the doctor
The magazine for BMA members
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AI OK?

How doctors are already using artificial intelligence

In their footsteps
Would you go on a walk with your patients?

A refugee's tale
From Nazi Germany to a northern mill town

The human factor
The impact of online consultations

In this issue


JESS HURD

Welcome

Phil Banfield, BMA council chair

Like the wider BMA, this magazine seeks to ensure doctors' voices are at the heart of the most pressing issues our profession faces, our NHS and our society. The November issue of *The Doctor* is no different – as we investigate AI (artificial intelligence) in healthcare, the effects of the COVID-19 pandemic on general practice and communities and visit a 'no-restraint' mental-health hub aiming to effect transformative change.

I often hear of innovation in healthcare happening 'despite' not 'because' of the NHS. The decade-plus of austerity has left the NHS with unstable foundations, which must be stabilised urgently to enable large-scale systematic evolution.

Last month, the BMA published a set of principles to support the safe, effective, ethical and equitable adoption of new technologies in medicine. In this issue, we speak to the doctors at the forefront of this modern revolution and find out about some of the latest developments – from AI-enabled stethoscopes to screening projects which could change the face of cancer diagnosis and treatment. As Bharadwaj Chada says in this feature, there is no question about the effects technology could have but 'doctors need to be front and centre of discussions'.

Our profession's response to the COVID-19 pandemic remains one of the most remarkable collegiate efforts I have witnessed during my career. Hospitals generated space by closing down elective care, and GPs picked up the pieces, in addition to their already crippling workloads. This included managing shielding lists and rapidly vaccinating the population. GP practices adapted almost overnight to meet a daunting challenge of unprecedented proportions.

Some of the changes to general practice driven by the pandemic and heralded as reform, risked unintended effects of dehumanising, compromising, and fragmenting care. We speak to the doctors and researchers who remind us of the core value of the human touch in the doctor-patient relationship.

At the heart of medicine is a doctor-patient relationship built on trust, supplemented but not replaced by technology or AI. It still takes human expertise to avert the garbage in, garbage out bias of using a wrong algorithm from the start. It still takes doctors to rebuild our NHS to a state that the profession and patients can be rightly proud of again. It still takes doctors' voices to be heard for any of this to happen.

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AT A GLANCE

NI rise a threat to GP services

UNDER PRESSURE: Practices and staff at risk if extra costs are not reimbursed

GPs fear widespread cuts to services and closures of practices because of proposed increases to their employer NICs (National Insurance contributions) announced in the Budget.

Chancellor Rachel Reeves announced that the rate of employer NICs would increase by 1.2 percentage points to 15 per cent, with the level at which employers begin paying NICs for each employee reduced from £9,100 to £5,000.

This will come alongside a 6.7 per cent increase in the national living wage, to £12.21 an hour, from April as part of measures to raise an extra £40bn per year in tax.

With general practice 'on its knees' after more than a decade of cuts to public services, the BMA GPs committee for England is calling on the Government to cover these costs by uplifting practice funding to protect them and their patients and honour its pledge to 'fix the front door' of the NHS. Some 60 local medical committee officers, who support practices looking after as many as 40 million patients, recently attended a support network meeting alongside an officer of GPC England.

Some warned 'this could be the end of us' and urged the BMA to escalate its continuing collective action in response. 'We ... never expected it from a Labour Government,' the meeting heard.

David Wrigley, a GP in north Lancashire and deputy chair of GPC England at the BMA, who attended the meeting, said: 'Over 10 years of cuts to public services has left general practice on its knees. Faced with one of the biggest financial and employment crises ever faced by our profession we're also expected to meet increasing demand with limited resources.

'[Unless this cost increase is covered by uplifting practice funding for staffing costs, the] chancellor's plan to increase employers' National Insurance will place an enormous added burden on practices already operating on the tightest of margins to remain financially viable.

'If the Government decides to press on by not covering these increased costs for practices, which previous governments have done, then this will lead to more difficult decisions for practices and force many to cut back on the services we provide.

Dr Wrigley said: 'The whole profession has been committed to working in the NHS since its inception in 1948.'

'There is a real risk that if the Government does not take action on this issue then general practice could become like dentistry with NHS dental deserts across the country.

'If the Government is fixing the "broken NHS" then it must rethink this decision and work with us to immediately reassure GPs of [additional funding to cover this cost increase], which will protect practices and allow us to offer the services our patients deserve.'

In a letter to Mr Jones, Katie Bramall-Stainer, chair of GPC England, said GPs were 'deeply concerned' about the mounting costs, which would amount to an extra £865 a year for an employee on a salary of £30,000.

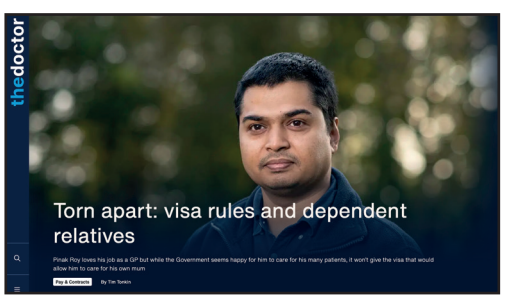
'We are calling upon yourself and the Treasury, alongside the Department for Health and Social Care, to provide absolute certainty at the earliest opportunity, that GPs, as designated public authorities, will be [supported] in full for this additional financial burden,' she wrote.

GPs have been defined as 'public authorities' for 25 years. Dr Bramall-Stainer explained this means: 'We are not like traditional businesses who can increase costs to absorb financial pressures.'

A NEW CHAPTER

We've launched the first dedicated website for our content, at **thedoctor.bma.org.uk**. We are encouraging members to opt out of receiving the printed magazine by logging into the BMA website and adjusting your preferences. At the end of this year, for cost and environmental reasons, *The Doctor* will be fully digital, and the print edition will no longer be sent.

thedoctor.bma.org.uk



WELCOMING: The community adult mental health hub in York

No locks, no stigma

A new initiative to create safe, supportive spaces for those with mental health conditions could help spare some the trauma of being admitted and detained. **Ben Ireland** reports

'I'll never forget the first time our daughter was sectioned,' says Ros Savege, a mother and carer of a woman with complex and co-morbid mental health conditions including schizophrenia and enduring psychosis.

'The driveway was full of cars: lawyers, approved mental health professionals, psychiatrists, police and others. All of a sudden, all these people arrived. It's the only way the system worked.'

As a member of York Mental Health Partnership, Mrs Savege has been a leading voice on a project to transform mental health services in the city. One of its aims is to reduce the likelihood of experiences such as her family faced one of the three times her daughter was detained under the Mental Health Act.

York's Connecting our City project was recently awarded £2.4m from NHS England to develop a 24/7 community adult mental health hub.

> 'People get support with everything around them in their life as well as the interventions'

Its vision is of holistic, wrap-around care at any time of day or night, providing a safe space for those with mental health conditions with no locked doors, no discharge and no stigma.

There will be no need for a referral to the hub, which will operate alongside existing

psychiatric hospitals and crisis services, with the aim of reducing the likelihood of people reaching a stage where they need to be formally admitted or detained. It hopes to provide support for those in distress, looking at the societal context of their needs.

