comment

"Unless £4.8bn is a taster the white paper will not level up the UK" **MICHAEL MARMOT**
"By April we could be flying blind as to covid infection prevalence" **HELEN SALISBURY**
PLUS The stigma of mental ill health in the NHS

ACUTE PERSPECTIVE David Oliver

How much say do doctors have over policy?

I sometimes see doctors complaining that we're ignored and marginalised by politicians, government, and national agencies in health policy decisions. I think we have more influence than we realise. That doesn't mean getting all of our wishes granted—even when we agree what our priorities are. And our influence will wax and wane depending on how sympathetic the government is and how conducive the wider economic and political climate.

Not winning every argument doesn't mean we haven't won any. Some of the biggest wins are policies we stop or modify before they're enacted. In a heavily centralised and politically accountable state system, medical professionals need to work hard to campaign on how healthcare services are funded, designed, and delivered. We have four key strengths in influencing.

First, professional credibility. Doctors and nurses consistently top the league for public trust, and the NHS remains the institution that makes people most proud of the UK. Our daily conversations with patients and their families influence public perceptions and hence politicians.

Second, position. Doctors have senior roles in government departments and national agencies. Their power is partly positional, but they're also credible experts and advisers. This extends to doctors on standing advisory committees.

Third, collective power. Medical membership organisations and patient group charities have tremendous influence. Sometimes they do this by campaigning, and sometimes they respond to policy consultations, resulting in the modification, improvement, or dropping of policy initiatives.

Fourth, expertise and evidence. Doctors produce new research, evidence summaries and data, evaluation of service models, and audits that can affect policy thinking. These may involve public interventions for preventable ill health and inequalities, NHS workforce or care gaps, or better treatment access and capacity.

Doctors are rarely expert in policy, campaigns, or communications. We need skills and training and a greater focus on measuring our impact. We can also form campaigning coalitions with other professions, charities, sympathetic politicians, or media around a common cause.

Finally, although speaking truth to power is important, and while swathes of public policy are not in our gift, service leadership and best practice are central to medical professionalism. We must be seen to be offering constructive solutions and not just looking for government help or criticising every policy decision.

We are stronger than we think. Even if it doesn't always feel like it.

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Service leadership and best practice are central to medical professionalism

OPINION Michael Marmot

The levelling-up plan: a missed opportunity

It is time for ministers to reverse course after a decade of austerity

"Bliss it was in that dawn to be alive but to be young was very heaven." Wordsworth may have moved from the lakes in the north of England to France by the time he wrote Book 10 of *The Prelude* but, then as now, bliss is unevenly distributed in Britain and the heavenly nature of being young depends a great deal on where in the country you live. Being young in the north of England—"north" being from the Midlands on up—means life chances are a good deal worse than being young in the south. Risk of death at most ages is greater: over the decade from 2010 onwards the health disadvantage in the north grew bigger, and it got worse again with covid-19.

A particular challenge to improving health is that, in general, health inequalities are bigger in the north east and the north west than they are in London and the south east. Classify people by where they live and classify where they live by the Index of Multiple Deprivation and we find, for people living in the least deprived decile, there is little regional variation in life expectancy. If you're rich it matters little in which region you live. But the greater the deprivation, the greater the health disadvantage of living in the north. Or, to describe the same data differently, the social gradient in life expectancy is steeper in the north than in London and the south east. It has been thus at least since the 1970s.

Social determinants of health

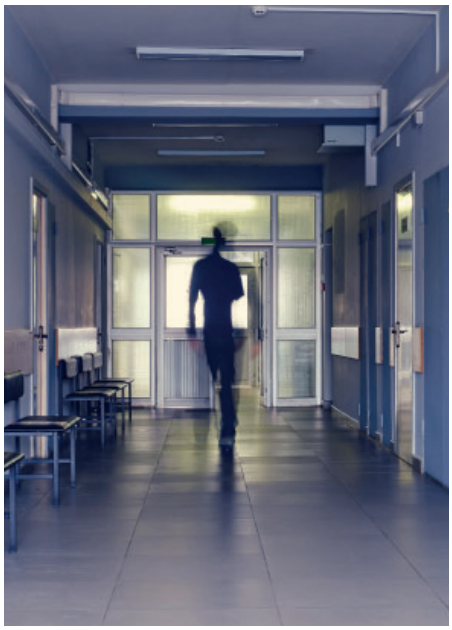
In the decade after 2010, the life expectancy gradient in the north grew steeper still. Worse, life expectancy for the poorest decile declined in the north east, Yorkshire, and Humber. Years spent in ill health increased. Our several reports from the UCL Institute of Health Equity, and others, make clear that these health inequalities are not primarily a healthcare issue, but have much to do with the social determinants of health (the conditions in which people are born, grow, live, work, and age) and the structural drivers of those conditions (macroeconomic, environmental, and the structure of society, including institutional racism).

