comment

"Just ordering more people to be discharged won't work" **DAVID OLIVER**
"A prescription for broccoli and apples isn't the answer" **HELEN SALISBURY**
PLUS Long covid PROMs; the community care backlog

THE BOTTOM LINE Partha Kar

We need leaders who represent NHS staff

If there's been any silver lining at all to the pandemic, it's brought into sharp focus the many health inequalities based on ethnicity. That focus has moved the dial of the debate, but many would argue that actual progress has been painfully slow.

Last November, prompted by concerns from whistleblowers, NHS England and NHS Improvement's northwest directorate issued a highly critical review of the Christie NHS Foundation Trust. "An experience of bullying, harassment and racial prejudice was described along with a lack of respect at work," the report stated.

This focus on racial inequalities is not something that needed a pandemic for us to start the discussion. Yet conversations in NHS leadership circles about health inequalities are still distinctly uncomfortable. In the nursing and medical professions there's a striking lack of diversity in more senior roles. Of NHS England's board members at the last count, just one of 11 members wasn't white (as it is on the website as I write this).

We hear that "times are changing" and progress is "a matter of time." Yet, in the latest NHS shake-up, where the new integrated care systems are in the process of appointing their chief executives, 41 of 44 have had their appointments made, and only one isn't white. A counterargument is that non-executive director representation has increased—but anyone familiar with NHS structures will know where powers or responsibilities sit, and merely increasing non-executive director numbers to make boards' proportions look better is sleight of hand at best.

As well as representation, this is about respecting your workforce. To anyone suggesting "the best person must win": you need to be "in the game" to win. Detractors are quick to point out a lack of applicants, but stories abound of discrimination and "internal candidates" being offered positions. And it's tricky to be a role model when, like others in leadership roles, you're battling through treacle—and you're the one with shoes of lead.

But role models are starting to appear. Conversations, though uncomfortable for some, are happening. I'd encourage everyone to raise their voice and make those conversations louder. We need independent panels, maybe even blind interviews. If the NHS can find time to implore other countries' staff to come and help, it can also ensure they have the opportunity to progress and are not simply left to fill the posts "others don't want to do."

The best person for the job? Yes, always—but on a level playing field, please. If our system can't do that or the data show no improvement, perhaps we need to discuss quotas. Words are easy. Actions are tougher—which is why we need representation in leadership to take the issues seriously.

Partha Kar, consultant in diabetes and endocrinology, Portsmouth Hospitals NHS Trust
drparthakar@gmail.com
Twitter @parthaskar
Cite this as: *BMJ* 2022;376:o293

If our system can't offer a level playing field, perhaps we need to discuss quotas

BMJ OPINION Manoj Sivan and colleagues

Using condition specific PROMs when treating long covid

Global healthcare needs agreed measurement metrics to capture patient experience or the effectiveness of treatments

Post-covid syndrome, or long covid, affects an estimated two million people in the UK, and extrapolated prevalence data suggest more than 50 million individuals worldwide.

Long covid is a multisystem condition with more than 200 symptoms across most of the organ systems. With up to 30% of covid health burden related to covid induced disability, long covid presents substantial challenges for healthcare worldwide. Services globally are investing in these new pathways of care, but there are no agreed measurement metrics yet to comprehensively capture patient experience or the effectiveness of treatments, partly due to lack of clear biomarkers for the condition.

Patient reported outcome measures (PROMs) have been shown to facilitate communication, engage patients in their care, tailor care to individuals' needs, and show value for money. Given the large scale, relative novelty, and multifariousness of long covid syndrome it is unsurprising standardised assessments of functioning, disability, and health are lacking.

Currently, long covid services are using PROMs developed for other conditions such as respiratory conditions (Medical Research Council Dyspnea Scale), anxiety disorder (Generalised Anxiety Disorder Assessment) and depression (Patient Health Questionnaire), and a range of others that have not yet been validated for use with long covid. However, this approach has several limitations. Such measures, in our experience, are cognitively burdensome to long covid patients, do not comprehensively capture the spectrum of symptoms, cannot directly engage with the underlying biological mechanisms, and are reported not to be meaningful by patients, families, and clinicians.

Daily fluctuations

Using a range of symptom specific measures makes it challenging to repeat the measures frequently to capture daily fluctuations, and implementation is difficult in busy services overburdened with a large caseload of patients. There is the added danger of misleading management: for example, individuals scoring highly on anxiety scores may get diverted to psychological services when their anxiety is being driven by underlying dysautonomia that needs medical optimisation.

Clinicians, services, and researchers need to invest their energies in developing and validating long covid specific PROMs or

We need to develop the least burdensome set of PROMs that can be used across the world

validating existing PROMs for use in long covid routine clinical practice and research settings. Condition specific PROMs can provide valuable information on symptom range, severity, and functional impact. More importantly, in combination with research, they help understand underlying mechanisms, phenotypes, and traits in this heterogeneous clinical syndrome.

Such measures can be used to support self-management and monitoring, in addition to supporting services to align long covid care with health system goals. The PROMs need to measure not only symptom range, but also burden in daily activities, including impact on family life, leisure, and work. WHO provides a very useful framework of International Classification of Functioning Disability and Health (ICF) to understand the various aspects of any health condition and its interaction

BMJ OPINION Farah Jameel

The primary care backlog is a ticking time bomb

The word "backlog" has become synonymous with crowded hospital corridors, cancelled operations, and ambulance queues. The government has rightly placed an emphasis on addressing the backlog, but so far only focused on "secondary care."

Yet, there is another growing backlog–one just as significant–in our communities. Anticipating, preparing, and addressing it responsibly could hold the key to unlocking the pressure facing the wider health service.

Continuity of care delivered in general practice has been shown to be associated with lower mortality rates, fewer hospital admissions, less use of A&E, and fewer referrals for specialist care. Yet, this high quality, cost effective, and timely care is underestimated and poorly valued by policy makers. Every day, GPs and their teams

Tackling the build-up of care in our communities can help the wider system

juggle the needs of an ageing population, increasing prevalence of multimorbidity and polypharmacy, increasingly complex guidelines, and growing policy expectations of what can be achieved in each consultation. All the while contending with ambitious and unrealistic productivity targets and within squeezed budgets.