Funding for the hub has been awarded after a successful pilot scheme, which will continue to operate. A third site in the city is also planned.

York's transformation has been heavily influenced by the Department of Mental Health in Trieste, Italy, which pioneered a 'whole person, whole life, whole systems' approach to mental healthcare in the 1970s – in response to concerns about the use of asylums.

The Trieste model is backed by the World Health Organization and described as an 'open door, no-restraint system of care for recovery and citizenship'. Rather than focusing on clinical symptom reduction, it prioritises dealing with the social context of patients' conditions, fostering a sense of belonging, safety and inclusion under the mantra 'Liberty is therapeutic'.

Holistic offer

Over the decades in Trieste, there have been recorded drops in the number of mental health inpatients and emergency presentations, the number of involuntary treatments, incidents involving people with mental health conditions and law enforcement, as well as the suicide rate. Meanwhile, more people with mental health issues have been supported into employment.

Clinicians in York hope to replicate this as they further roll out the approach they've been working on since the closure of local psychiatric hospital Bootham Park in 2015, which originally opened as the 'county lunatic asylum' in the 18th century.

Consultant psychiatrist Stephen Wright, an independent co-chair of the York Mental Health Partnership, casts his mind back to before transformation work began: 'There was something of a crisis of services in York, where the fragmentation of the system and insane paradoxes played out.'

Explaining the principles of the new model, he says: 'Traditional mental health services have an access team, which offers some governed interventions, which people have to wait for. But by coming here they not only don't have to wait, but they also get a more holistic offer – they get support with everything around them in their life as well as the interventions.'

Fellow co-chair Lynne Gabriel, a professor of counselling and mental health, explains how the project required 'really dedicated people' to 'push at the doors of an antiquated system' in the early stages.

'There is no revolving door,' she says of the community approach. 'People come through one portal, access a compassionate human being and receive support with whatever they are presenting with. It was really important to stop that process of saying, "I can't help you here, go over there", that constant shifting of someone round a bigger system.'

The hubs will be run by a multidisciplinary team of clinicians, social workers, social prescribers and peer support workers from the NHS and voluntary sector.

'There's no pitting a medical model against a social model, we all work together,' says Prof Gabriel. 'But we do need that medical input.'

Early intervention specialist Dr Wright adds: 'There's always a danger of over-medicalising things. For GPs, in the traditional model, it would often be a referral or a prescription rather than an opportunity to have a closer look at someone's needs or whole life.

'Some things my team can do better than me, which is important for a doctor to acknowledge. But there is of course that need for prescribing and medical cover at all times.'

> 'It was really important to stop that process of saying, "I can't help you here, go over there"'

High engagement

Measuring outcomes could take 'generations', he says, noting the importance of having created a clear and co-produced set of principles. But results of a prototype study show early successes.

Of 33 service users, only one did not engage. Some 24 reported progress with the reasons they sought support. Service users reduced their drug and alcohol use, were given support with housing

SAVEGE: Endured 'absolute hell'

PAUCITY OF ESTEEM

and benefits, had their medication reviewed and had neurodevelopment screenings.

Dr Wright says more than 50 per cent saw 'significant clinical improvements, without any medical or clinical interventions', meaning 'non-clinical interventions improved clinical outcomes', something they hope to 'explore further'. Some have moved into paid peer support worker jobs at the hub.

For Mrs Savege, the pilot (which opened in 2023) has been 'a very different experience' for her and her daughter, which she is sure the 24/7 hub will build upon.

'We were living in absolute hell, despite a lot of support,' she says of previous care. 'Our daughter would be going from A to B to C. She would shut down because it used to be "who is it today?", "where are we today?", which added so many layers of disempowerment.

'She doesn't open letters, use a phone or use a computer, and that's not unique. Elderly parents can be the only people getting their adult children to an appointment, or clozapine clinic.

'Services might be getting these people stable, but they're under the radar. They're medicated, they're not overtly psychotic, so job done. But it does not provide any quality of life.'

Mrs Savege describes the 'barriers' and 'blockers' in traditional mental health systems, where patients are 'siloed' and 'labelled'.

'It's shocking, but you need a label to open doors,' she says. 'Who would like a label of schizophrenia?'

In contrast, the community hub offers 'a system which talks to each other and is co-ordinated' with 'one door to walk in with somebody there to help you'.

'There are no locked doors, no lanyards, we never signed in. When you walk in you don't [immediately] know if you're talking to patients, carers, support workers, psychologists. That openness builds relationships for somebody like our daughter, who doesn't feel like she belongs to any community.

'Everything is about relationships and trust, and so much more so when you're very unwell because the challenges of new people and new faces are so much greater.

'It's [also] about having confidence. If you know something is there, very often you don't access it. You don't need to escalate when a service is there, rather than feeling like there's nowhere to go.

'When you have complex issues, you need a broad support network. I don't know what my daughter experiences, I'm not sure even she can describe it, but it's a complete sense of otherness. You lose your friends, your contacts, you are stripped down to nothing, really, by very serious mental illness. Society has to find a way of filling enough of that gap.'

Risk assessment

Dr Wright agrees that difficulties can be 'compounded' when there is less support for those with mental health conditions, particularly out of core working hours.

WRIGHT: Endorses a more collaborative approach to care

> 'If you can't use coercive or restrictive techniques, you just have to do it differently'

He says the biggest challenge for clinicians in switching to a Trieste-style model is reassessing their approach to risk.

During the group's second fact-finding visit to Trieste, Dr Wright recalls then-director Roberto Mezzina explaining 'if the door is locked, the doctor is free; if the door is open the doctor is responsible'.

That take is in line with Italian Law 180, also called the 'Basaglia Law' after psychiatrist Franco Basaglia, who led reforms in Trieste. The law stipulates that admission to hospital be allowed 'only if it can be shown that community-based treatment options are not feasible or have failed'.

'We went with a really critical eye, thinking "how can we make this work?",' says Dr Wright, noting the differences between Law 180 and the UK's mental health act. 'If you can't use coercive or restrictive techniques, you just have to do it differently,' he says. 'We asked, "what do you do when someone is seriously intent on harming themselves?" Ultimately, you find a way, and the more collaborative it is the better.'

Dr Wright has since followed this principle in clinical practice

when dealing with what 'are often insoluble problems'. He says: 'If everyone can talk it through and agree a way forward, then if something goes wrong it's not because everybody hasn't had an opportunity to contribute.

'Things go wrong anyway. But there's still a culture where organisations don't want to take on risk. If they can keep the risk at arm's length, then they don't get in trouble. Ultimately, that risk doesn't go away, it just remains in the community – and sometimes it plays out even worse.

'So the responsibility [should be] for all organisations to actually recognise it, roll their sleeves up and collaborate.'

The York hubs will offer outreach as well as an open door. This could be for service users who haven't shown recently, or potentially vulnerable people for whom there are concerns.

'If you're not getting the help you need, you tend to escalate,' says Dr Wright. 'Then things get worse because the way the system operates [traditionally] is that you need to reach a certain threshold before you get help. That shouldn't be happening.'

