

comment

“A government that truly valued the nation’s health would have gone further” **JO BIBBY**

“You might be led to think MPs had nothing to do with the NHS’s problems” **DAVID OLIVER**

PLUS Mental health impacts of living in poverty

PRIMARY COLOUR Helen Salisbury

Open doors and open windows

Our practice has finally reverted to its pre-pandemic appointment system. Patients can book by telephone, online, or in person for either a face-to-face or a telephone appointment. They can also submit e-consultation forms. When we had to use telephone triage for all appointments earlier in the pandemic it reduced our efficiency: if, after a five minute conversation with a patient, you decided you couldn’t safely manage them or sort out their problem without an examination, another appointment was needed.

The conversion rate of telephone to face-to-face appointments varied between clinicians, but we all shared a sense of work being postponed or incomplete. We’d try to book face-to-face follow-ups with the same doctor, but this wasn’t always possible, so a second clinician had to pick up where the first one left off. In this situation you can either take the history again from scratch (which is inefficient) or rely on what your colleague has written, which will inevitably leave out some nuances. This loss of continuity isn’t just about information—it also affects rapport, which you need to establish afresh if you take over midway.

In theory, a written e-consultation might take the place of the first phone appointment, but in practice this often just turns a two stage process into a three stage one, with a form to read, a phone call to clarify, and a face-to-face appointment to examine.

We’re not completely back to normal. We’re still wearing scrubs—as a visual reminder to our patients that the pandemic’s not over. We wear FFP2 masks for all patient contacts, and we expect our patients to wear masks too. We also open the windows wide after each consultation, to change the air. Very

occasionally, patients decline to wear masks, in which case my window stays open throughout. This was fine during the brief spell of warm weather in mid-March and less fun when snow was blowing in over my desk last week, but, as I was doing an extra surgery to cover for a colleague absent with covid, I was in no mood to compromise.

It’s still early days for our “new normal,” and we don’t yet know how well it will work, although we expect more patients than before will choose the telephone for simple, transactional appointments. However, we’re also aware that, although no physical examination may be needed, some people find that being in the same room as the doctor contributes significantly to feeling heard and understood. As a doctor who is trained to use all of my senses and not just my ears, this is less stressful for me, and I’m more confident when I can see, touch—and occasionally smell—my patients.

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We still wear scrubs, a visual reminder to patients that the pandemic’s not over



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OPINION Jo Bibby

Sunak hasn't grasped that health and wealth are fundamentally intertwined

The chancellor hasn't learnt the lessons from the pandemic

On 23 March 2020, the UK government took the boldest step to protect human health in recent memory by putting the country into lockdown because of the pandemic.

The lockdown placed unprecedented curbs on people's lives and livelihoods. We will never know the counterfactual, but there can be no doubt that it saved many lives in the first wave of the pandemic—our most treasured institution, the NHS, from collapse. In the months that followed, the government frequently debated whether to focus on saving lives or livelihoods and had to make fine judgments over strengthening or loosening restrictions.

Two years later the spring statement shows no evidence that Rishi Sunak, the

chancellor of the exchequer, has grasped the pandemic's stark lesson that health and wealth are fundamentally intertwined. Accounting for policy measures, the Office for Budget Responsibility (OBR) projects household incomes to fall by 2.2% in real terms in the coming year. The poorest fifth are expected to experience the greatest falls. But the measures announced in the spring statement are focused on richer households who will receive £2 of every £3 of the gains.

Effects of poverty

Poverty is bad for your health. It takes a toll on mental health through the effects of unremitting anxiety from debt and insecurity. It takes a toll on physical health through both the effects of this stress and



The NHS is carrying an inconceivable burden. It was not set up to be the backstop for failings in wider policy

the limitations on people's ability to eat well and stay warm. Every day, NHS clinicians witness the effects of poverty on people's health through avoidable disease and delays to recovery following routine care.

The pandemic has stretched the financial resilience of many families to its limit. Many have run down their savings or increased debts to cope with the impact of covid-19 and measures to contain it. And there is no sign that there will be any let-up with CPI inflation set to peak at 8.7% at the end of the year. This continuing rise in the cost

OPINION Tom Pollard

Food bank use is a canary in the coal mine for mental health services



The NHS Confederation recently warned of a "second pandemic" of mental health problems in the wake of covid-19. Alongside the direct psychological impact of the past two years and the capacity of overstretched NHS services to respond, economic circumstances in the aftermath of the pandemic will play a key role in shaping the mental health fallout.

Millions of people were forced to turn to Universal Credit for support as they lost their jobs or saw their hours cut as a result of the pandemic. Although there are some signs of economic recovery, there are still more than twice as many people on Universal Credit as there were in January 2020. With the £20-a-week covid-19 uplift to Universal Credit removed in October 2021, unemployment benefits are now at their lowest rates in real terms since around 1990. Meanwhile, rapidly rising food and energy prices are driving up the cost of living.

The demand for food aid had already been increasing over the past decade but shot up at an alarming rate during the

pandemic. The squeeze on incomes that millions of households are facing is likely to drive many more into food insecurity over the coming months, and in turn to food banks.

I spent November and December 2021 talking to people in independent food banks in London and Kent about the circumstances they were facing and, in particular, the impact of their situations on their mental health. I approached these conversations as both a social policy researcher and a mental health professional (I work part time as a social worker in an NHS mental health crisis team). A new report, produced in collaboration with the Independent Food Aid Network and the Joseph Rowntree Foundation, documents what I heard.

Many of the people I spoke to directly and explicitly linked their worsening mental health to the difficult financial circumstances they were facing. For some, this represented an exacerbation of a pre-existing mental health problem, while others suggested this was the



of living will force increasing numbers to choose between essentials that are vital to living healthy lives—such as housing, heating, and food—or being driven into problem debt.