When the pandemic hit, GPs transformed services overnight: caring for the sickest patients, maintaining regular services, developing covid coordination and rapid assessment services, and delivering the nation's biggest ever vaccine rollout. Through the pandemic, patients have been reluctant to use services for fear of putting

with the affected individual that could be conceptualised in selecting measures to understand long covid in its totality.

Long covid patients need to be involved in the development, selection, and co-design of systems to implement specific PROMs. There needs to be early engagement with other stakeholders—clinicians, health informatics, governance, researchers, and commissioners. We need to develop the least burdensome set of PROMs that can be used across clinical and research settings across the world.

Through careful selection and robust, well planned implementation, PROMs, as part of a mix of initiatives, have the potential to enhance the care of the millions living with long covid.

Manoj Sivan, associate clinical professor and honorary consultant in rehabilitation medicine, University of Leeds

Shaney Wright, long covid patient and advocate

Sarah Hughes, research fellow

Melanie Calvert, professor of outcomes methodology, University of Birmingham

Cite this as: *BMJ* 2022;376:o257

more pressure on the system, or because they were afraid of catching the virus.This, alongside hospitals having to cancel non-urgent procedures, delay routine clinics, and redeploy staff, has led to a huge backlog of patients living with worsening conditions and, in some cases, now needing emergency care.

In addition, many people are now living with conditions they do not yet know they have. The pressures in hospitals mean GPs can refer a patient many times, but if there is no capacity those referrals will be rejected.

Emphasis must be placed on how tackling the build-up of care in our communities can help the wider system. With the proper resources, GPs and their teams will be able to safely look after patients in the community.

Farah Jameel, GPC England chair, BMA

Cite this as: *BMJ* 2022;376:o294

ACUTE PERSPECTIVE David Oliver

Diktats won't free up hospital beds

NHS trusts face pressure, blame, and critical headlines for failing to meet hospital discharge targets dictated by NHS England, while being "told to discharge" more patients. But these directives, issued by central agencies miles from frontline care, are only half the problem.

Set unrealistic expectations with insufficient resources and you set them up to fail. The ambition around discharge targets were always unrealistic. But central agencies never seem to learn that just demanding something doesn't make it happen.

In December omicron was surging through communities. By January, hospital bed occupancy was well over 90% and there were fears of inpatients being stuck in corridors—all imperatives to clear a huge backlog of elective cases. Hospitals needed beds. If patients were occupying beds when medically stable enough to leave—either to their own home or another care setting—they could put acute beds out of commission for new patients.

As part of 2020 pandemic discharge guidance, NHS England set out "criteria to reside" (now "reasons to reside") in a hospital bed, and anyone not meeting the criteria was deemed "optimised for transfer"—ghastly, depersonalising terms. Some of us have argued the criteria are based on scant evidence and not how most clinicians assess patients whose circumstances they understand.

For example, the criteria suggest anyone "not in the last hours of life," "with a National Early Warning Score less than 3," or "more than 48 hours after lower limb surgery or more than 72 hours after major abdominal surgery" is by default fine to go home. On 12 December NHS England and NHS Improvement wrote a "level 4 letter" to all trusts, telling them to halve the number of inpatients with "no reason to reside."

Two more letters went out on 22 December, asking trusts to be ready to discharge patients seven days a week (which they already can, subject to capacity and staffing) and to create temporary "bedded care centres" in facilities such as hotels. Surprise, surprise: the arbitrary target was not met within the arbitrary timescale. Because it never could be.

Some delays in discharge are undoubtedly due to hospitals' models of care, assessment, and planning. But it's hardly in the interests of trusts, which face a daily struggle for bed capacity, to keep patients frivolously. They don't need central agencies telling them to create more empty beds. Furthermore, many delays are the result of a well documented lack of capacity in community services.

Two years into a global pandemic, with major workforce gaps, no significant increase in out-of-hospital capacity, and tired practitioners, just ordering more people to be discharged won't work. Everyone in the system knows this—including, I suspect, those issuing the orders.

Writing guidelines and pathways, insisting on delivery at pace, and then criticising trusts when this proves impossible is irresponsible and delusional. Let's stop doing this, shall we?

David Oliver, consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com
Twitter @mancunianmedic

Cite this as: *BMJ* 2022;376:o246

It's hardly in the interests of trusts to keep patients frivolously

PRIMARY COLOUR Helen Salisbury

Levelling up—or punching down?

Last week the government outlined its "levelling up" agenda, a set of proposals intended to improve the lives of the most disadvantaged people in our society. The BMA is sceptical about the impact this will make, especially given the very modest investment announced. One proposal is for GPs to prescribe healthy food to individuals or families who need it.

How would this work? Would GPs identify families as poor and in need of a better diet and then write a prescription? I'm having difficulties imagining how those conversations would go. As the cookery writer and anti-poverty campaigner Jack Monroe has explained on social media, many things are wrong with this proposal. The concept at its heart is that the reason people on low incomes have unhealthy diets is because they make poor choices, not because they have very little choice. It's undignified and demeaning to make people apply for food vouchers or hampers rather than constructing society in such a way that such handouts are unnecessary.

Food bank use is driven largely by inadequate and delayed welfare benefits, exacerbated recently by rising prices and the reduction in universal credit. The Trussell Trust, the largest network of food banks in the UK, provided 2.5 million emergency food parcels in the year to April 2021, up 33% on the previous year. Perhaps if healthy food is available on prescription some of those clients might be diverted to the GP, but that doesn't solve the underlying problem.

A prescription for broccoli and a bag of apples really isn't the answer. You might be getting your groceries from the pharmacy rather than the church hall, but that parcel, however gratefully received, is still not what you'd have chosen for yourself: it's no substitute for money in your pocket to feed your family. And we would need to make sure that recipients have the fuel and equipment to cook the healthy food we prescribe, which is not a given.

You can't work in medicine and not be aware of the social and economic determinants of health. We know full well that the medicines we prescribe play only a small part in a person's overall health and wellbeing, the rest being a mixture of genetics and environment, including nutrition, education, and pollution.

