comment

"I loved in-person conferences. I miss them. I worry they'll never return" **DAVID OLIVER**
"Being a GP is not easy, but it is fascinating and deeply satisfying" **HELEN SALISBURY**
PLUS The despair of clinically extremely vulnerable people; fears of UK food aid charities

CRITICAL THINKING Matt Morgan

No news, for patients, is bad news

Our dog, Chester, recently had to be taken to the vet. We were worried he was seriously ill, and we waited anxiously at home for the results of his blood tests. Days turned into a week before we called the practice to check whether the results were back. "Oh, don't worry—no news is good news," we were told by a cheery receptionist.

I have said this to patients and their families many times. But being on the receiving end made me reflect on how no news in healthcare is not good news at all. Instead, it means continuous uncertainty and worry, tinged with the inability to move on, with no defined endpoint. No news means waiting for the phone to ring, or for that letter to drop through the door.

Over the years we have got much better at breaking bad news—but no better at breaking no news. "No news" also engineers inefficiency into systems, such as follow-up phone calls from patients who are "just checking" and repeat appointments with no data.

This is especially true of the 20% of new consultations in primary care that are classed as medically unexplained symptoms. This is also the conclusion reached at more than half of new secondary care referrals and for a quarter of all frequent attenders at medical clinics. No news, therefore, is not just a matter of timing: it can also be the final conclusion.

Although it is tempting to deal only with the root cause of delays, a gap between expectation and reality will always remain. A better option would be to provide some certainty to structure the uncertainty. An open system of tracking what stage tests have reached, much like a parcel tracker, could reassure patients that things are on course.

The same applies to the growing surgical waiting lists. Knowing you are 10th in line on the phone to a call centre is painful, but it's better than just having to listen to bad music. It allows you to make choices based on some data rather than on nothing at all. Opening up waiting lists to individual patients to help them track their progress may help. And telling patients, "Don't worry, it's not cancer," is fine—but making a subtle change and saying, "You have medically unexplained symptoms," is at least a positive affirmation rather than a denial.

I know I would benefit from more teaching, training, and research in dealing with "no news" as well as just bad news. Because no news is bad news for many patients.

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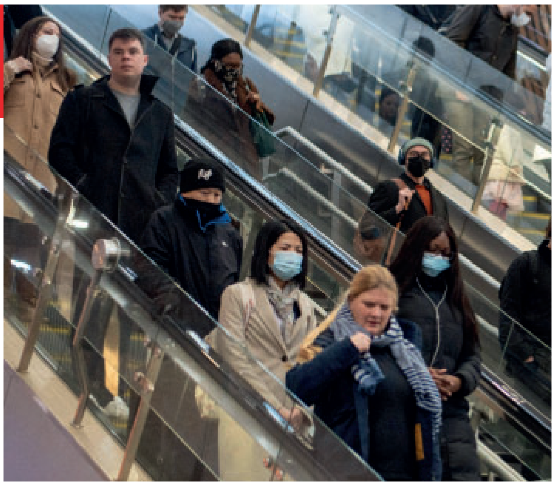
> A better option would be to provide some certainty to structure the uncertainty



OPINION Ceinwen Giles

For me and 1.5 million others who are extremely vulnerable, life has not returned to normal

Lifting all covid restrictions creates a growing sense of despair

I spent last week hoping I had covid. What started off as a scratchy throat developed into a stuffy nose, slight cough, and a general feeling of being unwell. "Could this be it?" I wondered to myself as I did multiple lateral flow tests.

Odd though it may be, my thinking was that although I was ill, I wasn't *that* ill. If this was covid, maybe I'd be okay. Of all the stresses over the past two years, the uncertainty about what covid may or may not do to me is one of the hardest to live with (note: it wasn't covid).

I have an immune deficiency which means I don't effectively create the B cells which play an integral role in fighting off infection. It also means I don't produce as good a response to vaccines as the average person. This means that despite having four covid vaccinations, since March 2020 I've lived a weird kind of half life, where I remain vulnerable to a virus that others are increasingly forgetting about.

At first, I shielded religiously. I saw no one but my husband and daughter, and I didn't dare go inside anywhere other than my home. The government sent me—and 1.5 million people like me—terrifying letters and texts warning us that we were at extreme risk. But they also put into place useful programmes, such as the delivery of food and medicines, and enabled shielders to claim statutory sick pay if they were unable to go to their place of work.

We all knew that this couldn't go on forever—and who would want it to? But, since the start of the "great reopening" in the middle of 2021, it seems the government has forgotten about the 1.5 million it was so eager to protect in early 2020. The shielding programme was paused in April 2021, then dropped a few months later. The Department of Health said I should follow the same advice as the rest of the population, but with additional precautions such as avoiding "enclosed crowded spaces." And this week Boris Johnson told us the pandemic is essentially over—all restrictions are to end, including the need to self-isolate.

No normal any time soon

For the vulnerable, the pandemic isn't over. Life hasn't returned to normal, and what has been a difficult two years appears to stretch ever further into the future with no real prospect of "normal" life any time soon. The government's message that "vaccinations are the best way to protect yourself" is hollow advice for people like us.

Somewhere between lockdown and freedom is a space where we could support those who are being shut out

Clinically vulnerable people now have no legal right to work from home, or to request different roles if they are at increased risk, or to claim statutory sick pay. Those of us with school age children face a daily game of covid roulette. Anti-vaccine rhetoric has reached fever pitch.

The sense of despair I feel as I am slowly left behind is crushing. *What is the point?* I wonder late at night as government advice means using public transport less, avoiding visits to offices and work events, and being unable to spontaneously participate in the taken-for-granted everyday pleasures of shopping or going to the cinema or a restaurant.

I know I am not alone in my despair. Many friends and colleagues who live with cancer or other conditions have contacted me over the past year, asking how I keep my spirits up. The answer is that I haven't. Other than virtual hugs and supportive words between us, we face being left out of the best parts of life by a government and some parts of society who think we all just need to "get on with it."

OPINION Sabine Goodwin

Food aid charities fear the worst as the cost of living crisis takes hold

At a recent meeting of the Independent Food Aid Network, it was clear things were getting worse, much worse. The perfect storm that emerged last October is rapidly turning into a flood of need.