The failure to protect people from the cost-of-living crisis doesn't simply risk a series of individual tragedies. It affects us all. As the economy fights to recover from the pandemic business leaders have clocked the estimated £100bn a year—and rising—cost of poor health to the economy. Sickness and early retirement on the grounds of ill health are an increasing concern for business as they reduce productivity, increase turnover, and deplete the labour supply.

Against this backdrop, a government that truly valued the nation's health would have gone further to create the conditions that support good health and protect people in the here-and-now, as well as building greater resilience against future threats to our health. The increase to national insurance thresholds fails to target the poorest households, there has been no action on benefits, and the additional £500m for the household support fund falls well short of what is needed. Inflation will also erode planned spending on public services that support health.

Spring statement failure

Government has many levers at its disposal. Its spending plans are critical, and this spring statement has singularly failed. Action is urgently needed to create an adequate welfare safety net. There needs to be a wider look at the policies across Whitehall that shape people's health—housing, transport, early years, and food policy. Many existing government commitments to curb exposure to risk factors, such as smoking, poor diet, physical inactivity, and harmful alcohol use, still haven't been followed through. Serious action is needed to raise the

standard of housing, with poor quality homes driving health problems that cost the NHS £1.4bn a year to treat. And with rents increasing again, the decision to freeze support for renters should also come under review or risk driving further insecurity and distress. Without this, the trend of the past decade of a widening gap in healthy life expectancy between richest and poorest is set to continue.

The NHS has carried an inconceivable burden over the past two years. It was not set up to be the backstop for failings in wider government policy. The more that the NHS is expected to pick up the pieces, the longer it will remain in a cycle of firefighting at the expense of prevention. The forthcoming Office for Health Improvement and Disparities white paper on health inequalities needs to set out credible policies to tackle hardship, insecurity in work and housing, the mental health crisis among young people, and our broken food system. The government took unprecedented action to protect people's incomes in 2020. If it doesn't take further action now, it may be 2022 rather than 2020 that casts the longest shadow on the nation's health.

Jo Bibby, director of health, Health Foundation

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People are psychologically consumed by the task of trying to make ends meet

first time they had struggled with their mental health. Even those who did not describe themselves as having mental health problems were often showing signs of poor mental health—constant worry, struggling with sleep, possible physical manifestations of anxiety.

The inadequacy of people's income—primarily from benefits but in some cases combined with earnings from employment—was not only causing material hardship but also meant that people were psychologically consumed by the task of trying to make ends meet. This left little space or energy for being able to plan for a better future or take practical steps towards achieving this. People spoke about a constant sense of pressure and struggle.

Although the political debate around mental health increasingly acknowledges the role of social and economic factors, this often doesn't translate into meaningful

action to tackle these factors. It is self-evident to anyone working in mental health services that the psychological distress many people are experiencing is exacerbated, if not primarily caused, by living in poverty. For all the additional funding for NHS mental health services that is desperately needed, a more efficient and effective way of tackling demand might be to improve the material circumstances of low income households.

Instead, the government seems to be unwilling to acknowledge the reality that an increasing number of people are struggling to make ends meet and that this will inevitably have knock-on consequences for people's mental health and, in turn, demand on mental health services. In April, Universal Credit and other benefits increased by 3.1% and yet at the same time inflation is projected to exceed 7%, increasing the gulf between costs and income for the poorest households.

Of course, the benefit levels are not the only factor at play here. The people I spoke

to in food banks were struggling with a wide range of issues—poor housing, debt repayments, childcare, and the difficulty of finding secure employment. But being able to rely on an income that covers their basic costs would relieve a huge amount of pressure and leave people with more capacity to tackle these wider issues. These are also challenges that require longer term policy responses, whereas people's incomes can be boosted overnight by increasing benefit levels to better reflect the cost of living.

The accounts I heard from people in food banks suggest a brewing storm of mental health problems being caused or exacerbated by the stress of living on an insufficient income and struggling to afford the bare essentials. If more and more people are allowed to slip deeper and deeper into poverty, we will be facing not only a huge human cost but a wave of demand for mental health support that could overwhelm NHS services.

Tom Pollard, mental health social worker, NHS

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NHS isn't to blame for its failings

The Public Accounts Committee does an invaluable job in holding the government, public bodies, and the civil service to account. But it comprises MPs from across the political spectrum who are, or were, part of the executive, legislature, or opposition.

Judging by its new report, *NHS Backlogs and Waiting Times in England*, you might think elected members had nothing to do with the NHS's problems. The pandemic has accelerated things, but the NHS's structural failings stem from years of terrible policy making and legislation. The MPs were there, just as Jeremy Hunt, now a chair of the Health and Social Care Select Committee, was health secretary for six years.

The report highlights six million people on waiting lists and the falling percentage of patients seen within target waiting times. It criticises the health department and NHS England and questions the elective recovery plan. These are legitimate concerns that affect patients. But MPs washing their hands of responsibility won't do.

The 2010 coalition government sent the NHS into years of "re-disorganisation" with the Health and Social Care Act 2012, when performance and satisfaction had been improving steadily. The NHS is—in the words of the Nuffield Trust's 2018 report—doomed to repeat this folly, as yet more primary legislation goes through parliament in the form of the health and care bill. Parliaments going back 20 years

have promised lasting solutions to social care funding, commissioned reports, and then failed to implement effective changes.