Although medicine is only one contribution to health, it's what GPs are trained to do—and, as we don't currently have enough of them, perhaps we should ask them to focus on preventive and curative medicine and the care of sick and dying people, rather than plugging the gaps in a failing welfare state.

Helen Salisbury, GP, Oxford
helen.salisbury@phc.ox.ac.uk
Twitter @HelenRSalisbury

Cite this as: *BMJ* 2022;376:o324

60 SECONDS, p 213

Food bank use is driven largely by inadequate and delayed welfare benefits

LATEST PODCAST

Listening up at work

In this episode of Doctor Informed, we hear from Megan Reitz and John Higgins, co-authors of *Speak Up: Say What Needs to Said and Hear What Needs to be Heard*, a book about navigating the politics of conversations at work. Reitz begins by describing the ways in which healthcare is similar to other industries in the barriers there are to staff speaking up:

"In any system, we label one another according to all manner of things—our hierarchy, our gender, our department, our specialism, our appearance. Those labels are constructed to convey different levels of status and authority, and that then affects expectations and assumptions around who gets to speak up and who gets heard. Of course, it also affects our perceptions of the consequences of speaking up.

"As we get more senior, and as titles get applied to us, we risk going into what we call an optimism bubble, which, when we're being a bit mischievous, we call a delusion bubble. You think you're more approachable than you are. You think people are speaking up more than they are. Essentially, you don't do the work that you need to do to help people to feel safe and speak up because you don't even realise you have to do the work."

Higgins shares what senior staff can do to try to be more available for people to speak up:

"One thing that I'd bear in mind is, if you want someone to speak to you as you get more senior, think about where they are going to be comfortable rather than where you're going to be comfortable. 'My door is always open' is an unhelpful phrase because it's saying I'm not that interested in you because you've got to come to my territory. If you're speaking to a more junior member of your team, where are they going to feel safest even if you're feeling a bit awkward?"

Listen and subscribe to *The BMJ* podcast on Apple Podcasts, Spotify, and other major podcast apps

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

ANALYSIS

Sarcopenia: early prevention or overdiagnosis?

The condition has recently been included in the international classification of diseases despite lack of evidence to support essential diagnostic aspects. **Christoffer Bjerre Haase and colleagues** argue that the change is a step towards overdiagnosis

As the global population ages, science and societies look for initiatives to handle the societal and individual problems that follow. One such initiative is the diagnosis of sarcopenia, the phenomenon of age related loss of muscle mass and function.

Around two billion people aged 60 years or older are expected to be diagnosed with sarcopenia by 2050.[1] Yet despite important research, uncertainties about the clinical value of diagnosis remain. We examine how modern medicine has established the diagnosis of sarcopenia without sufficient supporting evidence and ask whether it will lead to better prevention and treatment or to overdiagnosis.

SUMMARY BOX

Clinical context—Sarcopenia is defined as age related loss of muscle mass and function and is associated with increased morbidity and mortality. With rising numbers of older people, interest in the condition and possible treatments is expected to rise

Diagnostic change—Sarcopenia was first described in 1989 as the phenomenon of decreasing lean body mass with older age. The idea of sarcopenia as a disease was raised in 1997. From 2010 to 2014, six consensus definitions changed the focus to assessments of physical function. In 2016, sarcopenia was assigned the code M62.84 in the International Classification of Diseases (ICD-10-CM)

Rationale for change—Sarcopenia specialists' groups argued that an ICD-10 diagnosis would raise awareness and recognition of the condition, encourage funders and sponsors to allocate research resources, and support development of new therapies

Leap of faith—Early detection and treatment of sarcopenia will reduce morbidity and mortality and improve quality of life

Effect on prevalence—Based on the most used definition of sarcopenia, prevalence is estimated at 5-13% among people aged 60-70 years, and 11-50% among people aged >80 years. Worldwide prevalence by 2050 could be up to two billion

Evidence of overdiagnosis—Current literature, including studies on screening for sarcopenia, has not explicitly considered the risk of overdiagnosis. For now, overdiagnosis is inevitable since treatment does not differ from general health recommendations

Harms from overdiagnosis—No studies have investigated how people are affected by being diagnosed with sarcopenia. Indirect evidence shows that being labelled with a diagnosis that implies increased risk of morbidity and mortality imposes a psychological burden

Limitations of evidence—A diagnosis of sarcopenia has not been shown to improve prognosis. Sarcopenia treatment has not been shown to have better outcomes than general recommendations for physical exercise and diet. Moreover, the current diagnostic cut-off points, including sex and regional adjustments, are arbitrary and non-validated. It is not possible to distinguish between normal and pathological age related loss of muscle mass

The condition is positively correlated with falls and fractures, cardiac and respiratory diseases, cognitive impairment, low quality of life, and death

Criteria for diagnosis

Guidance from European and international specialist groups suggests a diagnosis of sarcopenia is probable when patients are found to have low muscle strength measured by either grip strength or chair stand test. Sarcopenia is confirmed when this is combined with "the presence of low muscle quantity or quality" measured by dual energy x ray absorptiometry, bioelectrical impedance analysis, muscle biopsies, computed tomography, or magnetic resonance imaging (table).[2] When patients also have poor physical performance, sarcopenia is considered severe.[2] The diagnostic cut-off point is given as 2-2.5 standard deviations below the mean of a sex and regional specific reference population of healthy young adults.[2] When recording the diagnosis, any underlying disease should be coded first. If none exists, sarcopenia should be coded before associated conditions such as generalised weakness.[4 5]

Sarcopenia specialist groups consider sarcopenia to be the most important cause of frailty in older people.[6] It is positively correlated with multiple health related conditions, including falls and fractures, cardiac and respiratory diseases, cognitive impairment, low quality of life, and death. The condition is costly because of increased hospital admission and an associated increased need for care while in hospital.[2]

Sarcopenia is common in older people but can also affect younger people. Ageing is the cause of primary sarcopenia. Secondary sarcopenia can have multiple causes, including lack of activity, age related decline in testosterone, genetic factors, and insufficient energy or protein intake because of anorexia or malabsorption.[6 7] Sarcopenia lasting for at least six months is considered chronic.[2]

