pressure on clinicians.

Alice C Tompson, research fellow; Claire Mulrenan, specialist registrar in public health; Greg Hartwell, clinical assistant professor; Mark Petticrew, professor of public health evaluation; May C I van Schalkwyk, specialist registrar in public health and NIHR doctoral fellow; Nason Maani, assistant professor, London

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Mission impossible?

Salisbury says that sometimes her job seems impossible because she can offer only an “endless series of sticking plasters” and cannot tackle the underlying causes of ill health. Doctors should be proud to offer plasters and should accept their weak power in tackling social inequalities at the point of care.

The social determinants of health are the conditions in which people are born, grow, work, live, and age, as well as a large set of forces and systems shaping daily life. The problems go far beyond healthcare. Inequalities are shaped at economic, societal, and political levels and are not under the control of primary care doctors.

Guidance on which interventions can reduce inequalities is still needed. But doctors can keep a patient centred care perspective. In a team based care approach, allied healthcare professionals as well as community or social workers could help tackle socioeconomic determinants and health inequalities.

Arnau Chiolero, professor of public health and epidemiologist, Fribourg

Cite this as: [BMJ 2022;378:o2057](#)

SAJID JAVID'S HEALTH SERVICE LEGACY

Javid's beliefs are at odds with NHS

Torjesen's assessment of Sajid Javid's brief term as secretary of state for health is far too kind (News Analysis, 16 July). Javid hasn't excelled in any of his ministerial posts (none of which he has held for long), and his time at the Department of Health and Social Care is no exception.

He had a tin ear when it came to understanding the English NHS reforms now under way, seeking to exert strong and misplaced control over their implementation. He launched the wholly unnecessary Messenger review of leadership—a costly distraction at a time of immense pressures on the NHS, which has yielded little of value.

Javid's core beliefs put him at odds with the ethos of the NHS. How can someone who reveres Ayn Rand—who rejected collectivist interventions in favour of individual self-interest—believe in an enterprise like the NHS, which subscribes to all the values Rand abhorred?

David Hunter, emeritus professor of health policy and management, Newcastle upon Tyne

Cite this as: [BMJ 2022;378:o2028](#)

TRIAGE IN GENERAL PRACTICE

Patients need confidence in the system

Telephone triage works for some conditions and not others (Letters, 9 July). The trick is to work out quickly whether the case is suitable for telephone triage. If not, it's important to find a face-to-face solution.

Triage lets the patient announce that they are in need. Quickly acknowledging that need can assuage much anxiety and frustration. Giving patients the confidence that their need will be dealt with in a timely manner is also important. For patients with complex needs, when seeing a GP who does not know them very well, a non-face-to-face announcement gives the system time to collect background information before dealing with the presenting complaint. Of course, that context can always be gleaned from face-to-face triage.

This is an important debate about how primary care organises itself so that patients have confidence in the system and healthcare practitioners feel in control and not constantly overwhelmed.

Graeme Mackenzie, GP, London

Cite this as: [BMJ 2022;378:o1857](#)

OBITUARIES

Lesley Lord

GP Halifax (b 1943; q Newcastle 1967; DObst RCOG, DMJ (Clin) Soc Apoth Lond, FFLM), died from acute myeloid leukaemia on 25 June 2022

Immediately after qualifying Lesley Craft married David Lord. She organised her own GP training while following David, who was in the army. In 1973 they settled as GPs in Halifax. Lesley became a police surgeon and was the doctor on call when the Bradford football fire occurred. She had to deal with the identification of 56 bodies, and this led to her doing postgraduate training in forensic medicine, gaining the diploma in medical jurisprudence, and becoming a founding fellow of the newly formed Faculty of Legal Medicine of the Royal College of Physicians. Music was a shared passion with David, and both were active in their local church. Lesley leaves David, two sons, and five grandchildren.