'Invisible' to services

Prof Gabriel explains how it is often frustration at the system, and a sense of rejection, that causes people to resist treatment and lash out.

She explains how the pilot hub worked with a service user who had 'a long history of disturbances with the police', had been homeless and 'written off by social services'.

'They misbehaved a little bit, but the team reached in to connect with that individual and very gradually relationships developed. They showed compassion, care and acceptance.

'There are some limits, of course – you can't bash staff in the teeth – but within that there is huge liberty to explore being in relationships with human beings who are accepting. An individual like that can find their feet in these loving relationships.'

GABRIEL: Team provides 'compassion, care and acceptance'

'There's something profoundly precious about coming across a human who looks at you, might touch your shoulder or be willing to have a cuppa with you. That, for some people, is so different from what they're used to.'

Prof Gabriel also notes 'clear indicators' of potential NHS cost savings by taking preventive action, though insists that would be a 'byproduct'.

'We're not doing this for savings, we're doing this for people,' she says. Mrs Savege adds that some people who are currently 'invisible' to traditional mental health services may also be more likely to engage with the community approach.

> 'The vision is to have a mental health system we're proud of'

'Nobody has been interested in the root causes before,' she says.

York has a proud history of innovative mental health services. In 1790, prominent Quaker William Tuke opened The Retreat, a humane alternative to the asylums of the day after concerns were raised about the treatment of a patient who died in care.

A recent HSSIB (Health Services Safety Investigations Body) report found that many mental health services are being run in 'dilapidated' facilities. It recommends 'making therapeutic care a priority'. The new Labour Government has set out its intention to transform the NHS into a more preventative system.

York's Mental Health Partnership hopes its mental health services can become a model for others to emulate, and says it aligns with recommendations from the Hewitt review and Darzi report. Prof Gabriel says: 'If we have enough evidence to show this is making a difference, then if more money becomes available, this could be the beginning of a movement. There have been seeds of this for a long time. People are beginning to notice that there's a different way of doing it.' Dr Wright adds: 'They've been talking about it for decades, the only thing that hasn't happened is actually implementing it. We have to demonstrate you can do that, and fund it adequately.

'The vision is to have a mental health system we're proud of. That's what we saw in Trieste. There's a lot of passion. They were showing it off. We want to do that too.'

The pandemic saw a rapid shift in general practice towards remote care and many of the innovations remain in hybrid form – but what effect do they have on patients? Two leading GPs set out to find out the answers and came to some worrying conclusions. By **Peter Blackburn**

The human factor

When Trisha Greenhalgh strained her ribs after 'overdoing it' at the gym, one of her colleagues, a sports medicine consultant, suggested an anti-inflammatory treatment. What happened next was a striking reminder of the effects of the increased use of technology in general practice.

The Oxford professor of primary healthcare filled in the online triage form her local GP practice runs and was greeted by a question which read: 'Do you have chest pain?' For most people the obvious answer to this question would be 'yes' – Prof Greenhalgh says, 'it was the worst "chest" pain I'd ever had in my life' – but she knew the correct answer for the purposes of this form was no because yes would mean being told to call 999.

Prof Greenhalgh wrote a note in the free text and explained the situation. Forty-five minutes later she had a text from her GP and a prescription for the drugs she needed. They were already waiting at the pharmacy.

'With digital access there are all these pull-down menus and pre-assessments'

'For me it was super-efficient. With an educated middle-class patient who knows how to play the algorithm it works. But for so many people they wouldn't have the health literacy to be able to do that. With digital access there are all these pull-down menus and prior questions and pre-assessments. You have to be able to navigate your way through it. I have a relative who has only a very basic understanding of health and technology, and if they didn't have me to help them, they would be struggling to get through the digital maze that is now the pathway to their GP,' she says.

In 2020, as the COVID-19 pandemic hit, primary care shifted heavily to remote care – with a 'crisis-driven expansion of technology' making digital booking, triage and information exchange routine. Alongside this, long-term condition monitoring was de-prioritised. Following the acute challenges of the pandemic, general practice restored full services using a blend of remote, digital and in-person care. It has been a period of monumental change, which has taken place in the context of more than a decade of austerity in the public sector, declining numbers of GPs, an ageing population, rising levels of multi-morbidity and increasing inequalities.

For Prof Greenhalgh and colleagues these developments raised a question which has not been previously answered by academic study: how have changes in technologies and working practices affected the quality in UK general practice?

Extensive research

To answer that question, a team of researchers were embedded in 12 GP practices, which they observed for 28 months – following and interviewing staff and patients as well as assessing

DIGITAL REVOLUTION: General practice saw a rapid crisis-driven expansion of technology during the pandemic

GETTY

‘Our idea was to sample just 12 practices but get to know each of them in depth and follow it over time. That meant we could actually paint a picture’

GREENHALGH: Studied 12 practices in depth

documents and data. This in-depth work was combined with interviews of stakeholders in strategic local and national roles, analysis of the GP patient survey and online reviews by patients, a 'multi stakeholder workshop' on quality and safety, assessment of the Care Quality Commission's state of care reports and the Health Services Safety Investigations Body's report on continuity of care and delayed diagnosis.

Prof Greenhalgh says that, when designing this new study, she had been struck by previous studies which had looked at the effect of remote and digital care on large numbers of practices but had not been able to explain why those effects varied so much from practice to practice. 'I thought we needed to study fewer practices, but in more depth,' she says. 'Our idea was to sample just 12 practices but get to know each of them in depth and follow it over time. That meant we could actually paint a picture. We didn't produce much quantitative data, we can't say "the answer is 42.3", but we found that certain problems affected all the practices and some practices were able to overcome some problems and some weren't. It's a slightly unusual study design, but I think it's one of the most successful research studies I've ever been involved with.'

'Our core belief is that we're in it for the community, for the whole person'

Rebecca Payne, a GP and the Reuben-Clarendon doctoral scholar at Oxford University, was one of the leaders of the project. She says the 'digital aspects' of general practice need greater consideration. The driving force for her involvement was her sense that, while things might look more efficient with technological processes, they often aren't.

The study's findings are striking. It shines a light on the increasingly difficult context of delivering quality in general practice – characterised by financial austerity, loss of resilience, increasingly complex patterns of illness and need, an increasingly fragmented workforce, material and digital infrastructure unfit for purpose and fewer in-person interactions.

The study also suggests most clinicians and support staff still aspire to traditional values of general practice like relationship-based, compassionate care and continuity but providing the human elements of care is increasingly challenged.

A partner at one of the GP practices involved in the study told *The Doctor*: 'It has been incredibly hard but in my experience many of us have stepped back and really thought, "why are we doing this?" And then you remember why you're doing it and that hasn't really changed. Our core belief is that we're in it for the community, for the whole person, for their whole family, for the whole journey – their whole life.'

On technology, and the benefits of hybrid services, many patients and staff reflected positively about convenience and flexibility – and other positives such as patients being able to submit blood-pressure readings were also raised.