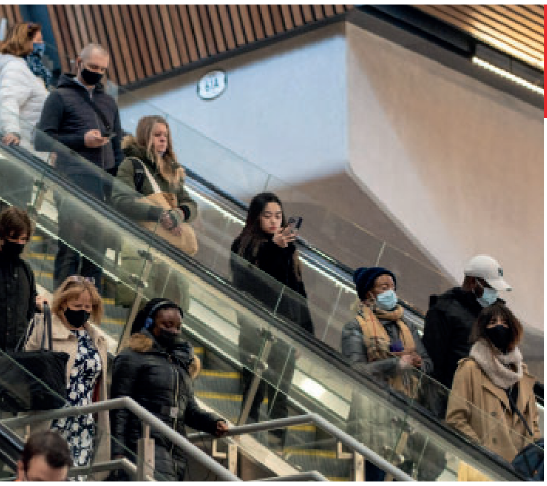
On top of the end to the £20 universal credit uplift, people on low incomes are now struggling with soaring bills and food prices, with a massive increase in energy prices and rise in national insurance contributions just around the corner. These drivers of poverty inevitably mean yet more people are needing, and will need, food banks to survive.

Food bank teams don't have the resources to cope with the wave of need on the horizon—donations have fallen as have volunteer numbers. Some members report cases of people who used to donate now needing support. Volunteers cannot be expected to cope with the scale of distress they witness.

Food banks are not equipped to deal with the wave of need on the horizon

Kate Brewster of the One Can Trust in Buckinghamshire says: "Numbers at our food bank are increasing at the highest rate we've known. Current levels are around double those six months ago. In the past couple of weeks, we've helped more than 700 people and around half of those are children. We dread to think what's around the corner." And Lianne Simpson of Diamond Hampers in Huntingdonshire says: "I have seen rising concern over the battle to heat the home or put food on the table. I am seeing people so upset because, even if provided with food, they have no way to cook it."

It's also striking to learn of the number of people in work who now need to access food aid. Charlotte White of Earlsfield Foodbank



It doesn't need to be like this. Somewhere between "lockdown" and "freedom" is a space where we could support those who have so much to contribute, but are being shut out. The government could appoint someone with responsibility for the vulnerable and immunocompromised, ensuring all policies have an equality impact assessment so they are not disadvantaged. It could ensure free testing continues, that those with covid isolate, and that access to antiviral therapies is made much more accessible. It could ensure masks continue to be worn on public transport and in shops. None of these precautions would hamper the public's "freedom," but would make life more manageable, and less stressful, for those most at risk.

When I think back to the early days of the pandemic, as friends and colleagues fell seriously ill and died, and as we clapped for the NHS, I was grateful for the scientists, doctors, key workers, vaccines, and research. We felt like a nation united. Now, two years later, after all the pain and sacrifice, it seems to me maybe we are not all in this together after all.

Ceinwen Giles, co-CEO, Shine Cancer Support

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in Wandsworth explains: "Recently we had a session where 50% of our guests had work of some kind."

What we are learning through food banks is only the tip of the iceberg. Recent data from the Food Standards Agency show that 4% of people in England, Wales, and Northern Ireland used a food bank in the 12 months to June 2021, but 15% of people went hungry or cut their food intake because of lack of income.

The measures announced by the chancellor barely scratch the surface of the financial crises faced by low income households. The government must do a great deal more to ensure that people's incomes, whether through social security payments or wages, match the rising cost of living.

Sabine Goodwin, coordinator, Independent Food Aid Network

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ACUTE PERSPECTIVE David Oliver

Has covid killed the medical conference?

Healthcare conferences in real life venues, with presenters and delegates physically present, have been cancelled or moved online since the pandemic started. I loved these events. I miss them. And I worry that they'll never return.

The opportunity to interact, socialise with, and learn from peers or meet professional leaders and experts throughout an event is immersive and enriching. Being just one of hundreds of people watching an online talk or panel discussion on a screen, with a couple of online questions thrown in, is very different from being in the hall with those speakers and colleagues. Likewise, wandering among conference posters, discussing them with their authors or others, is much better than reading online abstracts.

The skills and confidence gained—especially early in a career—by speaking to a live audience and gauging the reaction in real time, or by explaining and defending your poster, are different from those required online. Some readers might say, "So what? If the future is virtual, it's the virtual skills we now need." But when a whole peer community of practitioners make their way to a particular town and venue for a festival of learning it provides a concrete break from work or home obligations, and a high quality conference can send us back to our workplace enthused.

The move to virtual events is understandable. The institutions organising conferences have to assess the risk of financial losses. The uncertainty of the pandemic makes it hard to insure against cancellation. Without enough attendees, conferences become financially unviable. And covid-19 aside, people are increasingly conscious of environmental sustainability and reducing unnecessary travel, which could make conferences unfashionable and anachronistic. Domestic conferences accessible by public transport aren't necessarily bad for environmental sustainability, but ones involving mass air travel are increasingly hard to justify.

Study leave budgets have also been cut. Online events are cheaper for delegates. Commercial sponsors might prefer delegates in the hall, but healthcare workers are conscious of work-life balance. I know several UK medical organisations that have seen far higher numbers attending their educational events and research updates than they ever had in conference venues. And if meetings become "hybrid," falls in onsite delegate numbers can make venues unaffordable.

It may well take another year before organisers have the confidence to put on major events in live venues again. By that stage—after three years—will we be so used to online learning there'll be no going back, not least with a generational shift in attitudes?

I've gained a huge amount in terms of learning, experience, and professional networks from conferences throughout my career. They've often been among the highlights of my year. Increasingly, I wonder if what I feel now is nostalgia, rather than anticipation. I'd love to know what the rest of you think.