David Lord, Alan Craft

Cite this as: [BMJ 2022;378:o1950](#)



Dara Khadjeh Nouri

Consultant accident and emergency surgeon Edgware and Barnet hospitals (b 1937; q Barts, London, 1962; FRCS Ed, FRCS Eng), died from covid-19 on 3 October 2021

Dara Khadjeh Nouri was educated in England. After qualifying from Barts he did his surgical training at a number of hospitals in London and the South East. He worked for 12 years at the Cancer Institute at Tehran University, including spells at the war front. He returned to England in 1984 and was appointed as an accident and emergency surgeon; he later became the lead. He was always proud of his Iranian roots. He had many friends in both countries. On his retirement from the NHS he returned to Tehran, where he continued to work as a surgeon until limited by illness in his last years. He leaves his wife, Gill, and a son.

Tim Fowler, Ben Nouri

Cite this as: [BMJ 2022;378:o1952](#)



Ildikő Schuller

Consultant paediatrician (b 1961; q London Hospital, 1984; MRCPCH), died from motor neuron disease on 1 April 2021

Ildikő Schuller became a consultant paediatrician interested in paediatric oncology at Queen Mary's Hospital, Sidcup, in 1997. Service reorganisations took her to Queen Elizabeth Hospital in Woolwich in 2012, where she spent the rest of her career. In March 2020 she contracted covid-19 and was annoyed by her slow recovery. Time passed, her fatigue improved, but her motor function failed to follow. By the late summer of that year, she had joined a research cohort for an unusually aggressive type of motor neurone disease. The intrathecal drugs caused fasciculation that was as frightening as it was painful. She was invited to withdraw from the trial, but declined, staying on to the end. She leaves her husband, Michael, and their four children.

Mark Salter, Katrina Erskine, William Barry

Cite this as: [BMJ 2022;378:o1953](#)



Dhanji Damji Shah

Associate specialist in psychiatry Swallownest Court, Rotherham (b 1949; q Grant Medical College, Mumbai, India, 1973; MD, MRCPsych), died from hospital acquired pneumonia complicating

Parkinson's disease on 19 July 2022

Dhanji Damji (DD) Shah moved to the UK in 1977. He later developed an interest in psychiatry and worked at Swallownest Court medium secure psychiatric unit in Rotherham for 32 years. He used his broad medical knowledge to enhance the integrated approach to older person psychiatric assessment and treatment, gaining recognition locally and nationally and leading on psychiatric teaching to medical students and trainees rotating through Swallownest Court. His retirement was forced after 10 years of Parkinson's disease. However, he continued to find joy through Neelam, his wife of 42 years; their son and daughter in law; two grandchildren; and a love of travelling, reading, philosophy, and music.

Shailesh Shah

Cite this as: [BMJ 2022;378:o1955](#)



William Estlin Waters

Professor of community medicine Southampton (b 1934; q Barts, London, 1956), died from frailty of old age on 25 July 2022

William Estlin Waters ("Estlin") was senior house officer at the pneumoconiosis research unit at Llandough Hospital, Penarth, Cardiff, from 1960. He joined the epidemiology research unit in 1965 and moved to the University of Southampton on his appointment as senior lecturer in 1970. He was professor of community medicine from 1976 to 1990 and professorial fellow until his retirement in 1994 and later emeritus. He was on the Council of the International Epidemiological Association from 1971 to 1977 and 1981 to 1984, serving as membership secretary and general secretary from 1974 to 1977. Estlin is remembered for his love of his family and his passion for ornithology. Predeceased by his wife earlier this year, he died peacefully at home and leaves two sons and two granddaughters.

Robert M Waters

Cite this as: [BMJ 2022;378:o1956](#)



Helen Louise Wheeler

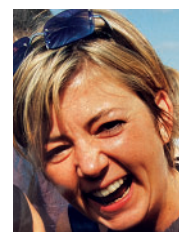
Consultant in genitourinary medicine University Hospitals Bristol and Weston NHS Foundation Trust (b 1969; q University of London, 1994; MRCP, Dip GUM, DFSRH), died from

metastatic breast cancer on 9 May 2022

Helen Louise Wheeler was born in Porthcawl and studied medicine at University College and Middlesex School of Medicine. She completed speciality training in genitourinary medicine in London and was appointed consultant at the Ambrose King Centre at St Bartholomew's and the London NHS Trust in 2005. In 2010 she took up her consultant post in Bristol. She was highly valued by patients, staff, and management for being so full of energy, with a warm and caring heart. In 2013 Helen became clinic lead and worked tirelessly with colleagues, management, and commissioners to design, cost, and deliver Bristol's innovative patient centred Unity Sexual Health service. She leaves her husband, Jay, and two young children.