Unintended consequences

Dan Beck is a GP at the Swiss Cottage surgery in north London, which has implemented an online tool that provides three or four text boxes for patients to explain their symptoms and what sort of responses they would like from staff. One GP at the surgery will – during normal hours – be assessing the forms and triaging patients and is often able to assess requests within 30 minutes before working out what type of consultation is required. The practice tries to provide continuity by allowing patients to request a named GP where possible.

There is still a team of receptionists who direct callers to the online tool but are able to help where patients need more assistance. 'Our online tool

PAYNE: Some 'depressing' findings

isn't a substitute for clinical interaction,' Dr Beck says. 'It simply allows us to put patients in the right place, make sure queries are getting through, and patients are getting what they need.'

Dr Beck recognises there is no system which works for all patients but here this seems to be a success. 'We're really proud of our offer for patients,' he says. 'I don't think you can bring in a tool like this if your practice is really struggling and expect it to make your demand/capacity profile more balanced ... but it can help you match your capacity to your demand.'

However, the work also reveals digital access and triage systems and multiple new staff roles designed to increase efficiency appear to have introduced many new inefficiencies as well as compromising quality, accessibility, patient-centredness and equity of care. The list of unintended consequences found is stark – including patients submitting multiple requests as triaging systems could only deal with one at once, skilled staff being needed for triaging, which reduced capacity elsewhere, and the rapid pace and high risk associated with triage increasing staff stress leading to burnout, sickness absence and staff turnover.

A GP partner at one of the practices, whose practice operates a hybrid system, said there are 'strengths for some people' but that technology can mean feeling 'surrounded' by structures when what you really want is to be seeing patients and that pressures to move to total triage could adversely affect lots of parts of their population.

'What are we doing?'

The study also found the quality of long-term condition management varies wildly, with some practices reintroducing in-person reviews while others rely on remote data entry by patients with care fragmented across different staff members with 'limited training'.

One of the most powerful parts of the study shows how the changes have crystallised the theory of the inverse care law, with the supporting revelation that efforts to improve equity and mitigate digital exclusion, like digital navigators, help in some areas but do not compensate for complexity of systems and extremes of structural disadvantage.

Dr Payne says: 'I think, for me, being really deep in the data, it was the most depressing thing I have ever written in my life. It was the sort of thing that makes you think, what are we all doing? All of these things you encounter as a GP in your clinical practice, but to have it all there in front of you and leaping out of the data ... It was so depressing.'

While the study hasn't produced huge amounts of quantitative data that leads to easy action points and immediate actions to address concerns, there must be many lessons to learn from such striking findings.

Dr Payne says: 'This is a call for holistic, relationship-based healthcare – not just a relationship with the patient but with the community and between individuals in the practice. We've replaced relationships with technology and we're not getting what we need from that.'

Prof Greenhalgh adds: 'Can we please just be there for people and be their doctors in a holistic way – looking after the individual, the family and the community and doing all the kinds of things around education and behaviour that we did in the old days.

'This approach was actually far more sophisticated than most of us realised. Now it's been transactionalised and we're beginning to realise what we've lost.' ■

'We've replaced relationships with technology and we're not getting what we need from that'

EMMA BROWN

BRANCH OF PRACTICE: Dr Aziz (centre left) and her walking group

In it together

Through community projects designed to nip health issues in the bud, GPs are aiming to give the power – and responsibility – for good health back to their patients. **Seren Boyd** reports

What do a citizen-science water project and a walking group for South Asian women have in common?

They're part of a small, quiet revolution in primary care taking root across east Surrey. Its aim: to redefine healthcare, locally at least.

It is spreading like mycelium, through an ever-growing network of social connections and often unlikely relationships. And it is spawning community allotments and orchards, exercise classes, support groups, even a football club.

Quite what these initiatives do for participants' health is not always easy to explain, harder still to measure. Yet, people are adamant they feel better for 'being part of something'; some are even going to their GPs less often.

All these projects have been supported by GHT (Growing Health Together), a collaboration between GPs, local organisations and community members to 'build health from the ground up'.

'Creating health is all about shifting power'

Or as its co-founder and director, GP Gillian Orrow, puts it, it's about 'creating conditions for health to flourish', not just preventing ill health. It's also about making the NHS more sustainable, both

GROWING HEALTH TOGETHER

ORROW: 'Creating conditions for health to flourish'

EMMA BROWN

GREEN SPACE: Drs Anderson and Aziz

environmentally and financially, she says.

As the Government tries to shift the dial away from reactive care, could the work of Dr Orrow and colleagues hold some useful lessons?

The wider ecosystem

At first glance it's an unlikely example of preventive health but River Mole River Watch is the very definition of tackling problems upstream.

Volunteers in the group's citizen-science project have been monitoring water quality for more than a year, and gathered evidence of how sewage seeping from a Horley treatment plant was contaminating the river, footpaths and a housing estate.

Not only have the group won national media coverage about a very real threat to their physical and mental health, they've also gained a sense of purpose, camaraderie, exercise and closer ties with nature. All these things help create health, says Dr Orrow, who has been involved with the project from its outset.

Research shows that lifestyle, income, education, employment, social relationships, and the built and natural environment together have far greater bearing on health outcomes than healthcare.

'Every part of this ecosystem contributes to and benefits from the health of the whole,' says Dr Orrow. 'So the underpinning vision behind GHT is about co-creating conditions in a community where everybody can be encouraged and enabled to contribute to the communal health and wellbeing of the local area.'

GPs often lend their support to kickstart and establish a project, and GHT might provide mentoring, physical space, connections or seed funding – £100 for a water-quality tester in the case of River Mole River Watch. But the initiative and drive lie with the community.

> '[It's] about co-creating conditions in a community where everybody can be encouraged to contribute to the wellbeing of the local area'

Of the many ideas which have sprung out of GHT, those that work best are conceived and led by people at the heart of the community who understand local need, whether that is a space to chat or a plot to grow vegetables.

One initiative Dr Orrow has been closely involved with is an African diaspora community group. Through cultural events and food, members now have a strong sense of belonging – and access to areas previously considered 'white spaces', whether parks, food banks or health settings.

'Community members, particularly those who've been underserved by statutory services in the past, know much better than we do what the gaps are,' she says. 'Creating health is all about shifting power.'

It's about shifting responsibility too. Before 2019, when the first expression of GHT was born, Dr Orrow had been growing increasingly exasperated at the burden of easily preventable disease she was seeing in the GP surgery. An academic clinical fellowship based at Cambridge's Institute of Public Health, and previous work with NICE (National Institute for Health and Care Excellence) on issues such as preventing dementia and frailty, fed into this frustration.

'When I talked to patients about lifestyle approaches to improve health and wellbeing, they'd constantly explain what the barriers were: "I can't afford the gym. I don't know anyone." I was hearing these barriers again and again.' But Dr Orrow didn't blame her patients but rather 'structural barriers'. Health professionals too have encouraged the public's over-dependence on them, however unwittingly, she believes; it's now vital doctors make the case, provide the evidence, that 'health starts at home'.

Removing barriers

Five miles away in Redhill, a group of older women from the South Asian community can be seen walking laps of the Memorial Park – before heading into a local

BEAT OF THE DRUM: The African Community in Surrey and Sussex group holds a music workshop

café for a cuppa. Their hijabs and cultural values make ordinary gym membership inaccessible to them: this is their club.