Depending on definition and the investigated population, the prevalence varies from 5% to 50% of people ≥60 years old (table 1).[1-9] The International Clinical Practice Guidelines for sarcopenia (ICFSR) recommend annual screening of everyone older than 65 in general practice or outpatient clinics using a tool such as SARC-F (box 1).[2 3]

Treatment for sarcopenia is currently supported by limited evidence and consists of resistance exercise, optionally supplemented with a high intake of essential amino acids and vitamin D.[2-7] Testosterone has been suggested as a potential treatment and new drugs are under development, such as myostatin inhibitors.[7 9]

Definitions of sarcopenia and estimates of prevalence			
AUTHOR	DESCRIPTION	DEFINITION	PREVALENCE
2010 European Working Group on Sarcopenia in Older People [1]	"Sarcopenia is a syndrome characterised by progressive and generalised loss of skeletal muscle mass and strength with a risk of adverse outcomes such as physical disability, poor quality of life and death"	Diagnosis is based on documentation of low muscle mass plus low muscle strength or low physical performance	60-70 year old: 5-13%, ›80 years old: 11-50%, ≥60 years old, worldwide: 600 million in 2000, 1.2 billion in 2025, and 2 billion in 2050. (Conservative estimate ›50 million people today, ›200 million in the next 40 years)
2018 European Working Group on Sarcopenia in Older People (EWGSOP2) [2]	"Sarcopenia is a progressive and generalised skeletal muscle disorder that is associated with increased likelihood of adverse outcomes including falls, fractures, physical disability and mortality"	"Sarcopenia is now defined as a muscle disease that may be acute or chronic." Criteria: 1. Low muscle strength; 2. Low muscle quantity or quality; 3. Low physical performance Probable sarcopenia is identified by criterion 1 Diagnosis is confirmed by additional documentation of criterion 2 If all three criteria are met, sarcopenia is considered severe	Not stated
International Clinical Practice Guidelines for Sarcopenia (ICFSR), 2018 [3]	"Sarcopenia is defined as an age-associated loss of skeletal muscle function and muscle mass, and is common in older adults… The most commonly used diagnostic tool is that of the EWGSOP"		6-22% adults aged ≥65 years with a variation in prevalence across healthcare settings

Rationale for change

In 1989, medical doctor and researcher in nutrition Irwin H Rosenberg introduced sarcopenia as a term to define and articulate the natural phenomenon of loss of skeletal muscle mass with age.[14] Eight years later, Rosenberg questioned whether sarcopenia could be defined as a disease.[15] During 2010 to 2014, six consensus definitions were agreed.[1-20] Each definition positioned sarcopenia as a disease, without reference to Rosenberg's concern. Instead, they focused on making sarcopenia more relevant for clinicians and patients by reorienting the definition towards muscle function rather than muscle mass, since muscle function and strength were more strongly correlated with clinically relevant outcomes, such as morbidity and mortality.[1-20]

An ICD-10 diagnosis was proposed in 2014 to "raise awareness" and "reduce treatment barriers."[21] Proponents argued that disease status would encourage drug companies to develop drugs[6] and incentivise research, just as it did for osteoporosis.[5 6] Sarcopenia officially became a diagnosis in 2016 with an international classification of diseases clinical modification code (ICD-10-CM) M62.84.[2-7] Since then, supporters have been working for the creation of a unique code for the ICD-11.[5]

Uncertainty of evidence

Everyone will experience muscle loss during their life, and some will experience greater loss than others. Nevertheless, the evidence to justify and specify the diagnosis in ICFSR is uncertain or missing (box 2), and the guideline admits: "There exists considerable room for improvement of the methodological quality of clinical trials for sarcopenia. The quality of supporting evidence for the management of sarcopenia was low."[3] The following three questions remain unanswered.

How is disease distinguished from normal age related changes?

Diagnostic cut-off points, including sex and regional adjustments, are currently arbitrary and non-validated. In addition, it is unclear which muscle quality indicators best predict relevant clinical outcomes or how best to measure response to interventions.[2] Sarcopenia researchers have described it as a "major challenge"[5] to recruit research participants who match the criteria for primary sarcopenia. This suggests a lack of diagnostic clarity and may make it difficult to obtain robust high quality evidence (box 2).

Does the diagnosis affect prognosis or treatment?

Evidence is lacking that patients who are diagnosed with sarcopenia have improved outcomes. Nor has sarcopenia treatment been shown to produce better outcomes than general recommendations for physical exercise and diet (see supplementary data on bmj.com).[22-25]

Furthermore, ICFSR found "very low certainty for the beneficial effects of resistance based training in adults with sarcopenia"[3] and low certainty regarding the evidence on protein supplementation. The safety and efficiency of medical treatments such as vitamin D, hormones, or creatinine are unknown because of inadequate data in people with sarcopenia,[3 9] and they are not recommended as first line treatment. For vitamin D, the guideline also notes that because of "the ambiguity of results and low sample size of the majority of clinical

It is unclear which muscle quality indicators best predict relevant clinical outcomes or how best to measure response to interventions

Box 1 | SARC-F (strength, assistance walking, rise from a chair, climb stairs, and falls) screening tool for sarcopenia[10]

Questions

- How much difficulty do you have in lifting and carrying 10 pounds? (None = 0, some = 1, A lot or unable = 2)
- How much difficulty do you have transferring from a chair or bed? (None = 0, some = 1, A lot or unable without help = 2)
- How much difficulty do you have walking across a room? (None = 0, some = 1, A lot, use aids, or unable = 2)
- How much difficulty do you have climbing a flight of ten stairs? (None = 0, some = 1, A lot or unable = 2)
- How many times have you fallen in the last year? (None = 0, 1-3 falls = 1, 4 or more falls = 2)

Sarcopenia is diagnosed if total score is ≥4

Performance data

The test has sensitivity of 0.21 (95% CI 0.13 to 0.31), specificity of 0.90 (0.83 to 0.94), positive likelihood ratio of 2.16 (1.51 to 3.09), and negative likelihood ratio of 0.87 (0.80 to 0.95).[11] Diagnostic odds ratio is 2.47 (1.64 to 3.74).[11]