The white paper funding allocation of £4.8bn shows the ambition is not yet equal to the task

It is likely, based on the evidence, that a decade of austerity and rolling back of the state from 2010 on is the root cause of this worsening health situation. Arguably,

OPINION Anonymous

Mental illness stigma made me hang up my stethoscope



I was a paediatric registrar driving home from an afternoon spent carrying out child protection examinations. At the traffic lights, the red light turned to green and the driver behind me honked their horn. I had fallen asleep at the wheel, the fourth time in two days. I was in the midst of a depressive episode and plagued with anxiety, but I went to work with a smile. I was fine. I had to be.

Two weeks later, I was signed off from work by my psychiatrist. As I left the appointment, I mentally listed the endless reasons why I couldn't possibly take time off. The shame and sense of failure I felt were overwhelming. I phoned my clinical lead and explained the situation. His first words: "When will you be back?"

Like many doctors, I had tried hard to conceal my history of mental health problems at work, preferring to live in silence than to risk professional prejudice and disgrace. Passing comments I had heard during patient handovers and derogatory phrases used by doctors such as "crazy," "mad," "attention seeking," or "psycho" had made me recoil even more from disclosing my struggles. In

Healthcare workers are not, and never were, superhuman

all the areas of medicine I had worked, an undercurrent of stigma attributed a level of blame to those with mental illness, as though it was somehow self-inflicted. Not knowing how else to manage these attitudes, I internalised them, growing to believe them to be true.

Self-stigmatising views are well documented among doctors and form a major barrier to returning to work after time off with physical or mental illness. This was no different for me. Three weeks off sick turned into 11 months, during which time I convinced myself I would never practise medicine again. I became the patient: therapy, medication, appointments. Yet with support and a well planned phased return, I successfully went back to paediatrics. I worked regular shifts with no out-of-hours for a year, proving to myself that I could indeed be a doctor again. Yet to complete my training I was required to recommence night shifts and change hospitals—things that I knew

government policies from 2010 to 2020 increased the slope—and so sloped up, rather than levelled up.

It is time to reverse course. *Levelling Up*, the much awaited government white paper, sets out the diagnosis of the problem and what needs to be done. There is much that is good in the white paper's 332 pages. It has four objectives for deprived parts of the country: boost productivity, pay, jobs, and living standards; spread opportunity and improve public services; restore a sense of community and local pride; empower local leaders and communities. It's hard to argue with any of that, particularly giving powers to metropolitan mayors. If those objectives were achieved it is highly likely that inequalities in healthy life expectancy would be reduced. The white paper then sets out 12 missions that cover living standards, transport, research and development, digital connectivity, education, skills, health, wellbeing, pride in place, housing, crime, and local leadership. What's not to like? Achieve the other 11 missions and health equity will improve.

The problem is that this white paper reads as though it was not the product of a political party that has been in power for 30 of the last 43 years and is responsible for much of the damage. Manchester was the home of the industrial revolution, but the widespread de-industrialisation of the 1980s wreaked economic havoc on the north and tore at the heart of communities. The rise of the service sector contributed to the prosperity of London, but did little for the north.

Further, the austerity policies of the governments from 2010 onwards caused more hardship. Public sector expenditure fell, child poverty rose, and there were sharply regressive changes to tax and benefits. Latest figures from the Food Foundation show that 8.8% of households—4.7 million adults—experienced food insecurity in the past month. In the context of levelling up, the post-2010 cuts to local government are really telling—the more deprived the area, the steeper the cuts. It has been estimated that cuts to local government in the north amounted to £413 per person. By contrast the 2021 allocation from the levelling-up fund amounts to £32 per person in the north.