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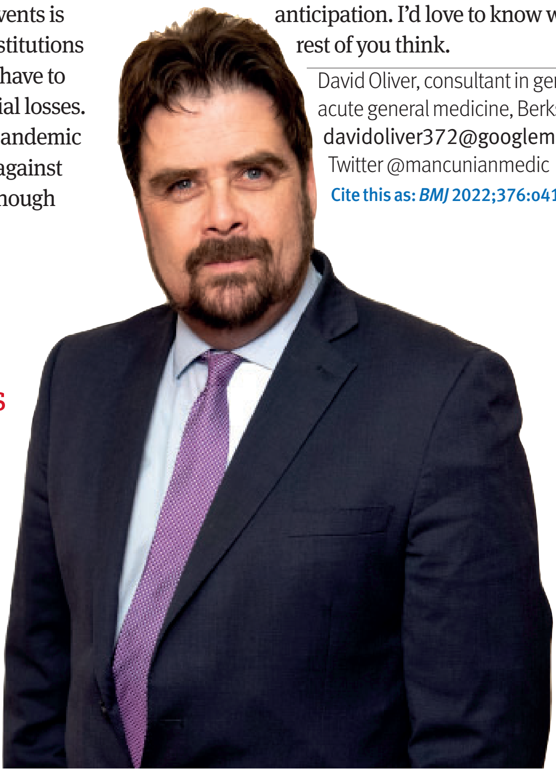
Conferences have often been among the highlights of my year



PRIMARY COLOUR Helen Salisbury

Primary care's complexity and joy

During my first year at medical school, a lecturer informed us: "60% of you will end up as GPs." His tone of voice made it clear that this destination would mark us as failures. A friend of mine, who excelled as a student and in a series of sought after training posts at famous hospitals, was asked why she was "dropping out of medicine" when she chose general practice as her career.

This bad mouthing continues in medical schools to this day and may have a part to play in the current GP shortage—while the number of consultants in hospital specialties has risen by 83% since 2004, the number of GPs has fallen.

Yet many of us in GP land escaped joyfully from hospitals into the community and have never looked back—despite the perception that, in doing so, we were copping out or settling for a less prestigious career. Overlooking (for a change) the ridiculously long hours, media targeting, interference by central government, and attempts at micromanagement through contract variations, this week I want to focus on why—despite all this—I love my job.

Some of what we do is simple yet satisfying. It's finding the right antibiotic to treat an infection or diagnosing a self-limiting condition and being able to reassure a patient who was fearing the worst. A lot of our time is spent with patients who have many things wrong; in these cases, we are endlessly juggling the medicines and symptoms of several different conditions, and the complexity of this work is intellectually stimulating. Alongside our technical training, the most powerful tool we have to help us work out what's wrong—and what we should do about it—is our knowledge of the patient.

Knowing how my patients normally walk and talk, how calm or worried they usually are, I can spot when they are unwell and I notice when they have lost weight or are less sharp than before. If I am lucky enough to know their family as well, I may have clues as to why these changes have occurred, or the cause of their worries.

Although the relationship is asymmetrical, my patients also know me. When I'm doing my job right, they trust in my commitment to them (despite my problems with timekeeping) and together we take difficult decisions and explore the limits of medicine. I am included in the important moments of my patients' lives: births and deaths, bereavements and reprieves.

I am not just any doctor, I am their doctor. It is not an easy job, but it is endlessly fascinating and deeply satisfying. The challenge for our political leaders is to create an NHS where this way of practising can flourish, to keep the GPs we have, and attract more doctors into the community.

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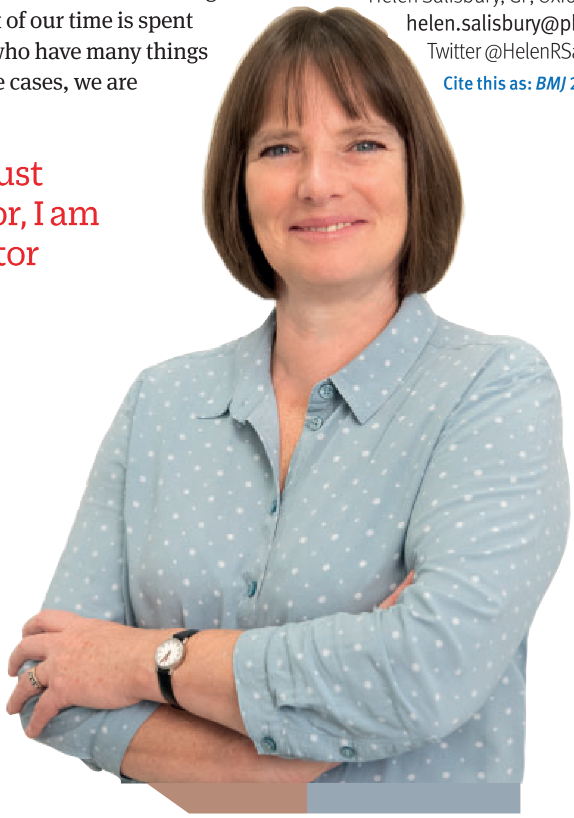
I am not just any doctor, I am their doctor



LATEST PODCAST

Fasting for Ramadan

With Ramadan approaching, clinicians may be approached by their Muslim patients to discuss managing their health conditions during the month of fasting. This week's episode of Deep Breath In—with Ammad Mahmood and Sahira Dar, authors of a recently published article on this topic in *The BMJ*—covers some of the many questions that doctors and patients may have.

Mahmood outlines why Ramadan has clinical implications for many people: "The key thing about Ramadan for most of us is that it's a real disruption of routines, and with that comes concerns about medication or altered patterns of sleep. Most people with chronic disease need to give some kind of consideration as to whether their medication is going to be compatible with a fast and whether any of the lifestyle changes that they're going to make is going to lead to any disruption of their health."

Dar describes the importance of approaching the consultation with individualised advice: "Ideally, this sort of consultation should start a few months before Ramadan so if any medication adjustments or blood monitoring needs to be done, there's enough time to do that. It's really important to find out what that patient's lifestyle requirements are. Do they have a very physical job or is it sitting at a desk? How do they want their Ramadan to be? Do they plan to fast every day? It could be that they just want to fast at weekends. So you need to find out what their beliefs are, what they want to do, and what their lifestyle is. It's not all or nothing, where if you're fasting at Ramadan you have to fast every day consecutively. You can advise, for example, that they fast some days or alternative days—there's always a compromise."

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

ANALYSIS

How can WHO transform its approach to social determinants of health?