The strength of evidence is rated as conditional with a low certainty and the tool has not been assessed against WHO's 10 screening principles or for risk of overdiagnosis.[2-13]

Current guidelines recommend the SARC-F for clinical use.[2 3]

Box 2 | Current uncertainties in diagnosis of sarcopenia[2-25]

Clinical practice

- No studies have shown any difference in treatment or prognosis following diagnosis
- Cut-off points for diagnosis are arbitrary
- Cut-off points for diagnosis are non-validated
- Cut-off points for gender and some regional specifications are missing
- It is unknown how to define muscle quality
- It is unknown which muscle quality indicators best predict relevant (clinical) outcomes
- It is unknown which outcomes are suitable for measuring intervention response[2]
- Studies are required to understand outcomes relevant and important to patients
- Studies are needed to investigate differences between primary and secondary sarcopenia[3]
- The strength of evidence for screening is classified as conditional with a low certainty of evidence.[3] The 10 principles for screening, defined by WHO,[26] have not been used to assess the screening tool[2-13]
- No studies have investigated the potential harms of being labelled with the diagnosis of sarcopenia
- No studies have assessed the risk of overdiagnosis.

Research

- Various definitions of sarcopenia are still in use, including the original, dating back to 1989[5 27]
- The variation of different primary outcomes used in sarcopenia interventions has been described as "extreme"[5] by sarcopenia researchers. One study of 123 interventions found that less than 30% of the interventions measured muscle mass and strength as primary outcomes[5]
- Recruiting participants who actually match the criteria of sarcopenia has been described as a "major challenge"[5] by sarcopenia researchers
- Future clinical trials are recommended to include the actual target population.[3]

trials on sarcopenia, there is a significant probability that health benefits may not outweigh potential undesirable outcomes."[3]

The World Health Organization already recommends that all people should be physically active, the positive effects of which are similar to those described for sarcopenia.[28] In 2002, WHO investigated sarcopenia, concluding that muscle strength can be increased with resistance exercise and a protein intake of 0.8 g/kg/day, which is lower than the average intake of the elderly people included in sarcopenia studies.[29 30]

Does the diagnosis cause unintended effects?

To our knowledge, no studies have investigated the potential unintended effects or harms of being diagnosed with sarcopenia. It is therefore not possible to assess the balance of benefits and harms, an essential part of the process of recommending a new disease.[31-33] ICFSR uses the GRADE system to evaluate evidence but assesses undesirable outcomes only in relation to vitamin D supplementation, stating that a "major concern is the lack of robust, large scale clinical trials with long term follow-up for older adults with sarcopenia."[3]

Risk of overdiagnosis

The decision to classify a phenomenon as a disease involves a delicate balance between several factors, among which the benefit-to-harm ratio and the ability to separate normality from pathology are essential. When this balance is skewed, overdiagnosis is likely to occur.

Clinically assessing and improving the health of a vulnerable patient does not necessarily require more diagnoses than those already available

Overdiagnosis is broadly defined as "making people patients unnecessarily, by identifying problems that were never going to cause harm or by medicalising ordinary life experiences through expanded definitions of diseases."[34] It occurs across all medical disciplines and is a harmful and costly global problem in modern healthcare.[33-36] No studies have investigated the possibility of overdiagnosing sarcopenia.

Proponents of classifying sarcopenia as a disease have compared its benefit to that of a diagnosis of osteoporosis and hypertension: "as a means to avoid disability."[5] This comparison is questionable and assumes that these conditions are comparable—for example, that severe harms could occur if sarcopenia is left undiagnosed and untreated, such as fractures in osteoporosis and stroke and cardiovascular events in hypertension. Moreover, whereas the potential harms of overdiagnosing sarcopenia are unknown, there is evidence that overdiagnosis of osteoporosis and hypertension could lead to increased absenteeism from work, lower self-rated health, and psychological and relationship harm from, for example, anxiety and depression.[37-43]

Early prevention or overdiagnosis?

Research into age related loss of muscle mass is undoubtedly important and will become even more valuable in the future as the population ages. From this perspective, research into establishing sarcopenia as a disease is reasonable. Benefits such as medical treatment and easier access to help from social care systems and health insurance providers could follow a diagnosis. In addition, a diagnosis might motivate patients to pursue a healthier lifestyle. Thus, establishing sarcopenia as a disease may come to be seen as a great medical achievement.

However, as essential diagnostic questions remain unanswered, diagnosing sarcopenia in clinic deserves further consideration. If sarcopenia is considered a disease, the current uncertainties among researchers will be passed on to clinicians, and eventually patients. Clinicians accountable for patients need to be comfortable with the justification of the disease status and the evidence that underpins it.

How to do better

Before establishing sarcopenia as a disease we need evidence that it meets essential diagnostic criteria. From a medical perspective, clinically assessing and improving the health of a vulnerable patient does not necessarily require more diagnoses than those already available.

Muscle wasting has long been recognised as a problem in the elderly population, but until medical science provides evidence in favour of a diagnostic category, we should look at sarcopenia as Rosenberg originally did—as a natural phenomenon of age related loss of muscle mass. A broader view may also support the creation of social, economic, psychological, and educational initiatives that consider not only the biomedical but also the social, psychological, and existential problems of growing older.

Christoffer Bjerre Haase, PhD fellow
John Brandt Brodersen, professor, University of Copenhagen
Jacob Bülow, researcher, Bispebjerg Hospital, Copenhagen
jacob.buelow.02@regionh.dk

Cite this as: *BMJ* 2022;376:e052592

LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

How can we help asylum seekers?

GPs have been tasked with assisting thousands of recently arrived migrant patients with little knowledge of English or UK healthcare systems. They are being warehoused in contingent or dispersed accommodation awaiting very delayed asylum decisions. Many are ill and have suffered horrible experiences.

Farrant and colleagues (Cover, 8 January) describe practical methods of trauma informed care developed by the Respond project for reducing harms to these very vulnerable children, women, and men. Their accommodation is funded by the Home Office through private contractors. Conditions in these sites have drawn widespread concern. Families may remain in one hotel room for many months or be transferred with minimal notice across the country.