Patrick Horner, Lucinda Farmer, Lindsey Harryman

Cite this as: [BMJ 2022;378:o1958](#)



Donald Pinkel

Innovated the treatment of childhood leukaemia

Donald Paul Pinkel (b 1926; q 1951), d 9 March 2022. The cause of death is not known.

Donald Pinkel, who has died at the age of 95, was at the forefront of the revolution that turned childhood leukaemia from an invariably fatal disease in the 1950s to one that can be cured in well over 90% of cases.

Total therapy

Antifolate drugs such as methotrexate were used to treat children with leukaemia, and other antimetabolite drugs were discovered, including corticosteroids, but responses to single drugs were short lived and the leukaemia came back.

The breakthrough came from St Jude Children's Research Hospital in Memphis, Tennessee, US, where Pinkel took the bold step of giving combinations of active drugs.

Pinkel took the bold step of giving combinations of active drugs to children with leukaemia

He called this "total therapy" and in a series of relatively short studies with only 50-100 children with leukaemia, the survival rates improved from zero to 50%.

Further progress has been made by the development of cooperative groups which can enter large numbers of children into randomised clinical trials. These are now the main method used across most cancer types to improve prognosis. In the early "total" studies, relapse occurred in unexpected sites of the body—for example, the central nervous system and testes. Pinkel called these sanctuary sites and the effective use of intrathecal drugs and craniospinal irradiation were the breakthrough that helped better long term survival and cure.

But Pinkel and other pioneers of the time recall the hostility that they faced from

established doctors who were sure that the treatment was futile. Pinkel recalled being told, "Childhood cancer is hopeless, until we know its cause, and besides cancer is an adult disease, not a paediatric problem. Don't give those poisons; let the children die in peace. Don't waste your career pursuing a hopeless cause."

Pinkel had a determinedly stubborn streak and thankfully was undeterred by criticism.

Early life and career

Donald Pinkel was born in Buffalo, New York, on 7 September 1926. His father, Lawrence, was a hardware salesman and his mother, Anne, a housewife. After high school he enlisted in the US navy and studied biology and medicine at Cornell University. He later qualified in medicine at Buffalo and joined the US Army Medical Corps.

During his service he contracted polio and for months was severely paralysed and left with a significant limp. As part of his recovery he worked with Sidney Farber, a paediatric pathologist considered the "father of modern chemotherapy," in Boston and developed a lifelong fascination with leukaemia.

In 1956 Pinkel was appointed as chief of paediatrics at Roswell Park in Buffalo but found the climate difficult because of his post-polio disability. A new children's hospital in Memphis—St Jude Children's Research Hospital—opened and Pinkel was recruited in 1962. He felt that this was the place where he could test his ideas for leukaemia treatment. The hospital remains one of the world's leading children's cancer research centres.

In 1974 he was invited by the British Paediatric Association to give its prestigious Windermere lecture in Harrogate. His lecture is remembered as modest in tone but impressive in terms of presentation of results and clarity, especially given that there was still much scepticism about his ideas among senior paediatricians.

The UK Medical Research Council had already established a committee to design studies in childhood leukaemia, but paediatricians were not referring children to the growing number of specialists who had access to these trials. The effect of Pinkel's lecture was to alert paediatricians to the fact that leukaemia in children was now treatable and it resulted in a step change for referral of all such diagnosed children to the rapidly developing children's cancer centres with all the supportive care which was necessary to manage them.

Pinkel moved to Milwaukee and Houston before retiring in 2001. He completed his career by teaching basic biology at a local state polytechnic. He received many awards for his work, both from the US and elsewhere. In later years his disability worsened and he died at his home in San Luis Obispo in California at the age of 95.

He was a large, quietly spoken man of little ego and great integrity. He married Marita Donovan in 1949, and they had eight children. They eventually divorced and he married Cathryn Howarth, an English paediatric oncologist from Leeds, whom he had met on his visit to Harrogate. They had one child, and both survive him.

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