Among the regulars is Uzma Aziz, a local GP for whom this walking group is the answer to the same kind of frustrations Dr Orrow had been feeling.

Over the years, she had noticed that many patients from her own South Asian community were presenting with pre-diabetes, hypertension and mild obesity in their early 40s.

'Ten minutes in the consultation wasn't enough time to address all this, especially when people have very fixed cultural beliefs in the way they live,' says Dr Aziz. 'It takes a complete change in lifestyle. I thought maybe we could attract them somewhere they wanted to socialise and take that opportunity to address some of these areas.'

'When you connect with people at the same level, they're more likely to tell you the challenges they're facing'

The walking group, which Dr Aziz set up with a community development worker, soon led to a 'legs, bums and tums' class and swimming lessons for some of the younger women. There is talk of adult tricycles in the Memorial Park next.

Through links with other local partners and not-for-profits, these groups have blossomed into the AWWH (Asian Women Wellness Hub). As well as exercise, AWWH has offered screening and health checks, healthy-eating workshops, information sessions about palliative care, even art and craft activities. There are now more than 100 women on its WhatsApp group.

GHT has been funded by NHS Surrey Heartlands since 2020. None of the initiatives it's involved with has required large injections of money: it cost £20 to set up the walking group for about 10 women but already some are now socialising and exercising outside it too.

Dr Aziz gives a fair bit of her own time to AWWH: she's only funded for four hours a week with GHT. But she enjoys the women's company and is gaining their trust.

'When you connect with people at the same level, they're more likely to tell you the challenges they're facing, without thinking you're going to be judgmental. It's not about hierarchy: you're removing barriers.'

'Nature-based solutions'

One of the reasons the AWWH walking group is so successful, Dr Aziz suspects, is that it reconnects the women with nature.

'These are mostly working-class women who came to the UK in the '60s and '70s,' she says. 'They used to live in villages, they would grow their own food. Here, they've been living in council flats and small accommodation, with too many people under one roof. Nature brings back memories for them.'

Many of the GHT initiatives, in fact, are about taking people back into nature. Central to its vision is the belief that human health is indivisible from nature's. Dr Orrow is fascinated by the parallels between biodiversity loss in nature and similar erosions in biodiversity of the human microbiome in industrialised nations, for example.

Perhaps not surprisingly, the seven GPs who have protected time for GHT work now think twice about prescribing medication as a first resort.

Merstham and Redhill GP Ivan Anderson stresses that, for many, medicine is vital and life-changing but he is passionate about exploring whether, for some, 'nature-based solutions' could be a better option.

From helping with sense-making to sleep patterns, mindfulness to microbiome boosts, nature is a 'huge untapped resource for health', he says.

More than a year ago, before he joined GHT, Dr Anderson and the patient champions at his Redhill practice set up a walking group which meets at the surgery every Wednesday morning, whatever the weather. It's been a roaring success.

KEEPING FIT: Members of the AWWH participate in a legs, bums and tums class

'Maybe having a healthcare professional involved and starting at the surgery gives it credibility,' says Dr Anderson, 'but some patients turn up every single week. Some come for the exercise but some have found friendship through the walks.

'You could go to a gym and walk on a treadmill but the important bit is that connection with nature and others. I've always found nature very healing: it helps me regulate myself.'

Among other initiatives, Dr Anderson has helped plant a community orchard and is now piloting nature-based wellbeing sessions for surgery staff.

He is also now applying some of the lessons learnt from GHT in his clinics, recently starting 90-minute group consultations for patients with high blood pressure.

'I enjoy all of my job but the nature-based and health-creation work has kept the passion for general practice going,' he says. 'It sometimes feels like you're making a bigger difference when you're involved with communities. There's power in groups.'

> 'The nature-based and health-creation work has kept the passion for general practice going'

Optimism

GHT is part of a wider push towards integrated primary care in East Surrey in response to the Fuller Stocktake report. A key commitment for East Surrey Alliance is listening to local citizens' needs and reflecting these in decision-making about how health services develop.

To this end, GHT has already catalysed 'health and wellbeing networks' bringing together staff from GP practices, community partners and patients. The local GP Federation and primary care networks have been core to GHT's success. It is showing other promising signs, too.

Feedback from the South Asian women of Redhill includes moving testimonies such as: 'I felt alive after a long winter hibernation.' A woman who took a neighbour to an exercise class for older people in Smallfield said: 'She hadn't been out of the house for years and was lonely and down... Now she comes every week and has even joined the craft group too.'

In a sample of 13 members of that same exercise class, 61.5 per cent have sought fewer GP appointments since 2023, which equates to a 22 per cent reduction or 36 appointments overall.

Participants' blood pressure, weight, BMI and blood glucose levels also declined.

The GPs involved in GHT are under no illusion: this is no quick fix, says Dr Aziz.

'This is not an antibiotic which will show a result in 48 hours. If you have educated a younger mother on how to feed her kids, you're not going to see the result in a month, even years, but you are going to see a healthy adult with good eating habits. You're planting seeds.'

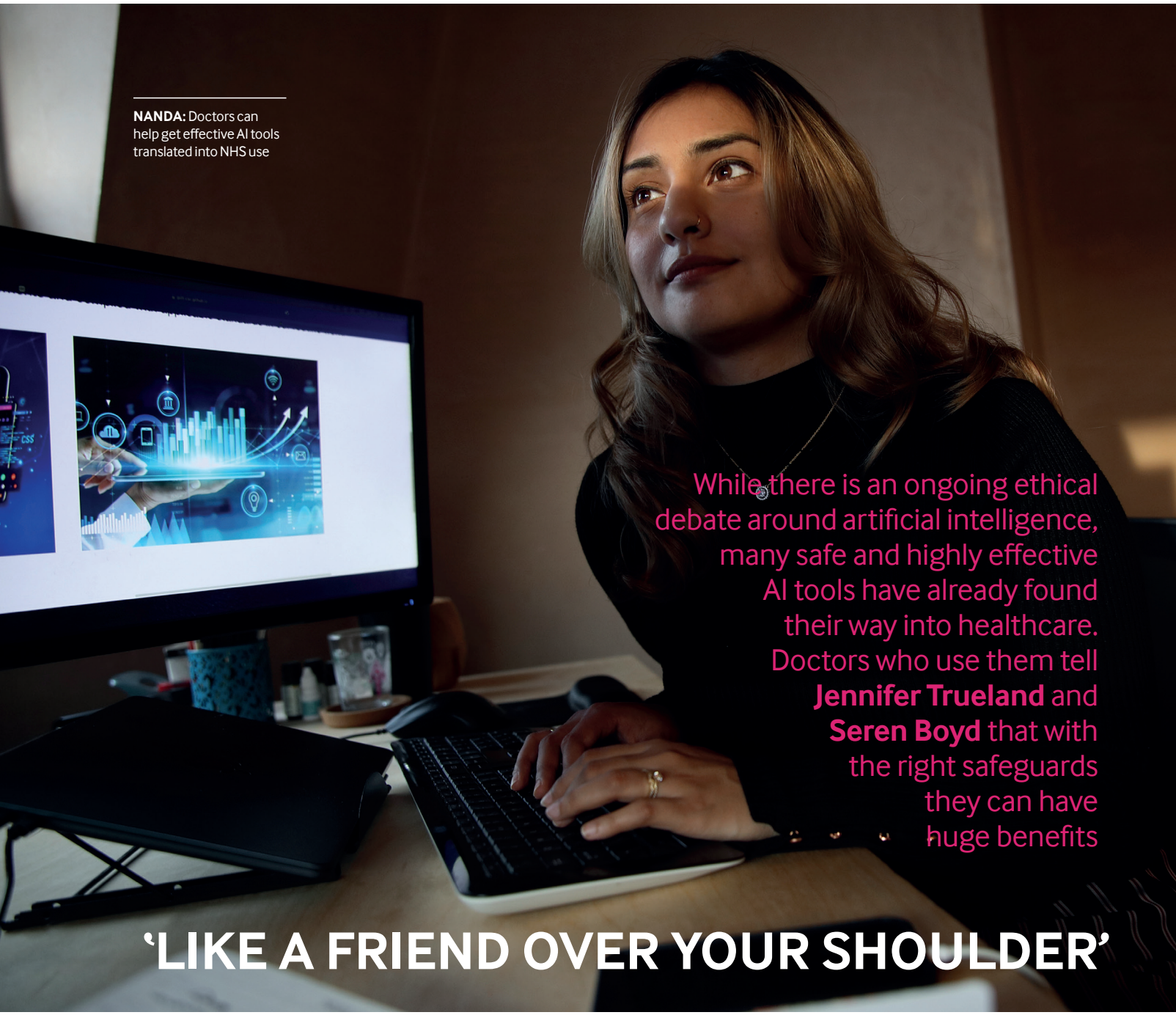
It is, however, making doctors feel more optimistic about their work. For Dr Anderson, his GHT time is the 'highlight of the week' because he sees patients being empowered to take control of their health.