Decisions to transfer migrants are taken on a weekly basis but are rarely communicated in good time to those affected. Medically unplanned relocations are common, though no data are published. Moving patients without consideration of medical consequences has led to interruptions of treatment and investigation, with serious consequences for them, for public health, and for health services. Many practices are unwilling to register asylum seekers.

What can doctors do to reduce avoidable harm to these patients? Patients should be given copies of their summary care records in print and electronically. This could include identification of scars and trauma symptoms indicative of torture or other human rights abuses. Several advice sheets are available for patients explaining their rights to NHS care. At least one clinical commissioning group has told practices to inform accommodation contractors and the Home Office's "independent medical adviser" about patients' clinical circumstances mandating delayed transfer. This clearly requires informed patient consent and regard for confidentiality.

The adviser's remit and decisions should be subject to scrutiny and appeal. Finally, harms and risks from medically unplanned transfer should be audited and the results published.

Frank W Arnold, doctor, London

Cite this as: *BMJ* 2022;376:o302

HEALTHCARE FOR ASYLUM SEEKERS

Recognise suffering and improve responses

Thank you for emphasising the acute health injustices that asylum seekers face (Cover, 8 January). I provide expert witness reports for asylum seekers' humanitarian health needs. The documentation that healthcare professionals provide is vital.

Experience of trauma, torture, and other violence affects trust in healthcare professionals, and many asylum seekers do not attempt to access healthcare even in times of great pain. Initiatives such as Respond—that create communities between asylum seekers and healthcare professionals—are life saving.

Farant and colleagues note the impact on mental health of waiting for a decision about an asylum claim. This point must not be underestimated. I have worked on cases that have been ongoing for over 10 years.

Medical education on refugee and asylum seeker healthcare is lacking, and I hope that along with greater recognition of suffering there will be improved responses to how such suffering is treated to integrate medicine with morality.

Ayesha Ahmad, academic senior lecturer in global health, London

Cite this as: *BMJ* 2022;376:o221

Advocating for migrants outside the system

The Respond model designed to meet the complex needs of asylum seekers (Cover, 8 January) mirrors other attempts to "bridge the gap"—both between the healthcare system and patients who are often excluded and between primary and secondary care.

Even more vulnerable than newly arrived migrants are those whose asylum claim has been rejected and are at risk of either exiting the system and living "undocumented" or being placed in an Immigration Removal Centre while they await enforced return to their country of origin.

Research into the healthcare standards of Immigration Removal Centres is limited, but people who have been detained describe major issues with healthcare provision and quality. Doctors employed in these settings run the risk of conflicting obligations to their patient and employer.

Improving services for new asylum claimants is of the utmost importance, but we must also continue to advocate for patients as they "exit" the system.

Nathaniel J T Aspray, GP, Gateshead

Cite this as: *BMJ* 2022;376:o272

FETAL ALCOHOL SPECTRUM DISORDER

Following Australia's example

Aiton describes the UK government's needs assessment for fetal alcohol spectrum disorder (FASD) as "a wake-up call to a wide range of health professionals" (Editorial, 8 January). More than this, substantial investment will be needed to improve the current situation. The UK could do with following Australia's example in terms of commitment to FASD prevention, diagnosis, and support.

Australia, like the UK, has an estimated prevalence of FASD of over 2%. Australia has recently committed to a substantial investment of A$37m (£20m) for FASD diagnostic services and has launched a national awareness campaign. Critically, a substantial proportion of the funds will be spent on boosting FASD services, so that people affected by this condition can get the diagnosis and the support that is vital to reduce longer term adverse outcomes.

The UK needs to make a proportionate investment to make sure that the needs of people with FASD are met.

Penny A Cook, professor of public health, Salford; Raja A S Mukherjee, consultant psychiatrist, Redhill

Cite this as: *BMJ* 2022;376:o279

Belfast—a personal journey

We went to the cinema last week. Hardly something to write about. But this was different. It was the first time since the start of the pandemic. And it was different in another way too. Usually we go for entertainment, but this time it was a personal journey, to see a film that took me back to the city of my birth. That film was, of course, *Belfast*. Written and directed by Kenneth Branagh, another Belfast boy who later moved to England, this semi-autobiographical film is shot in black and white. It conveys the grim reality he experienced as a child in 1969, growing up in poverty just as what we now know as the Troubles were beginning.

The Belfast captured in the film, and experienced by the young Branagh who is loosely represented by the 9 year old Buddy, its star, was in many ways far from the one I inhabited. He lived in what was then one of the most deprived areas in western Europe. Rows of two up two down Victorian houses had only outside toilets. Some didn't have running water. I was brought up in the leafy suburbs, with parents, uncles, and cousins who were doctors. But I was familiar with the scenes portrayed. My parents' general practice straddled the sectarian divide. Their patients were divided by their religion, but united in poverty.

Riots, barricades, bombs

Often I and my brother, who would later take over their practice, would help out in their surgery or the local pharmacy. And it was at those times that we, like the young Branagh, witnessed riots like those portrayed graphically in the film. I still recall the time, when crossing a barricade, that a volley of shots smashed into the wall a few metres above my head.

As my school was in the centre of Belfast, lessons were frequently interrupted by bombs. For us the greatest risk was from those that went off as we went home. We were fortunate that no one in my year group was killed (although one, who joined the police, would later be murdered). But we did have many close escapes, more than once coming home covered in the ingrained soot released by explosions, sufficiently shocked for my teetotal great aunts to reach for the medicinal brandy.

So what has this to do with medicine? A lot. Just like his father, played by Jamie Dornan—himself the son of a professor of obstetrics who taught me as a student—Buddy's grandfather had gone to England for work when he was younger. He had worked in the coal mines and his lungs bore the scars. We see him in Whiteabbey Hospital, a TB hospital in which my mother worked before I was born. We don't know whether it was TB or lung cancer that killed him. But even if it wasn't on the death certificate, we are left in no doubt of the role that poverty played, what we now call one of the "causes of the causes."