The government could argue that they want to make a fresh start, but the allocations thus far show that their ambition is not yet equal to the task. The 2021-24 allocation of levelling-up funds, according to the white paper, is £4.8bn. The white paper draws attention to what Germany spent to "level up" when the former Democratic Republic joined the Federal Republic: €2trn over 25 years—about £70bn a year.

If the current £4.8bn is a taster, a start, and the white paper represents a whole scale rejigging of government, with resources on the scale of Germany's levelling up, then the objectives and missions are exactly what is needed. If, as the UK chancellor has made clear, the regressive cuts to public expenditure will not be reversed and, when he can, he is more interested in cutting taxes than levelling up, we can expect health inequalities to continue. A missed opportunity.

Michael Marmot, professor and director, Institute of Health Equity, UCL

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were not good for me. Feeling undervalued and unfulfilled, I began to contemplate a career outside of medicine.

Like many doctors, I found it hard to imagine a different life for myself; my training had been so niche and my language was so full of jargon. Yet as medics we have a multitude of transferable skills, and so in 2019 I hung up my stethoscope to retrain as a primary school teacher.

In March 2020, along with the 15 000 other doctors who had left the GMC register or given up their licence in the past three years, I was asked to reinstate my registration to help during the covid-19 pandemic. I was halfway through my teacher training and knew I was not emotionally resilient enough to return to a completely overwhelmed NHS so I opted out. Guilt and cowardice consumed me. Instead, I homeschooled my children and continued my studies, watching the toll that the pandemic was taking on my medical colleagues.

There is no doubt that my experience as a paediatrician has shaped the way I teach and communicate with pupils and their families. The relationships I have with the children reflect the empathy I showed to my patients, and colleagues have commented on how pupils with additional needs benefit from my medical background. Although I now have a new career, being a doctor is still inextricably part of who I am. This core sense of "medical self," described by Clare Gerada in her book *Beneath the White Coat*, is and always will be part of my identity.

As we begin to emerge from what has hopefully been the worst of the pandemic, I find myself contemplating a return to medicine. Yet I worry whether my mental health will survive in a culture where stigma still prevails.

At a time when more healthcare staff than ever are likely to be emotionally and mentally depleted, we must focus on creating safe environments where health professionals can be supported to talk and reflect on how they feel. There are resources and guidance out there on how organisations can reduce stigma and encourage conversations about mental health, including tackling ignorance, opening up the conversation, and using personal testimonies to normalise mental health struggles. Several services also provide NHS staff with online, confidential peer support groups that are facilitated by an experienced practitioner, which have proved successful during the pandemic. NHS trusts and other healthcare organisations should highlight these services to their staff and continue to find ways to promote an open culture about mental health.

This pandemic should put an end to the myth that our healthcare workers are somehow invulnerable to the frailties that are an inevitable part of being human. We are not, and never were, superhuman. Talking was what saved me. And by revealing a more vulnerable and honest version of myself, the people around me felt able to share the parts of their lives they had chosen to conceal. Many healthcare staff will be feeling grief stricken and defeated by the events of the past two years, yet workplace stigma around mental health will only make this worse. It is only by talking that we can start to break down these barriers and begin to heal.

Anonymous ex-paediatric ST5, UK

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PRIMARY COLOUR Helen Salisbury

Why numbers matter

Medicine involves lots of measuring and counting. We weigh babies to check that they're thriving (and especially when we're worried that they're not). We monitor blood pressure, blood sugar, cholesterol, and kidney function. At a practice level, we measure the proportion of our patients who have had their cervical smears done or been given advice about smoking, and we're incentivised to do this through the Quality and Outcomes Framework (QOF).

Measuring is rarely neutral. It focuses attention and, even with no other specific intervention, can bring change. This monitoring effect is the reason some people will improve their fitness when they use an exercise tracker or will lose weight after logging what they eat. For both the individual patient and medical organisations, we're often chasing targets, getting a blood parameter to below X or waiting times down to Y. Over the years there have been many debates about QOF, and advocates for patients with illnesses that don't feature in the framework have highlighted that doctors' attention and efforts may be skewed instead towards areas that are rewarded.