Dr Aziz feels the same. She has been able to refer an older, recently widowed patient to the Smallfield exercise class; it reminded her how helpless she had felt previously at not having anything practical to offer a woman in a very similar position.

'With all the constraints and challenges of the NHS, we need to do things differently,' she says.

Dr Orrow is aware that rethinking primary care may be daunting for many GPs and seems 'a million miles away' from their current reality. But she insists 'primary care has a really exciting role to play' in health creation.

'My advice is to focus on relationships and talk to colleagues about the art of the possible. Start small, and go where the energy is.' ■



NANDA: Doctors can help get effective AI tools translated into NHS use

While there is an ongoing ethical debate around artificial intelligence, many safe and highly effective AI tools have already found their way into healthcare. Doctors who use them tell **Jennifer Trueland** and **Seren Boyd** that with the right safeguards they can have huge benefits

'LIKE A FRIEND OVER YOUR SHOULDER'

Akriti Nanda is no data scientist or wonk – but then she doesn't need to be.

As a clinical fellow in AI (artificial intelligence), she is using her specific expertise as a doctor to ensure cutting-edge technologies are safe, fit for purpose, and – importantly – make it from the lab to the patient.

She is one of a growing band of doctors who are enthusiastic about the benefits AI can bring – and who believe it is vital doctors are at the table at every stage, from design to implementation to deployment.

'The use of [AI] in healthcare is evolving and I'm very optimistic of the future'

'We don't need people making more algorithms,' she says. 'But there almost seems to be this bottleneck between the research and getting it actually implemented in the NHS. I'm never going to be a data scientist who is writing the code, but [as doctors] we can use our expertise to be that bridge and help things get into the NHS.'

There is – rightly – a lot of debate about AI and its implications for good and potential for evil. Even some of the pioneers in the field have been clear in warning that it could lead to various disastrous scenarios from development of chemical weapons to destabilisation of society.


SARAH TURTON

There is little doubt safeguards are required – as the BMA set out clearly in a report on AI published last month (see *Key principles*, p18). But in the meantime, almost under the radar, AI tools and solutions are making their way into healthcare, and some of them are already making a huge, positive difference.

Not surprisingly, radiology is at the forefront. Gerald Lip, a consultant radiologist and clinical director of the North East Scotland Breast Screening Programme, gives tangible examples. A case in point is a recently completed evaluation of the breast-screening programme in Scotland, where an AI tool was used as a 'safety net' to look at scans.

'The AI was able to pick up an additional 10 per cent of cancers in this screening population,' he says. 'That's a real-life example where it made a difference.'

Early intervention

Another involves using an AI tool to spot lung nodules on chest X-rays. 'You can pick them up sooner and smaller, before they have a chance to spread, and as a result they're caught at an earlier, more treatable stage,' he says. 'There's a benefit to patients, there's less chemotherapy, they've got a higher survival rate as well.'

As a doctor, he really appreciates the assistance of this technology, especially in a busy work environment. 'It's like having a friend over your shoulder pointing at one or two things and saying, "Would you like to have another look at that?"'

Dr Lip, who also chairs the AI committee of the British Institute of Radiology, says there are risks, such as automation bias, where people trust the AI too much, or bias in the AI tool itself, for example discriminating based on ethnicity or gender. 'We need to maintain a belief in our own medical skills,' he stresses. 'Having understanding of AI means educating yourself about how AI works to ensure you don't have bias.'

And while AI is very helpful in administrative tasks such as transcribing patient notes or writing reports, doctors should remember their names are at the bottom, he adds. 'We have a duty as reporters or physicians to ensure that what is written is the true word.'

AI is here to stay, says Dr Lip. 'We're already using it in our phones, in our chatbots, in our cars – but the use of it in healthcare is evolving and I'm very optimistic of the future.'

Ms Nanda, a specialty trainee 4 in general surgery in south London, was first drawn to learning more about AI around the time ChatGPT started to gain traction. 'I think it was the first time that the general public had really been exposed to the power of AI and how easily accessible it is – you can have it on your phone or your laptop; you don't need some supercomputer in the hospital to use this powerful technology.'

Her clinical fellowship in artificial intelligence is a year-long programme hosted by Guy's and St Thomas' NHS Foundation Trust, which is open to clinicians across the NHS. The fellows – mostly doctors – work on a project involving real-life application of AI in healthcare, as well as learning about the topic more broadly.

'The fellowship is really good because it upskills you – it doesn't require you to have a master's in artificial intelligence or a PhD, just a real interest in it.'

She is working on a project that uses AI to improve radiotherapy planning – potentially saving hours of clinician time. Rather than an oncologist looking at the hundreds of 'slices' or pictures which make up a CT scan, and manually drawing round a tumour, plus surrounding organs that need to be protected, the technology does it for them. 'It's a very long and laborious process [for the oncologist] but the software we're implementing does it automatically, based on lots of CT scans that it's been trained on, so the oncologist just has to sit and edit them.'

> 'We need to maintain a belief in our own medical skills'

Saving time

There are still many sets of human eyes on it, she adds. 'It's got lots of humans in the loop – but the feedback we're getting is that it's saving almost an hour and a half per scan.'