Again, this was all too familiar to me. After graduating, I started on a journey that I hoped would lead, eventually, to a consultant post in medicine. Three years later, with my newly acquired MRCP, I began a series of medical registrar posts, soon taking up a research post in the Department of Medicine at Queen's University. But the work I was doing in the laboratory was miles away from the problems of the patients I was seeing, patients from the same part of Belfast that the young Branagh had left over a decade earlier. TB was still common and some even had scurvy or beri-beri. It was then I decided to change direction, joining the public health training programme.

The introductory course I now teach takes my students through the different determinants of health. We start with the scientific, the mechanisms I learnt in my pathology lessons, before moving on to the social determinants, so clearly conveyed in the film.

We then move on to the corporate determinants of health. They don't feature in the film, but they were something I was also very familiar with, even if, like "social determinants" I never used those words. I learnt about the role of the flax industry in high rates of byssinosis and the toll of asbestos related disease in shipyard workers. The first death certificate I wrote was for a man who had retired weeks earlier after a lifetime working in a tobacco factory. He had spinal secondaries from a primary in his lung. Even then, in my youthful naivety, I reflected on how the free cigarettes they handed out had saved them from paying his pension.

It is the political determinants that, for me at least, provide the backdrop for the scenes in the film. As a child, looking at the miserable conditions in which my parents' patients lived, regardless of religion, I wondered why they didn't join together to demand better conditions. Later I would learn that

The city in the film was in many ways far from the one I inhabited. But I was familiar with the scenes portrayed

the prospect of a united working class was a threat to those who wielded power, whether as employers or religious leaders (of both denominations). It was only later I discovered research, to which I would subsequently contribute, showing that divided societies are less willing to invest in collective goods, such as social infrastructure or health services.

Divided societies

Since I left Northern Ireland my work has taken me to many other divided societies, including Sarajevo under siege, the Russian-Georgian border, Lebanon, and Israel. Each was different, but there were many parallels. The suffering I saw was firmly rooted in the actions of politicians.

I am sure that my experience in Belfast has given me a deeper understanding than I would otherwise have had. And it shaped my response to those politicians who still encourage division, including those who have promoted a hostile environment for migrants in the UK and who, unforgivably in my view, are currently using Northern Ireland to pursue their deeply misguided Brexit policy.

One recurring scene in the film has Buddy with a drawing of a fork in a road. Kenneth Branagh and I have followed very different roads since leaving the city of our birth. But both of us were shaped indelibly by our experiences there. And for me, while his film is not primarily about public health, it reminded me why, all those years ago, I set out on the road that I have followed for four decades.

Martin McKee, professor of European Public Health, London School of Hygiene & Tropical Medicine

Cite this as: *BMJ* 2022;376:o278

OBITUARIES

David Samuel Filer

GP and police surgeon (b 1931; q Cambridge 1958; FRCGP), died from aspiration pneumonia on 3 December 2021

David Samuel Filer was a GP in Shepherds Bush, London, and a forensic medical examiner for Hammersmith and Fulham police stations for over 30 years. He was a GP trainer and international lecturer in forensic science, as well as the "anonymous" GP behind the column "A Week in the Surgery" in *GP* newspaper. A former chairman of the local medical committee and the local family practitioner committee, he was involved in undergraduate selection at Charing Cross Medical School, postgraduate teaching for GPs and police surgeons, and was a former chairman of the London Police Surgeons. David died from aspiration pneumonia at the Royal Free Hospital in London while being treated for bladder cancer. Predeceased by his wife, Lesley, in 2017, he leaves four daughters, 11 grandchildren, and four great grandchildren.

Gail Tchiprout

Cite this as: *BMJ* 2022;376:o65

Oscar William Hill

Consultant psychiatrist (b 1929; q Cambridge/ Middlesex Hospital 1956; FRCP, FRCPsych), died from mitral valve disease and old age on 29 March 2021

Oscar William Hill did his clinical studies at the Middlesex Hospital, where, in addition to learning a great deal of medicine, he taught himself to swim in the nurses' pool and learnt to carve a turkey while on the wards at Christmas. He joined the training rotation at the Maudsley in 1961. He gained a consultant post at the Middlesex in 1974, based at St Luke's Woodside Hospital in Muswell Hill. Every year, Oscar took his family to spend Christmas Day with the patients, drawing on the turkey carving skills he had learnt as a medical student. On his retirement he was honoured by having the Oscar Hill Service for patients with borderline personality disorder named in his memory. He leaves his wife, Jennifer; children; and grandchildren.

Sarah Williams

Cite this as: *BMJ* 2022;376:o33

Abu Khaled Muhammed Akramul Haq

Consultant anaesthetist (b 1941; q Chittagong Medical College, University of Dhaka, East Pakistan, now Bangladesh, 1966; DA, FFARCS), died from aspiration pneumonia after a cerebrovascular accident on 5 September 2021

Abu Khaled Muhammed Akramul Haq ("Akram") arrived in the UK in 1968 to undertake higher training. He was appointed consultant anaesthetist at Queen Mary's Hospital, Sidcup, at the age of 34. He later moved to Havering NHS Trust, Romford, in 1995 and retired in 2009. Akram was a keen follower of sports, especially cricket. He was a popular and active member of his local community in Dartford, Kent, holding positions on the Racial Equality Council. He was respected by his peers and colleagues and was elected president of the Bangladesh Medical Association in the UK in 1995. He leaves his wife, Rosie; three children; and four grandchildren.

Mohammed Wajed, Shabana Haque, Noel Haque

Cite this as: *BMJ* 2022;376:o63

Sajidah Asmat Hussain

Consultant orthopaedic surgeon (b 1969; q Nottingham, 1994; FRCS (Orth) Edin, MSc), died from haemopericardium secondary to dissecting aortic aneurysm on 8 November 2021

Sajidah Asmat Hussain ("Saj") was possibly the first student at Raund's Comprehensive School to obtain a place at medical school. She did her postgraduate training in Nottingham, Derby, South East Thames Region, and Sydney. She tried multiple surgical specialties before settling on orthopaedics. She was appointed as a consultant orthopaedic surgeon with an interest in upper limb surgery at Lincoln County Hospital in 2010. Her main interests were shoulder arthroscopy and replacement. She visited and operated with experts in the UK, Europe, the USA, and Japan to develop new techniques to deliver an outstanding level of care. Saj leaves her husband, Richard; daughter, Tara; and three older siblings.