Brexit is causing tangible harm to clinical recruitment and retention. It's not as if MPs weren't warned of the risks. "Points based immigration" has also deepened the workforce crisis, and the mood music is off-putting to staff wanting to come or remain here, such as the overseas nurses enticed here in the pandemic who are being asked to repay substantial immigration and training costs if they return home.

The failure to plan for the workforce goes back decades, as we complacently relied on overseas staff. The failure to retain staff is partly a result of terms and conditions and real terms pay cuts overseen by governments. It was Hunt as health secretary who picked a needless scrap with junior doctors in 2015, and the current government has publicly briefed against GPs repeatedly.

In the 2022 British Social Attitudes survey, public satisfaction with health and social care fell to its lowest since 1997. Respondents were clear that workforce and funding were the root cause of failings, and these lie firmly at the feet of parliamentarians. Maybe the Public Accounts Committee should have issued something of a mea culpa about the role of MPs, rather than shifting the blame onto public officials and NHS executives.

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MPs washing their hands of responsibility won't do



LATEST PODCAST



Great explanations

Giving an explanation to patients for their symptoms is a key part of a consultation, yet it's not always straightforward. Doctors may be unsure of the diagnosis or worry about how an explanation may be received. Roger Neighbour, a former GP who's written books on doctor-patient communication, joins this episode of the Deep Breath In podcast to discuss how doctors can make their explanations more effective:

"When anybody gets any kind of health problem, there are a number of questions that form in their mind. They want to know what's happened—what actually has gone wrong? They want to know why it's happened to them and right now. They want to know what would happen if you did nothing about it—what would be the natural history? Would it get better? Will it kill them? Last, but not least, they want to know what's to be done about it. Those are people's priority information needs, and whatever else we tell people, we need to make sure that we cover those bases."

Amy Price, a research editor for *The BMJ's* patient and public partnership, also shares her thoughts on the value of explanations in a clinical encounter:

"To me, an explanation builds trust—it reduces assumptions and meets expectations. I won't proceed with any medical procedure or diagnostic without an explanation. It also helps me as a patient to know where the provider is in terms of their knowledge on current evidence. Sometimes the explanation is 'I don't know.' And, as an honest explanation, that's 100% OK. Saying 'I don't know, but maybe we could try this' or 'I don't know and I know the evidence may say something contrary to this, but this is what's worked for me in my practice' are perfectly acceptable explanations and they also build trust."



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

ANALYSIS

Action on patient safety can reduce health inequalities

Providers and health systems should use inequitable differences in risk of harm to reimagine their role in tackling unfavourable social determinants of health, write **Cian Wade and colleagues**

Health inequalities are widening in many high income countries and have been thrown into focus by the pandemic.¹⁻⁴ Not only have black, Hispanic, Asian, and other marginalised ethnic groups in many high income countries had disproportionate death rates from covid-19, but non-covid health outcomes have also worsened.⁵⁻⁷ These unfair and avoidable differences in health between population groups are driven by a range of social determinants such as education, poor housing, and unemployment that contribute to social exclusion and disadvantage.¹

When people already negatively affected by unfavourable social determinants of health seek care, healthcare itself may exacerbate health inequalities rather than mitigate them.⁸ One way in which this occurs is when patients experience disproportionate levels of harm from the healthcare they receive. For example, a 2022 review in the UK found that ethnic minority women's experiences of poor communication and discrimination during interactions with healthcare staff may explain some of the stark inequalities observed in maternal health outcomes.⁹ Healthcare may therefore be less safe for some patients than others.

Patient safety is the science and practice of minimising harm and error experienced by patients while receiving healthcare.¹⁰ Harm typically centres on a "patient safety incident" in which a failure in healthcare causes physical or psychological injury to a patient.¹¹⁻¹² Most clinicians would recognise patient safety incidents such as administering a drug to the wrong patient as potentially extremely harmful and preventable (box 1), but it is less clear whether the concept of harm should encompass population level health inequities such as more severe diabetic complications in one group compared with another.

We focus here on patient safety incidents to emphasise that the responsibility for their avoidance lies directly with the healthcare system and its workforce.

KEY MESSAGES

- Patient safety incidents experienced disproportionately by marginalised patient groups exacerbate health inequalities
- Biases embedded in the healthcare system, its workforce, and medical practice drive these differences in risk of harm and can be used as an entry point for solutions to these issues
- Viewing health inequalities through the lens of patient safety identifies an additional line of action for which healthcare professionals and systems have a clear responsibility



Box 1 | Examples of harm from healthcare: patient safety incidents

- Postoperative complications: infection, deep vein thrombosis, pulmonary embolism, haematoma, pressure ulcer
- Adverse events related to medications: administering to the wrong patient, failure to check allergy status, wrong dose, wrong site of administration
- "Never events": wrong site surgery, retained foreign object post-procedure, transfusion of ABO incompatible blood components
- General harms: dehydration, falls, hospital acquired infection, delayed detection and response to clinical deterioration
- Psychological harm: restraint of patients, inadequately treated pain, other negative patient experiences of healthcare

Patient safety incidents are experienced unequally

Evidence is growing that patient safety incidents are experienced unequally. Inpatient safety data from the US indicate that adjusted rates of perioperative pulmonary embolism and sepsis among black patients are 28% and 24% higher, respectively, compared with white patients admitted to the same hospital.¹³ These data add to evidence from a range of high income settings that patients from ethnic minority communities are at increased risk of hospital acquired infections, adverse drug events, and pressure ulcers.¹⁴⁻¹⁶ Socioeconomic disadvantage has been associated with higher rates of death from avoidable causes such as delayed healthcare interventions, as well as delays in promptness of resuscitation after in-hospital cardiac arrest.¹⁷⁻¹⁸ In addition, patients with learning disabilities have been shown to experience harmful delays in the timely diagnosis of sepsis.¹⁹

We hypothesise that disproportionate harm from healthcare further compounds the existing social or economic disadvantage of these patient groups, thereby exacerbating health inequalities. Viewing health inequalities through the lens of patient safety presents an avenue for tangible action on health inequalities for which healthcare professionals and systems have a clear responsibility.