She believes it's important for doctors from all specialties to have an understanding of AI – and crucially, to know the

LIP: Doctors retain clinical responsibility

CHADA : Educate doctors and patients in AI

> 'Doctors need to be front and centre of discussions – along with patients'

right questions to ask. 'We're about to be hit by hundreds of companies knocking on the NHS's door and they're going to say, "Hey, we've got AI, we can solve this problem for you." We need people in the NHS to understand what they're doing, to be more cautious but also to get the best out of the technologies that there are.'

Bharadwaj Chada is also undertaking the fellowship in clinical AI programme. A GP trainee in London, he has already seen first-hand the effects AI can have on the day-to-day workings of general practice.

He and his colleagues were perhaps most excited about ambient note-taking (see *Super scribe*, facing page) for automatic transcription. But an AI-enabled stethoscope which can diagnose heart abnormalities and disease in 15 seconds impressed him, too.

What he really liked about the tool, however, was that it also helped with workflow in terms of what to do if a patient is incidentally found to have heart failure, for example. 'It tells you who to refer to and what medications to start. Often, when AI is rolled out, it's done in isolation without really an understanding of how it affects people's workflows and what it means for service redesign. But this was packaged as something you can actually use, and tells you what you should be doing about whatever the AI solution might be throwing up.'

As part of the fellowship, he is working on a project with South London and Maudsley NHS Foundation Trust to use predictive modelling to identify adults at high risk of needing mental healthcare based on their first presentation to mental health services. The idea is that the modelling will suggest who would benefit most from intervention such as timely visits in the community and ensuring they are on the right drug therapy.

Doctor involvement

Dr Chada believes clinicians and patients should be educated in AI, in part so they can ensure the solutions deployed in the NHS are ones which are needed. 'With some tech solutions, they're hammers in search of a nail,' he says. 'Having doctors who are conversant with the use of these technologies and who know the questions to ask, and who know the context in which it's being used is important, as is knowing how things were done before, what data is needed, the ethics and governance, and the explainability of AI change management – so if you're introducing an AI solution, what else needs to happen?'

There is an enthusiasm and appetite for AI, especially among his younger colleagues, he says. 'Doctors need to be front and centre of discussions – along with patients. There's no question the tech is great, but it's the implementation we need to get right. We need to think about the impact on training, on staff, integrating into workflows, the unanticipated consequences of change. All these things can necessarily only be figured out if doctors are involved throughout the life cycle of the design and deployment of AI.' ■

Key principles

The BMA is behind AI adoption as long as it meets set criteria

In October, the BMA published *Principles for artificial intelligence (AI) and its applications in healthcare*. It says the BMA supports the adoption of new technologies that are safe, effective, ethical and equitable; and that support doctors to deliver the best possible care, improve care quality, and improve job quality.

- AI must be robustly assessed for safety and efficiency in clinical settings
- Governance and regulation to protect patient safety are vital
- Staff and patient involvement throughout the development and implementation process is necessary
- Staff must be trained on new technologies (initially and continuously) and they must be integrated into workflows
- Successful AI requires a robust and functioning NHS to be effective
- Existing IT infrastructure and data must be improved
- Legal liability must be clarified.

Super scribe

AI has the ability to cut through admin tasks, allowing doctors to give more time and attention to patients

Surrey GP Dave Triska (pictured right) is an enthusiastic early adopter of AI technologies. He's also now a consultant to AI manufacturer TORTUS and to NHS England on AI in healthcare.

He uses AI tools daily, for text generation for administrative tasks such as writing practice policies, and for 'ambient transcription' (note-taking) during patient consultations.

The time and cost savings of using AI to do the heavy lifting of administrative functions are obvious. He helped another practice save £1,800 a year, by teaching them how to use AI to review their policies rather than pay a consultant.

Importantly for Dr Triska, a form of 'medical AI scribe' such as TORTUS frees him up to concentrate fully on the patient, rather than having to take notes and write up a summary. He allows time to check AI transcriptions for accuracy but now regularly finishes a session 10 to 15 minutes early.

'If you're taking notes yourself, you are using two different bits of your brain: the memory bit is working really hard to structure and organise [information], while your creative thinking and processing bit is trying to come up with novel solutions,' he says.

'Now my energies are totally focused on problem-solving, finding creative solutions for the patient.'

Patients are much less worried about AI than healthcare professionals often are, he finds. He's done more than 4,900 consultations using TORTUS and only one patient asked him not to use it.

In the short term, he is adamant that adopting some of AI's applications could help the NHS out of its administrative quagmire, while insisting that the types of AI used need regulating.

'Let's not all go chasing AI unicorns: we need to be looking at the lower-hanging fruit. The functional admin side of things is the easiest thing where we can have a dramatic impact on care delivery almost overnight.'

He wants to see more doctors involved in advising not only manufacturers, but also central bodies such as NHS England. 'You need to have clinicians on board who are actually using products day in day out, and have an understanding of what they need,' he says. 'Otherwise, we end up with the delivery of stuff that's completely hopeless.'

EMMA BROWN

'Now my energies are totally focused on problem-solving, finding creative solutions for the patient'

Fellow champions

Doctors can join a programme to speed up their understanding of AI

The NHS Clinical Fellowship in AI is a 12-month programme integrated part-time alongside clinical work. Applications for the fourth cohort are expected to open this month, with the programme running from August 2025 to August 2026.

Programme manager at Guy's and St Thomas' in London Beatrix Fletcher says it's expanding year on year from 11 in the first year to a likely 35 for cohort 4. Most of the fellows in the first three cohorts are doctors but applications are also invited from other clinicians. It's important, she says, that all members of the multidisciplinary team have some understanding of AI technologies.

'It's absolutely essential the people who act as the decision-makers about what is used in patient care should include all stakeholders, including patients,' she says. 'But doctors are really well-placed to understand their patients. They're the ones that interact with them more than someone from an IT team from an organisation or a company that's developing a product. Doctors understand their patient population intimately – for example, what is acceptable risk, what's not acceptable, and how to quantify the harm of a potential product.'

Doctors also understand their workflow, know how other workforce groups are impacted by their decisions, and have a good awareness of local governing politics and policies. 'Without that perspective, there's a danger that products are brought in that don't focus on patient benefit and might create a system that's more burdensome.'

Visit **http://bit.ly/4fG2zRU**

A refugee Jewish doctor who escaped Nazi Germany to flourish in a working-class northern town is celebrated in a new book. **Phil Clark** reports

A HARD ROAD

It is difficult to envisage a harder route into the profession than the journey taken by Elena Zadik, the subject of memoir-cum-biography *Elena: A Hand Made Life*.

Born in Kharkiv, Ukraine, in 1919 she was a refugee twice as a child – the second time when moving to England in 1936. She left her parents who were forced to remain in Nazi Germany to pay off family debts to fulfil her dream of training to become a doctor. The odds were firmly stacked against her as she arrived in a freezing and far-from-welcoming London. As the book puts it: 'Who would want a female doctor? Without a British education? Or a proper address?'