The World Health Organization has a pivotal role in reducing health inequities but faces five fundamental constraints to progress, argue **Unni Gopinathan** and **Kent Buse**

The social determinants of health are the circumstances in which people are born, grow, live, work, and age, and these are shaped by the inequitable distribution of power, money, and other resources in society.[1]

Differences in income or unequal exposure to environmental risks contribute to unfair health outcomes within and between populations, something the covid-19 pandemic has brought into sharp focus.[2]

The World Health Organization was created as a multilateral United Nations agency to support and convene member states to tackle health issues through international collaboration and coordination. The importance of economic and social conditions for health was codified in WHO's founding constitution in 1948,[3] and the link between socioeconomic factors and health was highlighted again in 2008 with the report of the WHO convened Commission on Social Determinants of Health.[1] The report emphasised that health inequities are a consequence of poor social policies and unfair economic arrangements and called on governments, civil society, local communities, private sector, and international agencies to take action. Although the report motivated detailed national and regional assessments of the effect of social determinants on health inequities,[4,5] its recommendations have not been widely translated to policy and practice[6]—a failure that arguably laid the grounds for the unequal effects of the covid-19 pandemic.[2,7]

The continuing harm from social inequality shows WHO ought to do more

WHO has undertaken a range of actions on social determinants of health at global, regional, and national levels. Globally, it has drawn attention to social protection, housing, and the empowerment of women and girls through its work, for example, on tuberculosis and sexual and reproductive health and rights.[8,9] In 2021, it launched a multiyear initiative to support countries in prioritising actions on social determinants on health[10] and announced a new research agenda to inform action.[11] A further initiative is the Council on the Economics of Health for All, which is examining how health should be valued as a central public policy objective.[12] The Pan American Health Organization and WHO's Regional Office for the Eastern Mediterranean have issued regional assessments with recommendations spanning fiscal policy to environmental conservation and gender rights.[13,14] Cooperation strategies between some WHO country offices and ministries of health have also prioritised work on social determinants of health.[15]

Although these activities are welcome and important, the continuing harm from social inequality shows WHO ought to do more.[6] WHO faces general organisational constraints to effectively fulfilling its role in supporting member states to act on social determinants of health. Chief among these is the lack of unconditional funding that the organisation can spend at its own discretion; this inhibits WHO's autonomy to pursue activities it thinks carry the greatest value.[16,17] Beyond this and other general obstacles,[18] there are constraints that are specific to the social determinants of health agenda. Informed by the literature at the intersection of public health policy and the fields of political science, policy studies, and public administration, we discuss these constraints and propose actions for tackling them.

Five fundamental constraints to progress

The first two constraints are tied to WHO's role as a specialised UN agency focused on health, which means that it primarily engages with and advises national ministries of health. Yet important policy changes that influence the social determinants and related health outcomes—for example, those pertaining to access to quality education, environmental protections, or decent working conditions—are designed and implemented outside the health sector. The health sector rarely has much influence over the formulation of such policies.[19-21] WHO's first constraint is therefore that it has limited interaction with or influence over some of the key agencies and ministries that shape social determinants of health.

The second constraint is the apparent tension between WHO's health mandate and the need to support other sectors' leadership while stewarding the social determinants of health agenda. Intervening on the social determinants of health involves policies and interventions that affect health outcomes through complicated causal

KEY MESSAGES

- The covid-19 pandemic highlighted unfair differences in health outcomes and the need to pay greater attention to the social determinants of health
- WHO should demonstrate that addressing social determinants of health is critical to achieving its mission and foster leadership from other sectors in pursuit of greater equity
- WHO should invest in a research programme to underpin its guidance on these determinants with a broad evidence base
- WHO should promote politically bold messages more forcibly and hold member states accountable through monitoring

Five point agenda for WHO to address the fundamental constraints to effective action on the social determinants of health (SDH)

Fundamental constraint	What does it mean for WHO?	Proposed WHO action	Examples of actions
The value of SDH is championed by the health sector, but the main policy changes required are in other sectors	WHO is not the key authority that convenes actors about policies in other sectors that impact health inequities	Share its ownership of the health agenda and promote leadership from other UN and multilateral organisations with relevant mandates, expertise, and networks on the policy choices needed to promote health equity	Partnering with the UNDP on advocating legislative and regulatory measures that can help reduce risk factors for non-communicable diseases[36]
Tension between WHO's health mandate and the need to support other sectors' leadership on SDHs	WHO risks internal professional resistance to emphasising the role that policies in other sectors have in shaping outcomes across WHO's disease focused areas	Show that WHO considers SDH critical to achieving its mission and supporting countries to achieve SDG3	Building and strengthening staff capacity for dealing with SDH and generating greater internal appreciation of how a dominant biomedical orientation can divert critical attention away from social determinants and the influence of other sectors
SDH is a broad and multifaceted agenda—motivating and sustaining political attention on it can be overwhelming for the health sector	WHO is too overstretched to establish multisectoral partnerships and advance progress on every issue on the SDH agenda	Tailor its intersectoral approach to capitalise on synergies and mitigate harms and focus on areas where WHO's authority on developing norms and standards can generate the greatest value	Using the effect on specific disease burdens to promote equitable polices (eg, effect of social protection on tuberculosis burden),[37] motivating involvement of other sectors by highlighting how their core sectoral policy goals reduce health inequities, and paying special attention to commercial determinants of health and how governments can mitigate these impacts[38]
Standard approaches to identifying, reviewing, and appraising evidence are insufficient for informing policy on SDH	WHO's approach to developing evidence informed recommendations is primarily tailored to inform interventions delivered by the healthcare system	Invest in methodological approaches for evaluating broader sources of knowledge and strengthen WHO's ability to produce recommendations on the complex causal pathways from social determinants to health inequities	Developing an ambitious research programme for SDH that involves different disciplines and community-based perspectives for generating evidence on sectoral policies needed to reduce health inequities[11]
Policies influencing SDH are politically charged, shaped by ideology and values, and influenced by commercial interests	WHO's biomedical orientation, member state driven agenda, and conventional response to ideologies and interests limits the secretariat in countering commercial and political drivers of health inequities	Exercise its authority on global health to draw critical attention to the ideologies and interests that run counter to the goal of health equity, mobilise civil society, and hold member states accountable by monitoring their actions	Challenging high income countries to support patent waivers, equitable sharing of vaccines, and labelling the hoarding of vaccines as morally indefensible[39]

pathways that originate, for example, in laws that discriminate, tax systems that are regressive, or environmental degradation resulting from corporate activity that most affects people with the least resilience. However, the biomedical orientation that dominates within WHO[22] and the health sector more generally[21-25] diminishes the space for thinking about social determinants of health and fully appreciating their influence on health inequities. Those within the health sector might also be reluctant to acknowledge the influential role that policies in other sectors play in shaping health outcomes[21-26] as it might be perceived as a call to divert resources and influence away from the health sector.