Although many patient groups may experience disproportionate harm from healthcare, we focus on harms affecting marginalised ethnic groups across community and hospital care settings in high income countries with a majority white population. This includes, but is not limited to, patients from black, Hispanic, and Asian ethnic backgrounds. The availability of evidence relating to these patient groups enables us to build a compelling case for urgent action that may benefit other patients who experience disproportionate harm from healthcare.

Harms from healthcare exacerbate health inequalities

People from marginalised ethnic backgrounds are more likely to be harmed by healthcare because of interpersonal and structural factors that shape their care experiences. These factors include ineffective communication during clinical care, implicit biases among healthcare providers, and medical educational and clinical treatment approaches designed around white patient populations as the norm.

Ineffective communication between clinicians and patients can cause harm to any patient. However, those with poor proficiency in the dominant language of the healthcare system, including migrants, are at heightened risk of harm because of medication errors and misunderstanding verbal advice.²⁰ Whereas digital tools could augment written healthcare communication, some may lack access to privacy for video consultations. Negative healthcare experiences and poor communication from providers can deter marginalised ethnic groups from seeking timely medical attention, thereby increasing their risk of deterioration while at home.²¹

Unsafe interactions between providers and patients because of discriminatory clinical care also occur more often among patients from marginalised ethnic groups. Discriminatory care is underpinned by implicit biases of healthcare providers and is perpetuated by structural racism.²²⁻²⁴ For example, a large retrospective cohort study in the US found that black patients were nearly half as likely as white patients to be prescribed appropriate opioid pain relief for conditions such as abdominal and back pain.²⁵

A meta-analysis of data from the UK and other high income countries indicated that black patients are also at twice the risk of compulsory psychiatric detention compared with white patients.²⁶ These examples of psychological harm corroborate the experiences of many black patients with sickle cell disease, who report that stigmatisation and implicit biases affect clinicians' interpretation of their pain and delay administration of adequate pain relief.²⁷

Implicit biases are propagated by medical school curriculums in the US and UK, which are largely designed for a default white patient population and therefore underprepare the health workforce for the diverse populations they treat. For example, dermatological signs have traditionally not been taught on darker skin thereby increasing the risk of missing potentially serious disease in these patients.²⁸ Historical under-recruitment of patients from marginalised ethnic groups into clinical trials may contribute to these problems by limiting understanding of differences in the safety and effectiveness of commonly used medications across diverse patient populations.²⁹ Examples include the greater risk of angioedema from angiotensin converting enzyme inhibitors and intracranial haemorrhage from thrombolysis in black patients compared with white patients.³⁰

Medical school curriculums also tend to consider ethnicity and race as having a clinically relevant biological basis rather than as a social construct.²⁴ This drives flawed assumptions among healthcare professionals about how race should influence clinical decision making. These assumptions are further reinforced by biased, race corrected clinical algorithms. Seeing race, rather than racism, as a determinant of disease increases risk of harm from misdiagnosis or inappropriate treatment, which in turn widens health inequalities.³¹ One example of this is the way in which correcting for ethnicity when estimating glomerular filtration rate risks inappropriately delaying dialysis and kidney transplantation in black patients.³² In these ways and more, harms stemming from implicit biases and structural racism in healthcare exacerbate health inequalities for some marginalised groups.

Data shows the quality of care among socially disadvantaged patients is particularly enhanced by effective shared decision making

Adopting a patient safety lens to reduce health inequalities

Framing worsened health inequalities as a product of lapses in patient safety identifies lines of responsibility and enables healthcare providers to tap into lessons from decades of improvement in patient safety to highlight tangible actions to mitigate them (box 2).

Identify a clear line of accountability for unequal harms

The first way in which a patient safety lens can help reduce health inequalities is by highlighting chains of responsibility for action. As individuals engaged in clinical decision making, healthcare professionals have the power to make a difference by adjusting their clinical practice to help achieve equal patient safety for all.

Meta-analysis of predominantly US data shows that the experience and quality of care among socially disadvantaged patients is particularly enhanced by effective shared decision making interventions.³³ Healthcare professionals should ensure they use culturally sensitive and linguistically appropriate patient decision aids, as these have been shown to significantly improve the effectiveness of diabetes control among marginalised ethnic groups.³⁴ They could also use materials from global patient safety initiatives that aim to empower patients to be active partners in improving their safety during potentially risky healthcare events such as surgery or taking medications.³⁵ Qualitative data from the Netherlands indicate that elements of safety, such as earlier detection of deterioration, could be enhanced by more routine involvement of relatives or other advocates in clinical care of patients from marginalised ethnic groups.³⁶

Beyond actions at an individual level, we require a strong and diverse healthcare leadership to clearly communicate the message that delivering unequal safety of care represents a failure of a healthcare system. This will generate the impetus and resources necessary to establish evidence based policy that improves the safety of marginalised groups. The Institute for Healthcare Improvement is an example of an international organisation that has prioritised issues relating to inequalities in patient safety and produces actionable recommendations for healthcare providers.^{37 38}

Healthcare leaders must also ensure that health inequalities and implicit bias training are a continuous vertical element of workforce training curriculums so that providers can anticipate and mitigate elements of their practice that may be biased against marginalised groups.³⁹ Decolonising medical school curriculums will promote transformation from a white dominant model of medicine to one that is conscious of how entrenched system biases increase vulnerability to poorer health outcomes among marginalised ethnic groups.²⁴