At a fundamental level, it's impossible to count or measure every ingredient of high quality general practice. What my patients may need most is my quiet attention while they struggle to express their grief, their pain, or the fear sparked by an innocuous symptom and an online search. The ability to reassure is dependent on trust and may rely on a relationship built over many consultations—something not caught by any metric. There's no tick box to say, "Patient reassured; no investigations necessary," although this is arguably one of the biggest contributions GPs make to the efficiency of the NHS.

Just as measuring something can highlight its importance, failure to do so can suggest the opposite. And ceasing to measure something that used to be regularly monitored and reported sends a strong message. Since we're no longer required to do a confirmatory PCR test after a positive lateral flow, the only reliable count of covid infections in the UK now comes from a weekly survey by the Office for National Statistics. Last week we learnt that not only does the government intend to stop publishing daily statistics but the survey itself may be stopped in April—meaning that we'll be flying blind as to the prevalence of infection, the emergence of mutations, and the ongoing risk to our vulnerable patients.

I can only hope that no one in a position of power believes this level of ignorance about an ongoing pandemic would be helpful—and that these decisions will be rapidly reversed.

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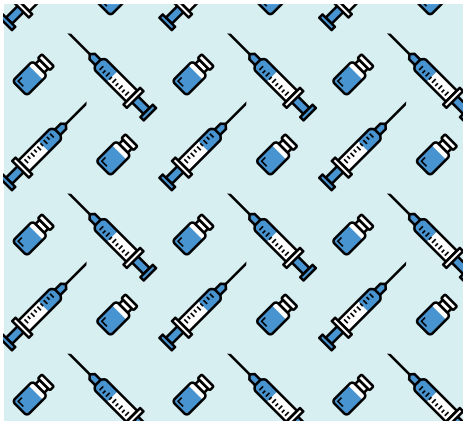
Just as measuring something can highlight its importance, failure to do so can suggest the opposite

LATEST PODCAST



Covid-19 vaccine mandates

In many countries vaccine mandates are being rolled out, but are they without harm and do we have evidence about how effective they are? In this episode of Deep Breath In, Juan Franco, a GP in Argentina and the editor in chief of *BMJ Evidence-Based Medicine*, talks about how we might assess the efficacy of a mandate:

"Effectiveness will always try to focus on patient outcomes, which would have to do with reducing hospital admissions, deaths, or cases, but most of the evidence here is based on surrogate outcomes, such as uptake of vaccines. So, with a mandate, we're thinking that if vaccines are effective and vaccination rates go up, then we will have better outcomes, so that's a little bit indirect."

Franco talks about how this evidence might be sought: "Ideally, we'd do randomised controlled trials or other types of trials—for example, step wedge trials in which you can randomise neighbourhoods into progressively taking a mandate and seeing how effective that is in increasing the vaccination rate. That would be the purist side of evidence based medicine. But at the same time, we have to think about the benefits and harms of this intervention. So, for instance, with a vaccine mandate, are we marginalising a group of people, especially minorities, that there's existing evidence to say there's more hesitancy in. If you have a mandate, what kind of message are we sending to those people? A lot of these questions that relate to the benefits and harms need another type of evidence. Perhaps we need more qualitative evidence and more evidence from sociology and other disciplines that will help us understand what's going on."

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

ANALYSIS

A post-covid economy for health: from the great reset to build back differently

A return to a business as usual economy would be a fatal mistake argues **Ronald Labonté**

PRIYA SUNDRAM

The global economy was still struggling with the fallout of the 2008 financial crisis when the covid-19 pandemic hit, collapsing supply chains and depressing economic activities worldwide. Almost immediately there was talk of the need for a "great reset" or to "build back better," hinting that any economic recovery to pre-pandemic normality should not simply default to business as usual. The pre-pandemic economy was already creating massive wealth inequalities, accelerating climate change, and fomenting mass migrations of people fleeing poverty, drought, or conflict.