The sheer size and heterogeneity of the social determinants of health agenda is a third constraint. Conceptually, the agenda emphasises that numerous factors—including education, income, tax justice, environment and climate change, labour rights, gender inequality and discrimination, and racism—act as determinants and reinforce each other in shaping health inequities. It has been hard for an overstretched WHO to mobilise global and national political attention to issues across this vast terrain of determinants,[6] especially compared with solutions that revolve around the delivery of medical care, drugs, and vaccines.

A fourth constraint is a misalignment between the standard approaches WHO uses to produce evidence informed recommendations for clinical interventions and the approaches needed to construct an evidence base for policy choices to intervene on the complex causal pathways of social determinants of health.[27 28] WHO has recognised limitations to its conventional approach to guidance development and proposed ways to adapt it.[29-31]

Finally, perhaps the most important constraint for WHO is that policies affecting social determinants of health are politically charged, shaped by ideology and values and influenced by powerful economic and commercial interests.[21-35] Climate change and environmental protection, gender equity, social housing, or a basic minimum wage and social protection are all areas where values and interests can diverge deeply across the political spectrum.

Each of these constraints is amenable to change. We suggest that these should motivate a strategic shift in how WHO approaches the social determinants of health and propose a five-point agenda for WHO to tackle the fundamental barriers to effective action on social determinants of health (table).

Use SDGs to foster leadership from other sectors

The sustainable development goals (SDGs) agreed by UN member states for 2030 highlight how actions in multiple sectors influence health. For example, SDG1 on poverty reduction, SDG5 on gender equality, and SDG8 on decent work are critical to achieving SDG3 on healthy lives and wellbeing. Other multilateral organisations such as the World Bank, the UN Development Programme (UNDP) on poverty reduction, Unicef on educational policy, or the International Labour Organization (ILO) on labour rights and social protection, hold greater responsibility for supporting countries and non-health sectors to achieve those goals. Ongoing, collaborative work on the SDGs is an opportunity for WHO to share ownership of the social determinants of health agenda and to advance work on social determinants with multilateral organisations with relevant sectoral mandates, expertise, and networks. In so doing, WHO can foster the leadership of these organisations in tackling social determinants of health and drive collective prioritisation of health equity.

The Global Action Plan for Healthy Lives and Wellbeing, which commits WHO and 12 other multilateral agencies to work together on the health-related targets of the SDGs represents a positive step in this direction.[40] Together, these institutions can advocate for specific policies that countries should adopt, finance, and implement in each sector. For example, WHO and UNDP have come together to promote legislative and regulatory measures countries should consider to reduce risk factors for non-communicable diseases.[36] Similarly, the UN Environmental Programme (UNEP) used air quality guidance developed by WHO as a starting point for a global assessment of air quality laws.[41] WHO can also build on the various cross sectoral responses to covid-19, such as gender responsive social protection[42] and interventions supporting early childhood development and educational services.[43] These highlight the important contributions different sectors make to achieving public health goals and further strengthen intersectoral actions forged between health and other sectors. WHO should support health ministries in keeping these lines of communication open to promote health equity.

Build knowledge and capacity within WHO

A balance has to be struck between encouraging institutions in other sectors to act on social determinants of health and giving social determinants higher internal priority within WHO. Building and strengthening staff capacity will be crucial to ensure the social determinants of health cut across WHO's work. Greater internal appreciation of the importance of social determinants of health can be generated through compelling examples of how health inequities have been reduced by working across sectors. For example, WHO has, through its work on health risks such as air pollution, engaged with other multilateral institutions and national policy makers on far reaching issues such as energy and transportation policy.[44] Such experience could be used to motivate other areas of the organisation to more explicitly address the social determinants in their work.

Focus on intersectoral synergies and mitigating harms

In responding to the broad and multifaceted nature of the social determinants of health, WHO can tailor its approach to be more strategic in approaching other sectors and partners to advance work. For example, WHO may be able to use its work on specific diseases as an entry point to promote policies in other sectors that improve health equity, such as expanding social protection to reduce the burden of tuberculosis.[45] However, reiterating the imperative to reduce health inequities alone is unlikely to compel other sectors to contribute to addressing social determinants of health, especially as they have their own core goals and outcomes.[46] Appeals for collective action on social determinants of health must therefore highlight, when relevant, the advancement of mutual goals across sectors. For example, sectoral goals such as free and high-quality education, expansion of access to affordable and sustainable public transport, or conservation of natural resources can be advanced through policy options that also benefit health.

> Policies affecting social determinants of health are politically charged

At the same time, drawing on evidence of harms to health, WHO can be more prominent in calling on governments to mitigate harmful determinants strongly driven by commercial interests ("commercial determinants").[47] Commercial determinants include exposure to harmful products (eg, processed foods or sugar sweetened beverages) and practices of transnational corporations (eg, environmental degradation or infringements on labour rights and working conditions).[48] WHO has had some success advancing evidence informed policies and regulations that oppose powerful commercial interests that harm health, with a key example being its role in securing the Framework Convention on Tobacco Control. The recently established programme on commercial determinants is a timely and promising step in this direction.[38]

Embrace a broad evidence base

Recommendations from WHO on the social determinants of health must rely on a broader evidence base than is typically considered when assessing the effectiveness of clinical interventions.[28] It should invest more in developing methodological approaches and a broader research programme to strengthen its guidance on social determinants. Crucially, different disciplinary and community based perspectives on evidence for action should be sought. Furthermore, the absence of strong evidence—as classified by the conventional evidence hierarchy—should not dissuade WHO from advocating for ambitious reforms and policies that can promote health equity.[49]

More fundamentally, WHO should accept that its legitimacy does not rest solely on its ability to synthesise scientific evidence but also in taking people's concerns and values into account, especially considering the public's willingness to support progressive policies in pursuit of health equity.[50 51-53] Accordingly, evidence generation should also focus on what states should do to remove institutional and political constraints to addressing social determinants of health.

Articulate politically bold messages

Pursuing progressive approaches to reducing health inequities relies on developing evidence informed global norms, generating demands for policy makers to act, and implementing mechanisms for securing political accountability.[21-35] Growing health inequities are the result of poor policies, which are at times driven by a politics influenced by commercial organisations. WHO should be more explicit about these political drivers and use its authority on health to counter proposals and actions that go against health equity.