Box 2 | Selected solutions to reduce inequalities in patient safety through action by individual healthcare professionals, healthcare leaders and system level action

INDIVIDUALS

- More routine involvement of advocates from patients' communities in healthcare interactions to reinforce communication and ongoing support in care
- Purposeful consideration of how the social background of a patient may dictate risk of harm from healthcare, and adjust management and follow-up plans accordingly
- Use of culturally and linguistically appropriate shared decision making tools to empower involvement of marginalised patient groups in their care and safety

HEALTHCARE LEADERS

- Support a diverse healthcare leadership that pushes these issues into the consciousness of the workforce and mobilises the system towards meaningful action
- Race conscious approaches to healthcare education with greater emphasis on racism and discrimination (rather than race) as determinants of disease
- Systematised co-design of clinical services and clinical information with members of marginalised patient communities

SYSTEM LEVEL ACTION

- Avoid using systematically biased clinical prediction tools and algorithms unless clear empirical justification for race adjustment has been established
- Strengthen capabilities for stratified analysis of patient safety event reports according to important patient characteristics and the translation of these data into tangible action
- Clinical trials must recruit an appropriately diverse cohort, report relevant social determinant characteristics, and conduct relevant stratified analyses that determine effectiveness and safety of drugs and devices

Improve how patient safety incident data are analysed and used

Understanding of the unequal risks of harm from healthcare across different patient groups—and thus the ability to intervene—is limited by the availability of robust national and local patient safety reporting systems that disaggregate data by characteristics such as ethnicity and socioeconomic status.⁴⁰ Furthermore, studies (including those drawn on here) often aggregate diverse ethnic groups into single categories such as “black patients.” This obscures the heterogeneous sociocultural experiences of distinct communities that may influence their experience of healthcare, and therefore limits understanding of the safety issues they face.⁴¹

Although disaggregating data may improve insight into these issues, health systems must still be capable of enacting measurable improvements. The World Health Organization's global patient safety action plan explains how this could be achieved through innovation in digital infrastructure, including by using patient safety incident data to build risk prediction models that identify the patients at greatest risk of harm.⁴² Risk prediction models linked to electronic medical records could support healthcare professionals to identify patients at risk and modify their practice to mitigate heightened risk of harm. For example, in one large teaching hospital in the UK, including maternal ethnicity in the first trimester risk assessment for placental dysfunction (with high risk patients given aspirin, serial growth scans, and offered induction of labour at 40 weeks) was associated with a decline in perinatal death rate among black, Asian and other ethnic minority women from 7.95/1000 births to 3.22/1000, which was not statistically significantly different from the rate in white women (2.55/1000 births).⁴³

Lessons from global movements in patient safety

Patient safety has seen substantial progress over the past two decades, largely because of patients highlighting unsafe care and advocating for system improvements.^{44 45} However, this forewarns of potential barriers that must be overcome as we seek to address the challenge of inequalities in patient safety. Marginalised ethnic groups are more likely to have implicit distrust of healthcare systems, and this may reduce their likelihood of raising safety concerns.^{46 47} Consequently, there can be a systematic tendency for patient safety investigations to be blind to the mechanisms of harm that disproportionately affect these patients. In the same way, subsequent recommended changes could be less effective in reducing the actual risk of harm.

Equity in patient safety will therefore require systems to empower all patients with the information and means to speak up on safety issues encountered both in hospital and while self-managing disease in the community. This could be aided by healthcare organisations recruiting people with lived experience as patient safety advocates to provide mentorship and a voice to patients from marginalised ethnic groups.⁴⁸

Conclusions

Risk of harm from healthcare is experienced unequally and compounds existing vulnerabilities to poor health outcomes, ultimately exacerbating health inequalities. Understanding health inequalities as failures in patient safety may help assign accountability for mitigating these inequalities and provides a body of experience from which to draw lessons. Resource constraints, doubts around technical feasibility, and concerns regarding the capacity of the workforce to improve their practice may be barriers to progress. Indeed, despite years of acknowledgment of racial disparities in quality of healthcare, little progress has been made.⁴⁹

Inequalities in healthcare are partly determined by widespread structural racism across many institutions, so solving these issues will rely to some extent on achieving progress on equality across the whole of society.⁵⁰ However, recent public scrutiny of racial social injustices may have opened an opportunity to deliver meaningful change.⁵¹ Although we have focused on marginalised ethnic groups, many of these findings are likely to be applicable to other marginalised groups and enable improvements in safety for all. Improving patient safety represents a real opportunity to reimagine the role that healthcare can play in reducing health inequalities.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

NHS organisational workplace inequalities

A new report from the NHS Race and Health Observatory has identified evidence of racism within the NHS (Opinion, 5 March), which should trigger alarm bells in NHS organisations at all levels. The report “found evidence of NHS ethnic minority staff enduring racist abuse from other staff and patients, and this was particularly stark for Black groups.”

Surely it is now time for all NHS organisations to introduce, publicise, and implement a “zero tolerance of racism” policy to support and protect NHS ethnic minority staff? Racism is harmful and does not enable a healthy workplace environment. NHS organisations have a duty of care towards employees, and this evidence shows that they are failing.

At a public research meeting, with NHS trust board members present, I asked whether there was a zero tolerance of racism policy in place at their organisation, and if not, why not. The questions were ignored. This indicates a lack of engagement, support, and prioritisation.