Richard Long, Mark Rowsell

Cite this as: *BMJ* 2022;376:o25

James Robert Murray

GP, co-founder of Shire Pharmaceuticals, author (b 1944; q Charing Cross Hospital, London, 1967; MRCS, MRCGP, DRCOG, LRCP, FFPM), died from seizures and traumatic brain injury on 5 December 2021 after a fall in June

James Robert Murray ("Jim") had a career that stretched across obstetrics and gynaecology, general practice, pharmaceuticals and drug discovery. Later he worked in HM Courts and Tribunals Services and became a published author. In 1975 he left general practice to pursue a career in drug development. In 1986 Jim, together with three others, co-founded Shire Pharmaceuticals. He became full time research director in 1990 and scientific director just before Shire's successful flotation on the London Stock Exchange in February 1996. Throughout his life, Jim was a passionate charity campaigner. He leaves his wife, Sue; six children; and eight grandchildren.

Toby Murray, Tom Philipp James Murray

Cite this as: *BMJ* 2022;376:o24

Kenneth Francis Robinson

General practitioner Repton, Derbyshire (b 1925; q Cambridge/ London, 1950; MA, DRCOG), died from old age on 12 August 2021

Kenneth Francis Robinson ("Ken") did national service with the Royal Air Force before training as a GP in Malvern and Newbury. He moved to Repton in Derbyshire, where he enjoyed a career as a "traditional" country GP, getting to know all his patients personally. The practice covered beautiful farmland, and on some occasions farmers would arrive on tractors in thick snow to pick him up to attend a home delivery or a sick patient. Ken was a passionate gardener and was often consulted about plant diseases as well as human ones. Later in life, he and his wife, Jane, moved to Letcombe Regis, Oxfordshire, to be near family. Predeceased by Jane, Ken leaves three children, eight grandchildren, and four great grandchildren.

Elizabeth O'Keefe , John Robinson, Philip Robinson

Cite this as: *BMJ* 2022;376:o22

Paul Bekkering

GP and co-founder of one of the first abortion clinics in the Netherlands

Paul Bekkering (b 1930; q Leiden, Netherlands, 1959), died from old age on 13 October 2021

Dutch GP Paul Bekkering recalled the 1970s and confronting a Roman Catholic padre demonstrating vociferously in the street outside the abortion clinic where he worked. Eventually the doctor turned away: debating was "pointless." Yet he and his and colleagues' actions were changing Dutch medicine.

Bekkering was one of four doctors who defied conservative Dutch society to establish the first official abortion clinic, Arnhem's Mildred House in 1971, 13 years before the practice became legal.

Early life and career

The conscientious local GP with a background in the Dutch colonies was not an obvious social radical. But when approached by, often very young and poor, women facing backstreet clinics or forced to try to travel abroad for an abortion, he was adamant. "Women ask for your help and then you have to do it, full stop," he recently told a television documentary looking back 50 years since he made history.

His teenage experiences shaped his view of human suffering. He was born in 1930 in Medan, Sumatra, into the privileged colonial world of the Dutch East Indies, the son of a water engineer. His mother died when he was 6, and five years later Japan entered the second world war, overrunning the colony. Paul, still only 11, spent three years in prison camps ending up in Si Rengorengo. There he experienced starvation, dysentery, malaria, and witnessed human suffering in the cruel regime. This seemed to drive his later work.

In 1968 Bekkering travelled to the UK to research safer abortion techniques

ARRE BEKKERING

After liberation, Bekkering's family returned to the Netherlands, where he quickly caught up on education, gaining a place to study medicine at Leiden University. There he met his future wife, Marye Merens, who understood him, having shared his childhood experience of Japanese prison camps: she was imprisoned on Java.

They married in 1957, he qualified two years later, and they settled down in Rheden, a small town just east of Arnhem, raising four sons. He was the local GP and his wife the practice assistant and later psychotherapist.

In the early days of the contraceptive pill, women would come to the family's home at night to beg for a prescription. Sometimes, if contraception failed, they would be left to the mercy of unscrupulous doctors doing a bad job. Bekkering tried referring women to hospital gynaecologists, but, with abortion still illegal, they all refused.

He researched contraception and in 1968 travelled to the UK with three colleagues with whom he would later launch Mildred House. With abortion now legal they visited London's Langham Street Clinic and the Birmingham Family Planning Clinic to study new, safer abortion techniques, including suction curettage.

Bekkering's doctoral thesis, *The Patient, the "Pill," and the GP*, appeared in 1969. At the same time the Foundation for Medically Responsible Pregnancy Termination (Stimezo) was launched. It was a time too when the Dolle Mina feminist action group were demanding to be the *Baas in eigen buik*, literally "boss of their own belly."

At a public meeting it emerged that Bekkering and colleagues' plans for an abortion clinic were the most advanced, so Stimezo backed them. In September 1970 he launched Mildred House—with Willem Boissevain, Conny Schreuders-Bais, and Emma van Waalwijk—plus a clinic nurse, Jeannette Corstiaensen.

Five months later, on 27 February, the first of 600 abortions planned each year took place, a number which would eventually increase to 4000. Two weeks later a letter was sent to GP colleagues in the region, informing them of this work. Not all responded favourably. The building, a detached house in a residential district, attracted demonstrations every fortnight.

Change in the abortion law

Arre, then 14, recalls how he and his brothers were forbidden from mentioning his father's work outside the house and how it remained uncertain whether his father would be prosecuted and jailed. More clinics followed elsewhere, however, as local authorities chose to tolerate abortion. A law permitting abortion in a licensed clinic or hospital was finally passed by a single vote in the Dutch Senate, coming into effect in 1984. Today almost 90% of abortions are still carried out in specialist clinics.

Bekkering recalled that he was just an ordinary GP but, to his surprise, he and the others were dragged into the abortion movement. They had an "avant garde mentality, a little revolutionary," he recalls but were "doing something good that was needed."

Predeceased by Marye in 2019, Bekkering leaves their four sons.

Tony Sheldon, Utrecht, Netherlands
tonysheldon5@cs.com

Cite this as: *BMJ* 2021;375:n3054