This was just one of many hurdles and crises the indomitable and bloody-minded Dr Zadik took on during an 'ordinary extraordinary life', which is presented in words, pictures and mixed media by her granddaughter Miriam Gold, an artist and teacher from London. Ms Gold's book is already garnering rave reviews, with *The Guardian* describing it as having 'unfathomable power and richness'.

> 'Who would want a female doctor? Without a British education?'

The book begins towards the end of Dr Zadik's 40-year career doing her afternoon rounds as a single-handed GP in the former mill town of Leigh, Lancashire, driving (badly – she proudly boasted to her granddaughter of never having had any driving lessons) her red, second-hand Mini with her granddaughter on the back seat. It vividly captures a time when GPs were close and lifelong companions with their patients. As Ms Gold puts it: 'My GP, through no fault of her own, I don't know her, she is a voice on the other end of the phone … whereas Granny couldn't get round a shopping trip without five people stopping her.'

Personal trauma

She was a local celebrity in Leigh. 'She looked a bit different and sounded a bit different. Leigh was a very cotton-and-coal town. And here was this Russian Jewish woman,' says Ms Gold. And to prove the point, Ms Gold has been contacted by families of ex-patients since the book was published in August. One son and grandson recounted the care Dr Zadik offered to two generations of his family as well as an instance where she lobbied the council to provide proper housing for his mother. 'She was a legend, a much-loved and respected pillar of the community,' he told Ms Gold.

The book is also the story of Dr Zadik's husband Frank (born Franz) – a German Jew and fellow refugee whom she met at medical school in Sheffield. The book describes the two as sharing 'a language for things that were unspeakable' given their personal backgrounds and romance blossomed while they regularly hiked in the Peak District. Frank went on to a distinguished career himself as an orthopaedic surgeon – he had a


MIRIAM GOLD

ZADIK: Led an extraordinary life

procedure for ingrowing toenails named after him called the Zadik procedure.

The couple endured unimaginable personal trauma early in their relationship – Frank was dubbed by British authorities an 'enemy alien' and sent to an internment camp in Canada for a year in 1940.

Bereft of Frank, Dr Zadik had also lost touch with her parents during the war before discovering their fate – sent to their deaths in Auschwitz from Vichy France – years later via her cousin who travelled to England to tell Dr Zadik the dreadful news in person.

> 'She couldn't get round a shopping trip without five people stopping her'

And professionally Dr Zadik was battling – working in the pre-NHS system with many poor and destitute patients not being able to afford her treatment, her husband then working abroad as a doctor in the army and all this while becoming a mother

There was no maternity leave, no family to offer support. 'She was lonely, depressed and overwhelmed,' Ms Gold writes and the language for much else of what she endured – 'the glass ceiling, institutional sexism and systemic racism' – had not been invented yet.

'Beacon of hope'

It is no surprise the advent of the NHS in 1948 came as a particular beacon of hope for Dr Zadik – it was 'the best day of her life', Ms Gold writes. Her euphoria at that moment even trumped the births of her four children as the health service was 'a joy for everyone'.

Dr Zadik retained this love until her death in 2006, having retired at 70. But just as during her working life she remained a ball of activity and energy even after hanging up her stethoscope – using her hands to knit, work with ceramics to churn out brown pots and take and develop her own photos.

What would she make of the NHS as it is now and the struggles in general practice in particular? 'It would upset her greatly to see the low morale,' Ms Gold says. 'She would hate to see how care is compromised by targets and workloads.'

Ms Gold also wonders how her grandmother's no-nonsense approach with patients would have been received today. 'Actually, probably really well I imagine as she was refreshingly blunt. She called a spade a bloody shovel as they say in Leigh …' ■

The author can be found on Instagram at ***@miriamgold***

Your BMA

As *The Doctor* goes fully digital, I would like to celebrate some of its achievements so far

The first issue of this magazine landed on members' doorsteps in September, 2018. It included in-depth features looking at the effects of Brexit on health and the medical profession, bullying in our workplaces and a series called *They come here*, which shone a light on the 'incalculable benefits' immigrant doctors bring to the NHS and society.

Ever since that first edition – you are now reading the 73rd – *The Doctor* has sought to buck the often-overwhelming trends of clickbait and shallowness in the media and investigate the issues which matter most to our profession in great detail, placing doctors at the very heart of that storytelling and the debate. As your current chair of the BMA representative body this has meant an awful lot to me and I know it has been important to so many of you too because you've reached out me.

The magazine has been a phenomenal success by any measure. Its writers have won numerous national awards – often competing with national news titles and organisations with huge budgets and staff rosters. Just last year two of our writers, Ben Ireland and Peter Blackburn, won a British Journalism Award and Mr Blackburn has been shortlisted again this year. Seren Boyd won and Jennifer Trueland was shortlisted for the MJAs (Medical Journalism Awards) – and these accolades are not unusual. The work of our team has been a powerful tool in advocating for medical students and doctors and increasing the external influence of the BMA, too, with our investigations featured across the wider media and having significant influence across the health landscape, and even in Parliament.

Next month's issue of the magazine, the 74th, will be the final publication in this iteration as we move to our new online home at **thedoctor.bma.org.uk**. While it will be sad to see the print edition of the magazine cease, I am tremendously proud of everything the team has achieved in that medium and I know they will go on telling the stories of our members and profession – and investigating the issues which affect our lives – with the same commitment and dedication.

For my last two *Your BMA* columns in this issue of *The Doctor* and the next I would like to celebrate some of the brilliant work the team has done amplifying our voices – so I will be reflecting on some of my favourite pieces and investigations.

I have often been most proud of the magazine for offering an outlet where medical students and doctors can speak about the most difficult of issues – often

thedoctor

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these are things we find it incredibly hard to talk about across society or where it doesn't always feel there is another safe space, and this magazine has been that place.

One that particularly springs to mind was in the piece 'For Alastair's sake', which was recognised at the MJAs last year. It told the story of GP Ruth Watt's dogged attempts to find answers over the death of her husband, Alastair Watt, a diabetes and endocrinology consultant in north Devon who took his own life.

He was struggling to cope as a single-handed consultant even before he suffered a traumatic brain injury in a cycling accident but, on his return to work, work-related stress became intolerable and, Ruth insists, was never addressed. It was important to give a voice to Ruth who said: 'We have to start talking openly about what happens when things go wrong, so lessons can be learnt.'

Another memorable piece was 'Fallen friend' where the colleagues of GP Louise Tebboth who died by suicide spoke movingly about having to carry on working as normal despite their intense grief over her death – and about coming to terms with their loss.

Other examples of *The Doctor* being this safe space for members and grassroots doctors were in recent work about sexism in surgery, the pieces lobbying for better support for doctors under NHS and GMC investigation – not least following the tragic death of consultant anaesthetist Sridharan Suresh – and in our work reflecting on the lives of the doctors who died fighting COVID-19.

In the next issue of the magazine, I will be looking back at more of the magazine's investigations and campaigns – among other work – to date.

As ever, I am always happy to hear from you and any questions you might have. To get in touch please write to me at **RBChair@bma.org.uk** or **@DrLatifaPatel**

Dr Latifa Patel is chair of the BMA representative body

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