NHS inequalities need to be challenged from inside and outside organisations, and policy alone is not enough. We need to review and evaluate how policies are implemented in NHS organisations because biased implementation of policies by human resources staff and line managers can create and sustain harmful workplace cultures. Evidence indicates, for example, a large disparity between doctors from ethnic minority backgrounds and their white colleagues in rates of referral to the GMC by NHS employers.

To tackle such disparities, we should introduce upward appraisal and social awareness and emotional intelligence skills training for all line managers in NHS organisations, as a starting point for improving workplace climate to help create, as Cary Cooper describes, “a culture of wellbeing,” where there is no place for racism.

Karen Saunders, consultant research neurophysiotherapist, Canterbury
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TIME FOR RADICAL ACTION ON RACIAL INEQUALITIES



Focus on defining the question

My anger at the continuing ill treatment of ethnic minorities is turning into sadness as I read more reports (Opinion, 5 March). As an overseas doctor who has tried to tackle racism over the years, I am sad not just

because of little progress, but because we still haven't learnt from our efforts.

Tackling racial discrimination would require a totally person centric NHS. Lansley was wrong about a lot of things, but he did propose “No decision about me without me” as an organising principle, and maybe we should start there. I do not want to be known as an Asian, Hindu, straight, old (and so on) patient; I am me, a human being, and all patients matter.

We are in denial that we, not “they,” have failed and that we need fundamental change. Concerted and radical action, a cross governmental plan—yes but on what, and by whom?

Rajan Madhok, retired public health doctor, Ruthin
Cite this as: [BMJ 2022;377:o857](#)

INTERVENTIONS TO INCREASE PHYSICAL ACTIVITY

Physical activity has manifold benefits

Primary care has an important role in supporting people to increase their physical activity (Research, 26 February). But action also needs to be taken in schools, hospitals, and communities.

We are concerned about the high numbers of people not doing enough physical activity and the disparities in participation related to age, disability, ethnic group, and gender. The Institute of Health Promotion and Education firmly believes that physical activity should be promoted to the whole population.

The government has a crucial role in creating environments that encourage people of all abilities, ages, ethnicities, genders, and incomes to be physically active. Facilities are important but so too are green spaces, cycling lanes, lighting, and transportation systems.

Physical activity contributes to good physical and mental health and has social and environmental benefits. Post-pandemic, promoting physical activity offers the government a positive way to reduce inequalities, level up, and create a healthier nation.

Michael Craig Watson, trustee; John Lloyd, honorary vice president, Institute of Health Promotion and Education

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LIFTING OF COVID-19 RESTRICTIONS IN ENGLAND

Assessing vulnerability to covid-19

Shemtob and colleagues highlight the importance of continuing risk assessment for covid-19 (Opinion linked to This Week, 28 February), a duty under health and safety law.

Employers, occupational health practitioners, and treating clinicians have been using a variety of assessment tools, most of which have not been based on evidence, or have attempted to integrate objective evidence with consensus. The result has been confusion and often bad advice. The “clinically extremely vulnerable” list has been the main source of consensus guidance, but it is not evidence based and is fundamentally flawed, failing to acknowledge the effect of age and the combined effect of risk factors.

We recommend covid age as a simple, evidence based tool that is readily accessible. The team producing the tool has been regularly updating the guidelines. For the one and a half million people advised to shield inappropriately, the tool can help to reassure them.

Anthony N Williams, consultant occupational physician, Temple Ewell

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DOCTORS SOMETIMES FAILING TO INFLUENCE POLICY

Unite with others for wider support

Oliver is right that uni-professional approaches might be misinterpreted as seeking advantages for one's own profession (David Oliver, 5 March). Wherever possible, it is best to unite with a public or consumer oriented group to show wider support for your arguments.

As president of the British Society of Rehabilitation Medicine in 2000, I was

alerted to the years long waiting times for the provision of electric powered indoor-outdoor wheelchairs. Discussions with relevant civil servants (n=3), charities (n=3), members of the Houses of Lords or Commons (n=3), and the chief medical officer showed widespread support for government intervention.

An appropriate letter was drafted and copied to the 10 interested bodies, resulting in the initiation of the Wheelchair

Services Collaborative, which directly supported nearly 50% of UK wheelchair services.

Proof of widespread support for the action you are fighting for greatly strengthens the case, particularly when user groups or relevant charities are supportive.

Andrew O Frank, retired consultant in rehabilitation medicine, Harrow

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HAS COVID CHANGED THE DEBATE ABOUT NATIONALISING GPs?

GP partnership is finished

Hodes describes partnership as bringing "so much long lasting job satisfaction." (Head to Head, 5 March). He speaks for a minority, given the current working conditions in primary care. The reality for many is an unsustainable workload exacerbated by the pandemic, a recruitment and retention crisis, and morale at a historic low.

My job frequently feels unsafe in terms of the amount of work I am expected to do, under time pressure, and the impact on my own health. Talk of personal resilience is a red herring—no one can be expected to work safely and effectively the way that NHS GPs are expected to.

Independent contractor status is doomed. One may argue this is deliberate: defund a system until it is in crisis, whip up anger and discontentment in service users, then provide the "solution" in the form of privatisation. Whether by conspiracy or cock-up, the GP partnership is finished.

Thomas C McAnea, GP, Sheffield

Cite this as: [BMJ 2022;376:o833](#)

It's time for a national doctors' service

Majeed and Hodes debate the nationalisation of GPs. What is the pay of a GP? Or a part time GP? What are the sickness, maternity, and paternity benefits? Why have no new practices been set up in the past 20 years?

That there is no answer to these questions shows the pathetic structure of general practice. We need a national doctors' service with national terms and conditions and protections. The consultant contract might not be suitable, but the same contract needs to be applied across hospital and community services.