By being more politically forceful WHO can bolster and mobilise civil society, especially those representing the most vulnerable and marginalised groups, and generate political support for policies that are resisted by ideological and commercial forces. WHO's principled stance on the waiver of intellectual property rights to accelerate technology transfer and access to covid-19 vaccines, which has given strength to the advocacy of civil society, is one example, although the policy is not yet adopted.[54] WHO regional and country offices could also have an important role in this mission[55]—for example, by empowering health ministries to work across government.[15]

Crucial juncture in global health

The unequal distribution of vulnerabilities laid bare by the covid-19 pandemic is at the forefront of the public's attention and, with it, considerations of how to ensure health equity as societies build back fairer.[2] In the wake of the pandemic, WHO has the opportunity to pursue a more transformative agenda on social determinants of health, starting by tackling the five fundamental barriers to effective action discussed above.

It will also be important to hold countries to account for their progress. Systematic and continuous global monitoring is often lacking, and strengthening monitoring is one of the priority areas of the 2021 World Health Assembly resolution on social determinants of health.[56] An opportunity exists to establish a monitoring system for action on social determinants of health that considers contributions from relevant multilateral agencies and corresponding national ministries, thereby also spurring sectors outside health to act. More effective WHO leadership on social determinants of health that more systematically fosters greater involvement of other sectors will be critical if countries are going to deliver on their promise of healthy lives and wellbeing for all by 2030.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Release anonymised data from yellow card scheme

I welcome *The BMJ*'s call for immediate public access to data on experimental vaccine trials undertaken by their manufacturers (Editorial, 22 January). But there is an even stronger case for public release of the anonymised individual patient data collected under the UK's "yellow card" covid-19 vaccine adverse events reporting scheme. When these data have been publicly released, as in the United States, their analysis has been crucial in identifying important safety signals.

The yellow card scheme is administered by the Medicines and Healthcare Products Regulatory Agency (MHRA), a government body funded by the UK public. The data are largely gathered by NHS staff. Despite this public financing, however, the MHRA has repeatedly refused to release the anonymised individual patient data for independent analysis (FOI 21/640). It argues that data release would be too onerous, yet paradoxically passes these same data to the vaccine manufacturers as a matter of routine (FOI 21/942). The MHRA's attitude would not be tolerated in the wider science community where access to raw data is now a prerequisite for publication in peer reviewed journals.

The only quantitative data made publicly available by the MHRA comprises a rudimentary summary of total adverse events classified by vaccine type and medical category. Vital information on relevant patient attributes recorded under the scheme (such as age and sex) are not provided, thereby precluding rigorous scientific analysis of vaccine adverse effects. Consequently, there is no opportunity for independent, scientific challenge of the MHRA's assertions that covid-19 vaccine adverse effects are rare and mild.

The safety profiles of the experimental covid-19 vaccines must be kept under strict and independent surveillance in the UK. This can be achieved only with immediate, public release of the anonymised raw data collected under the yellow card reporting scheme.

Richard A Ennos, retired professor, Edinburgh

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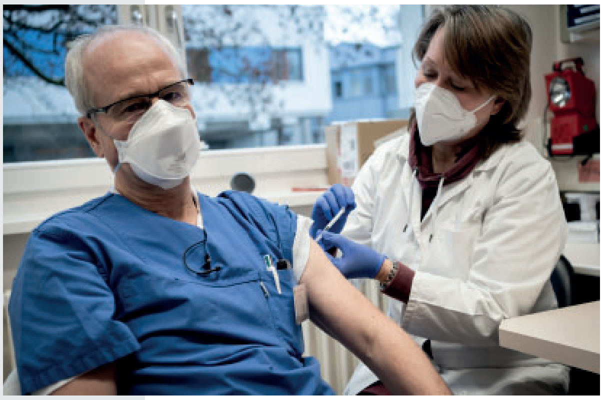
RELEASE OF RAW DATA ON COVID-19 VACCINES


PA/ALAMY

Individual patient data should be submitted to the EMA

Despite more than a decade of discussion, we are still struggling adequately to inform decision making in our healthcare systems (Editorial, 22 January).

Relying on processes in which drug companies curate individualised patient data (IPD) and decide whether to make them available is insufficient. We should require by law that all IPD are submitted to the EMA. The EMA should be developed into a data hub, which in addition to analysing data within its own approval procedures could also run analyses requested by other public bodies or make data available to independent researchers. This should not be difficult, as technical requirements (such as data standards) are already available from the FDA's routine data submission process.

This approach should be introduced through the current revision of European pharmaceutical legislation to ensure complete data transparency in all clinical trials—this is of outstanding public interest, and its introduction should be initiated now.

Beate Wieseler, head of drug assessment, Institute for Quality and Efficiency in Health Care, Germany

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FACEBOOK *v THE BMJ*

Fact checking cuts both ways

Like many readers I was concerned by the issues raised in your report about potential covid-19 vaccine trial misconduct (Medicine and the Media, 22 January).

Vaccine uptake is important for overcoming covid-19, so it is not surprising that many publishers and social media sites are trying to be responsible when it comes to negative stories about vaccines. But science and medicine are built on trust. When misconduct occurs we must investigate and report it so that harms can be mitigated and lessons learnt. Academic publishers have a key role in retracting papers and reporting on bad science.

It is therefore worrying if social media fact checkers end up undermining the academic quality control process. Surely fact checkers should be able to recognise the difference between a social media comment written by Joe Bloggs and an article published in an established professional journal or written by academics with good track records?

Simon E Kolstoe, reader in bioethics, Portsmouth

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Fact checkers should declare conflicts of interest

In the article on *The BMJ*'s experience with Facebook fact checkers, Gary Schwitzer of the University of Minnesota's School of Public Health highlights the "inherent conflict of interest" in using third party organisations to fact check content.

The "independent" fact checkers are obviously not really independent when they are paid by Facebook, which might have a major impact on the result of the fact check.

Fact checkers should always be identifiable with their full names, their affiliations, and their qualifications, as is common practice in science when discussing different views in public. They should also publish any potential conflict of interest. How can I be sure that the person is not partly paid by Pfizer or owns shares that might influence the outcome of the fact check?