The NHS should offer graduates a career structure with a choice of hours, specialty, portfolio, and foreign working. It should pay for training, exams, and study leave. It should protect and nurture doctors through their careers, offering non-clinical posts near retirement and a good pension. Above all it should encourage the best doctors to work in the most difficult places.

Simon D Price, retired GP, Chichester

Cite this as: [BMJ 2022;376:o832](#)

Only GPs can assess what primary care needs

No model of primary care—partnership, salaried, or a mixed economy—will deliver high quality, sustainable, equitable, and universal primary care while funding is calculated using the Carr-Hill formula. The cost drivers applied to remoter rural practices have



lessened, and pressures from the burden of chronic disease in deprived urban areas are much greater.

It is madness to argue that productivity and quality would be enhanced by the forcible subordination of the most productive assets in the system to hospital trusts beholden to the micromanagement of NHS England, which is in thrall to a secretary of state whose most relevant experience of honest labour might be a summer job in a biscuit factory.

The models possible under General Medical Services and partnership allow GPs and local commissioners to create the correct shape peg for the hole they have to fill, and only GPs are fundamentally capable of making this assessment.

Bob Hodges, general practice partner, Gloucester

Cite this as: [BMJ 2022;376:o827](#)

Author's reply to Hodges

Hodges is correct about the flexibility, efficiency, and cost effectiveness of the current independent contractor model of general practice. And yet, NHS England refuses to invest in or adequately support this model.

Recruitment and retention problems persist in general practice, and the gap between the demands on NHS primary care and the primary care workforce continue to increase. The independent model of general practice might do better in the future, but this would require changes to the General Medical Services contract that NHS England will never make. So the future is for GPs to increasingly be employed in salaried roles.

The question for the BMA and GPs is do they want GPs to be employed by the NHS with similar terms of employment to consultants, or do they want to be employed by private companies and "mega-partnerships," with the inevitable variability in terms of the employment they will offer?

Azeem Majeed, professor of primary care and public health, London

Cite this as: [BMJ 2022;376:o840](#)

OBITUARIES

Prema Basnayake

Anaesthetic specialist (b 1938; q Colombo Medical College, Ceylon, 1965), died from metastatic lung cancer on 1 October 2021

Prema Basnayake worked tirelessly to set up the first cancer hospital in Ceylon/Sri Lanka—the Maharagama National Cancer Institute—where he specialised as a consultant radiotherapist. After making the bold move to move to the UK to continue his career there, he retrained as an anaesthetist and took up his first post in Romford, Essex. It was there that he met his future wife, Mary, a theatre nurse. They worked together around the country before eventually settling in South Yorkshire. Prema showed a continual passion to learn about topics including world affairs, politics, and history. He will be especially missed for his love of dancing, his great sense of humour, and his desire to live life to the full. He leaves Mary; their daughter; and his two brothers.

N Ilangaratne, K Basnayake

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Molly Irene Mortimore

Paediatrician (b 1925; q Bristol 1948; DCH), died from frailty of old age on 5 November 2021

Molly Irene Mortimore (née Govier) spent her childhood in Exeter and trained in Bristol, where she was reportedly a diligent student and keen sportswoman. Her professional career reflected her love of children and concern for those less fortunate than her. After a period of training in London she worked in school medical services and community child health in Norwich, Northampton, and the West Midlands. Latterly she specialised in audiology and complex childhood disability. She retired first to Devon and then moved to Southampton. She was active in local churches wherever she lived, and her lifelong Christian faith seemed stronger as she became frailer. Molly was predeceased by her husband, Roger, in 2002. She leaves two sons, six grandchildren, and nine great grandchildren.

Andrew Mortimore

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Timothy Davies

GP (b 1946; q Southampton 1983), died from sepsis on 10 December 2021

Timothy Davies (“Tim”) qualified in politics, philosophy and economics at Oxford, obtained a business degree at the London Business School, and then became a senior administrator in the NHS, before he decided to become a doctor. He trained as a general practitioner in Sandhurst, Camberley, Surrey. In 1988 he became a senior partner and general practice principal in East Preston and Littlehampton, west Sussex. He retired in 2013 and moved with his wife, Ruth, to Bath, where he continued to work part time as a locum doctor. He made two short visits to work in Malawi, Africa, at the Zomba Central Hospital. He sustained a head injury as a result of a fall in London in October 2021 and died at the Royal United Hospital, Bath. He leaves Ruth, two adult offspring, and four grandchildren.

Ruth Davies

Cite this as: *BMJ* 2022;376:o552



Veronica May Gammon

Consultant ear, nose, and throat surgeon East Glamorgan (b 1925; q Royal Free Hospital, London, 1949; FRCS, DLO), died from bronchopneumonia along with peripheral vascular disease and old age on 27 December 2021

Veronica May Gammon (“Vera”) worked for a time at Guy’s Hospital, London, one of the first female doctors there. She also worked at other hospitals in England, but spent the greater part of her career in her native Wales until her retirement in 1984. Being a woman posed problems, but Vera overcame them to obtain a consultant post. She was a high achiever, academically and in sport. A gifted artist, specialising in miniatures, she was accepted into the Hilliard Society and Limners. A brilliant pianist, organist, and singer, she made several recordings and she was the local chapel organist for many years. She was also the president of the local Soroptimists. Vera never married.

Jill R Willey

Cite this as: *BMJ* 2022;376:o557



Bryan Hibbard

Emeritus professor of obstetrics and gynaecology (b 1926; q St Bartholomew’s Medical College, London, 1950; FRCOG), died from spontaneous subarachnoid

haemorrhage on 29 September 2021

Bryan Montague Hibbard was the first to suggest that folate deficiency might lead to complications in pregnancy, including congenital malformations. In 1972 he accepted a position as professor of obstetrics and gynaecology at the University of Wales College of Medicine in Cardiff. He helped transform obstetric care across the region. His work on folates continued and in 1991 the Medical Research Council organised a control trial confirming the need for supplementation in pregnant women. In 1995 he was awarded the Rank prize for scientific excellence in the subject of nutrition. Bryan’s wife, Elizabeth, died in 2019. Her remains, along with Bryan’s, are interred in the Garden of Remembrance at Llandaff Cathedral.

Robert Grassie

Cite this as: *BMJ* 2022;376:o553



Matthew Jeremy Norton Crocker

Neurosurgeon (b 1976; q Oxford University Medical School; MA (Oxon), FRCS(Neurology) 2011), took his own life on 27 January 2022

Matthew Jeremy

Norton Crocker (“Matt”) obtained a training number in the South London neurosurgery programme in 2005, taking two years out to undertake research into cerebral blood flow as a McKissock neurosurgery lecturer at St George’s University of London. He published more than 50 research articles on a range of neurosurgery and patient safety topics. He was appointed to the Atkinson Morley Department of Neurosurgery at St George’s Hospital in 2012 and within a decade built a considerable practice, specialising in complex spine surgery and surgery for intradural spinal tumours. Matt completed marathons, triathlons, and Ironman competitions. He married Helen Matthews, a consultant gastroenterologist, in 2003. He leaves Helen and their three children.

Timothy L Jones

Cite this as: *BMJ* 2022;376:o551



OBITUARIES

David Easty

UK corneal transplant pioneer

David Leonello Easty (b 1933; q Manchester 1959; MD, DO, FRCS, FRCOph), died from prostate cancer on 11 January 2022

About 4000 corneal transplants are carried out in the UK each year, according to NHS Blood and Transplant. “This is David’s legacy,” said John Armitage, emeritus professor of cryobiology at Bristol University.

David Easty’s vision led to the formation in 1986 of the nationwide corneal transplant service. He recruited Armitage from Cambridge in 1984 to research the potential of cryopreservation to allow unlimited corneal storage time.

Moorfields

Serendipity was a large part of the story. First, UK Transplant, as it was known then, was Bristol based. Corneas were a logical extension of its nationwide distribution of solid organs. Second, Easty had moved to Bristol after working under Barrie Jones, the doyen of ophthalmology in the 1960s



Easty was passionate in his support of the NHS and opposition to Tory health policy



and 1970s, at Moorfields Eye Hospital in London. Easty could not have had a more distinguished mentor. Jones changed the method and direction of ophthalmic practice at Moorfields, creating closer relationships between researchers and clinicians and between the hospital and the Institute of Ophthalmology.

A socialist, Easty was passionate in his support of the NHS and opposition to Tory health policy.

Bristol

Easty moved from Moorfields in 1971, becoming a consultant ophthalmic surgeon at Bristol Eye Hospital. He initiated several research projects and was soon supervising a team of five researchers. Building on his Moorfields work in 1968-69 as senior registrar in the virus clinics, he had a special interest in herpesvirus in the eye. At Bristol medical school he built an experimental research group in *Herpes simplex*, which flourished until the end of his career.

In 1982 he became Bristol’s first professor of ophthalmology. Like so many department heads, he was beset by funding problems. An unfashionable research area, ophthalmology attracted only about 2% of overall medical research funding, according to one estimate. In 1986 Easty founded the National Eye Research Centre to generate income.

Initially, research in Bristol was its main recipient, but as it grew so did its support of other charities; it has raised more than £17m for research in more than 20 UK universities. Perhaps most notably the charity, now known as Sight Research UK, funded the nationwide corneal transplant service, after initial backing from the Iris Fund for the Prevention of Blindness (IFPB).

The pre-existing eye banks, in East Grinstead and at Moorfields, provided

predominantly local services. The Bristol eye bank and its Manchester counterpart (opened in 1988) are now part of NHS Blood and Transplant.

The Bristol service was the first in the UK to use organ culture storage at 34°C. Increasing the storage time of corneas from just a few days to a month transformed routine corneal transplantation from an emergency into an elective procedure, greatly reducing the number of wasted corneas. Out-of-hours corneal transplants became uncommon, which benefited both patients and surgeons. More time in storage also enabled doctors to find the most suitable patient for each cornea, resulting in better graft results.

Obtaining more corneas was a huge challenge—there was, as now, a shortage of ophthalmologists. Easty, Armitage, and the IFPB lobbied for what became the 1986 Corneal Tissue Act, a private members’ bill enabling trained personnel, such as nurses and morticians, to remove donor corneas. Previously, only fully qualified medical practitioners had been allowed to remove donor organs.

On enlisting in the Royal Army Medical Corps for national service, Easty was dubbed “the Vampire” as medical officer to the 1961-62 British Antarctic Survey. He took regular blood samples from the 24 men in Halley Bay to establish the relationship of diet to serum cholesterol concentrations. The diet included tinned and dehydrated food, supplemented by occasional seal or penguin meat.

The majestic, bleak landscapes and the greens, blues, pinks, purples, oranges, and golds of the Southern Lights fired Easty’s love of adventure. In the 1960s he also lectured in anatomy at the University of the Witwatersrand, Johannesburg, and worked in the city as a general surgical registrar and general ophthalmic registrar at Baragwanath Hospital. He met his future wife, Bozana, a microbiologist and a Yugoslav refugee, in South Africa.

Married for 40 years, they had three children. Easty leaves Bozana, his three children, and his second partner, Nancy Shepherd, a family planning doctor. He also leaves four grandchildren.

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