Günter Kampf, consultant hospital epidemiologist, Hamburg

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OBITUARIES

Peter Beck

Consultant physician South Glamorgan Health Authority (b 1941; q 1965; MA (Wales), MD Lond), died from bronchopneumonia on 8 November 2021

Peter Beck became a consultant physician at Llandough Hospital, Penarth, in 1973. He became the leading general physician in the area in NHS as well as in private practice and also attained a masters degree from University of Wales in philosophy of healthcare. His contributions to the Royal College of Physicians and medicine in Wales were substantial, and he was a regular examiner for MRCP at home and abroad. Peter was a bon viveur with a deep knowledge of viniculture and also a wide circle of friends. He attended many international rugby matches in Cardiff and elsewhere. He served in the Royal Naval Reserve for over 15 years and attained the rank of surgeon commander. He leaves his wife, Lyn; two children; and five grandchildren.

John H Lazarus

Howell J Lloyd

Cite this as: *BMJ* 2022;376:o152

Jane Bomford Davey

Consultant in breast care Royal Marsden Hospital (b 1933; q Middlesex Hospital 1957), died from Alzheimer's disease on 27 December 2021

Jane Bomford Davey joined the Marsden in 1968 as the clinical assistant to Mr Peter Greening and helped him set up a well woman clinic that focused on the early diagnosis of breast cancer. It became possible to assess a woman clinically and access mammography and fine-needle aspiration cytology, where appropriate, at one or two visits. Before the National Breast Screening Programme in 1987, the early diagnostic unit found that screening women at greater risk led to higher rates of cancer detection in those with earlier disease. Jane was a skilled diagnostician, and she became one of the foremost physicians in the field. Jane was a long term member of Symposium Mammographicum and dedicated herself to improving breast care standards for women in the UK and abroad. Jim, her husband of 59 years, predeceased her. She leaves two children and three grandchildren.

Catherine Morrison

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William Grieves Donald

General practitioner Broomhill, Northumberland (b 1934; q Durham 1958; FRCGP), died from effects of vascular dementia on 29 December 2021

William Grieves Donald ("Bill") followed house posts in Newcastle Royal Victoria Infirmary with a three year commission in the Royal Air Force. After three years in a Norfolk practice that did not share his patient centred philosophy and a brief period in his father's business, Bill settled in the rural practice of Amble and Broomhill in north east Northumberland for 24 years, retiring in 1994. In 2003 Bill and his wife, Madeleine, moved from Warkworth to Brafield-on-the-Green, near Northampton, to be near family. Bill's last few years were tainted by dementia but his calm, benign personality remained, and he was ably cared for at home by Madeleine, supported by his children. He leaves Madeleine; three children; and nine grandchildren.

W J David McKinlay

Cite this as: *BMJ* 2022;376:o154

Jean Horton

Consultant anaesthetist (b 1924; q London, 1949; DA Eng, FFA RCS, MA Camb, FRCA, FHKCA, FHKAM), died from pneumonia on 21 October 2021

Jean Horton turned down a place at Newnham, because Cambridge did not award degrees to women, and she went to University College London. Although she was told "Not another bloody woman" when she applied for consultant posts, she was a neurosurgical anaesthetist in Edinburgh from 1960 to 1970, with a year's sabbatical in Lagos. She then helped set up a new neurosurgical unit at Addenbrooke's in Cambridge. In 1983 Jean moved to Hong Kong, where she became involved in the formation of a college of anaesthesiologists. Jean was elected a fellow of the college at its first congregation and was elected to its first council. In retirement in Cambridge she remained busy, singing, learning Spanish, and writing her autobiography.

Ann Ferguson

Cite this as: *BMJ* 2022;376:o155

Anthony Luder

Professor of paediatrics (b 1953; q University College London Medical School, 1978; DCH, MRCP UK (Paeds), died from metastatic rectal carcinoma on 4 September 2021

Anthony Luder, a founding professor of paediatrics at Bar Ilan University Medical School, northern Israel, and head of clinical paediatrics at Ziv Medical Centre, made an outstanding contribution to the development of medicine in northern Galilee. This region was deprived, with a mixed Jewish, Arabic, and Druze population, and Anthony's move there in 1992, after postgraduate training in Toronto and Denver, Colorado, together with his young family, was professionally courageous. With his colleague Michael Harari, he facilitated the humanitarian initiative treating injured and displaced children affected by the Syrian civil war. Predeceased by Judith, his wife of 41 years, he leaves Sharon, his second wife; three children; and five grandchildren.

Mervyn Jaswon; Jonathan Ledermann; Robert Luder

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Denis Simpson White

GP Dunmurry (b 1945; q Queen's University Belfast 1968; OBE, FRCGP), died from oropharyngeal carcinoma with metastases on 10 January 2021

Denis Simpson White did hospital posts at Belfast's Royal Victoria Hospital and after a trainee year in Ballymoney was one of the first GPs to complete vocational training in Northern Ireland. In 1972 Denis joined the family practice in Dunmurry, with his uncle, father, and cousin. His uncle had taken over the dispensary practice there in 1926. Denis enjoyed every day of general practice and was always relaxed, never hurried. He was an enthusiastic member of the Northern Ireland faculty of the Royal College of GPs and was chairman of the faculty board and provost. In 2002 he was awarded an OBE for services to medicine. He was captain and president of his local golf club in Dunmurry. He leaves his wife, Paddy; two children; and two grandchildren.

John White

Cite this as: *BMJ* 2022;376:o157

Edward Janavel Huth

Doctor, academic, and medical editor

Edward Janavel Huth (b 1923; q 1947), died from vascular dementia on 2 November 2021

Edward Huth, a leading figure in medical journal editing, has died at the age of 98 years. His life's work improved the science and craft of medical editing in all its dimensions, not just in his own journal, *Annals of Internal Medicine*, but in journals throughout the world.

ICMJE

This work began in earnest in 1978 when Ed and Stephen Lock, then editor in chief of *The BMJ*, organised a meeting of editors of influential journals to see if they could agree a standard format for citing references. They did agree, and the format was widely adopted. Initially called the "Vancouver group" after the locale of the first meeting, they became the International Committee of Medical Journal Editors (ICMJE). ICMJE continued to meet regularly and turned its attention to the everyday ethical dilemmas of publishing scientific journals, such as authorship, conflict of interest, editorial freedom, plagiarism, duplicate publication, fraud, and retraction. Lock recalls Ed's role as "interpolating sense into hair splitting and prolonged arguments" between the assembled editors. The resulting guidelines have been widely adopted by the world's journals. Ed also participated in the formation of another working group that became the World Association of Medical Editors (WAME), created to be more diverse and inclusive than ICMJE.

Ed Huth was a decisive editor who could separate the wheat from the chaff quickly

Ed's efforts to improve medical editing took many forms. He welcomed articles about medical writing and research methods in *Annals*. He lectured on medical editing throughout the world. He wrote books on scientific style and format, and how to write and publish in the medical sciences.

Annals of Internal Medicine

Ed graduated from the University of Pennsylvania Medical School in 1947 and served in the military while completing his postgraduate training. He began an academic career as a general internist, also at the University of Pennsylvania. In 1960 he became assistant editor of *Annals of Internal Medicine*. It was there that he found his true calling.

Ed was the editor of *Annals of Internal Medicine* from 1971 to 1990. He transformed *Annals*—partly to keep pace with technological advances and the expectations engendered by the principles enunciated by ICMJE. One of the most significant changes was the structured abstract. Every research article is preceded by a summary—the abstract—that helps readers decide if they want to read it in full. Until 1987, authors decided what to include in their abstract, often omitting important information for judging the quality of the research. The structured abstract ensured that this information was included. This innovation, now widely used, made its debut in *Annals* during Ed's tenure.

In 1980, the American College of Physicians, *Annals'* parent organisation, started a programme to develop clinical practice guidelines. Soon after, *Annals* began to publish these guidelines together with a review of the research that shaped them. Many professional medical organisations followed suit. The central role of literature reviews as the evidence base for guidelines led to concern about the uneven quality of the research included in the reviews. In 1987, *Annals* published an article summarising these concerns and offering guidance on how to choose trustworthy articles. The systematic reviews that grew out of this article made the best quality evidence the foundation of current medical practice.

Clinicians need to learn about new research evidence as it comes available, regardless of where it is published. Ed and Brian Haynes developed *ACP Journal Club*, a regularly published synopsis of recent clinically relevant and scientifically sound articles in internal medicine, presented as structured abstracts and expert commentary.

Ed was a decisive editor who could separate the wheat from the chaff quickly. But he also had a deep respect for the advice of his colleagues and saw little need to claim personal credit. Colleagues enjoyed working with him because of his decency, honesty, geniality, and humour. We remember him as a generous mentor who took us under his wing when we were first learning how to become editors.

Ed had many interests. He appreciated good food and wine. He was a pianist, and music had a large place in his life. While he preferred classical music, he was versatile—at a dinner party at the Fletchers' home, he spontaneously went to the piano and accompanied a rap the housekeeper's daughters belted out. Ed was intensely interested in his ancestors from the Waldensian valleys of what is now north west Italy. He was devoted to family life with Carol, his wife of 64 years, and his two sons and grandchildren.

Because Ed championed improvements in medical editing that began a long time ago, many today might not know their provenance and who took the lead. In remembering him and his contributions, we hope to close the circle.

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EDITORIAL

England's U turn on NHS vaccine mandate

An avoidable and costly episode that raises concerning questions about governance

Two years into a pandemic, with hopes of respite for exhausted healthcare workers repeatedly shattered by the emergence of new SARS-CoV-2 variants, those in charge in the NHS just want certainty. So it is little wonder that, over the past few weeks, they have become increasingly frustrated as they struggle to interpret the government's changing intentions for vaccination of their staff. But when this is over we should all reflect on what this episode says about how the country is being run.

On 9 November 2021, the health secretary told parliament that nearly all NHS staff must be vaccinated against covid-19 by April 2022,[1] enacting the necessary legislation in a statutory instrument laid before parliament on 6 January 2022.[2] Although controversial, mandates have been found to increase vaccine uptake.[3] Staff had until 3 February to receive a first vaccine dose or risk losing their job. Since the mandate was first announced, almost 130 000 staff have come forward to be vaccinated. But others did not, with about 5% of NHS staff expected to miss the deadline.[4]

Occupational health and human resources departments have had the challenging task of confirming the vaccine status of staff, some of whom may have been vaccinated abroad or under a different name from the one used at work. They then had to contact everyone who seemed unvaccinated, confirm their status, ensure they were aware of the consequences and, often, spend time providing reassurance about vaccine safety. This was a massive undertaking in a service already struggling with high rates of sickness absence related to covid-19. Universities training health professionals had to do the same for their students, at great expense.

The process of making policy in Westminster is broken

Throughout this time, NHS employers were voicing concern about the risk of losing key staff. By late January stories were emerging that the government was considering a U turn. Meanwhile, those working to implement the policy were questioning whether the mandate would be enforced. Some sort of an answer came on 31 January when the health secretary announced that he was launching a consultation on his intention to revoke it.[5]

Legal limbo

However, the legislation remains in place for now, posing a problem for NHS employers. Should they uphold the law as it stands or pretend that it never existed and, reasonably, assume that the government will not hold them responsible for failure to implement it? Of course, the possibility remains that someone else might—through judicial review. On several occasions during the pandemic the courts have had to remind ministers that adherence to the law—for example, on procurement of personal protective equipment—is not optional. And notwithstanding any future change in the law, the chief medical officer and others have made clear that getting vaccinated is a professional responsibility,[6] with implications for regulators and appraisers.

Could this unsatisfactory situation have been avoided? A report by a House of Lords committee that scrutinised the statutory instrument enabling the vaccine mandate is revealing.[7] The report noted how the draft instrument lacked detail on key expressions, such as "face to face" contact. It criticised the accompanying explanatory memorandum, which "lacks all practical detail," "fails to provide an evidence based argument," and does not mention lessons from earlier legislation on mandatory vaccination for workers in care homes.

The Lords report further questioned assumptions in the impact assessment, noting that the committee would expect to be given "very strong evidence," given the risks, but the health department "has signally failed to do so." It raised concerns about the lack of contingency plans for potential loss of staff. The committee then describes how, "Searching through these other documents has provided us with some understanding of what is intended" but expresses concern that "Unclear definitions may be 'interpreted'…to exceed what the legislation actually requires."

This episode is yet another example of how the process of making policy in Westminster is broken. Ideas, developed without consulting those affected, are briefed to friendly journalists. Parliamentary scrutiny is ignored. Those on the frontline are left guessing about what to do with unworkable legislation. It seems as if our political leaders view the classic text on governance in the UK, *The Blunders of our Governments*,[8] written by the political scientists Anthony King and Ivor Crewe in 2013, not as a warning but as a manual for how to run the country.

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