Are any of the policy playbooks arising from the economic chaos of the pandemic sufficient to ensure equity in people's access to the resources needed for health? Or are more radical measures needed to improve health equity globally while ensuring ecosystem sustainability? Are such measures even compatible with capitalism, however reformed this centuries' old system may become?

Are any of the policy playbooks sufficient to ensure equity in people's access to the resources needed for health?

NEIL WEBB

KEY MESSAGES

- As the global pandemic recedes, "greening" economic growth and improved employment and social protection measures remain central to a more health equitable future
- Proposed reforms such as harnessing private capital for social impact investments or a stakeholder model of capitalism are likely to be insufficient
- More far reaching change is needed with governments shaping markets to ensure that economic activities achieve urgent social and environmental goals
- A transformative shift to degrowth would avoid unsustainable and inequitable consumption of finite ecological resources and ensure human survival

The great reset: tinkering on the margins

One set of ideas for a post-covid-19 economy is described by the World Economic Forum as the great reset (www.weforum.org/great-reset/). One of the initiative's proposals is to direct a small amount of the vast wealth held by private investors to businesses whose activities align with the sustainable development goals. Examples include green energy initiatives or companies pledging to hire more women executives,[1] as well as investments in health and education. Investors are told they can make a profit and still "help save the world."[1]

The concept of green, socially responsible, and ethical investing is not new, but it has enjoyed a recent surge in portfolios. While an attractive plan on the surface, it does not address why private investors have accumulated such huge amounts of wealth. Moreover, a recent study found that over 70% of these portfolios are non-compliant with global climate change targets[2] and so will do little to reduce deaths from "heat domes" or fossil fuel pollution. The profit they generate, however, will increase wealth inequalities, indirectly worsening health inequities,[3] since such investing is mostly a prerogative of those who are already rich.

A related argument advanced by the World Economic Forum's founder, Klaus Schwab, is stakeholder capitalism. Corporations' roles are (or should be) to serve not only their shareholders but also their "employees, customers, suppliers, local communities, and society at large."[4] There is little to fault the ethos that everyone should benefit from economic activities. In practice, however, critics worry that this stakeholder model would be little more than a mask covering up the structurally entrenched value maximising behaviours of transnational corporations and wealthy individuals.[5] The economy would reset as it was pre-pandemic, with little change in how its underlying reliance on constant growth and capital accumulation was imperilling global health.[6]

Central to US and EU plans is promoting a circular economy in which there is a continuous recirculation of post-consumer materials so that there is "no such thing as waste"

Build back better?

Several of the world's advanced economies have taken slightly bolder steps in their post-pandemic plans to "build back better," the slogan adopted by the Biden administration's $3.5tn 10 year budget proposal for the US.[7] Originally proposed as a more ambitious (and costly) "green new deal" with hefty government investments in climate change and environmental, health, and social protection spending,[8] the plan was subsequently scaled back to $1.75tn to appease conservatives and those with links to fossil fuel.[9] Even that amount has yet to be affirmed by that country's "flawed democracy," with extreme social polarisation and low levels of trust in institutions and political parties.[10] If it is implemented, however, some consider that it will signal a "transformative shift"[11] that provides an advocacy base for more radical environmental measures. Similar arguments apply to the EU's next generation recovery fund and European green deal, which also face challenges from some right wing nationalist member states.[12]

Central to both plans is promoting a circular economy in which there is a continuous recirculation of post-consumer materials so that there is "no such thing as waste."[13] This reduces the overall ecological footprint of economic activity, protecting land and water resources essential to people's health. By reducing pollution it also minimises health risks, especially for those in low income countries, where much of the world's toxic waste eventually winds up. Governments could encourage a shift to a circular economy by making it a condition in procurement contracts, which account for a sizeable 12% of global gross domestic product (GDP).[14] Health enhancing social obligations could also be attached to such contracts—for example, gender equity, compliance with human rights obligations, or alignment with the SDGs.

Both plans, and other versions proposed by several other countries, are likely to improve health outcomes, at least in the short term and for those countries with the tax and fiscal space to invest in them. But they face three implementation obstacles. The first is concern over governments' pandemic inflated debt. Fiscal hawks are again calling for austerity measures similar to those imposed after the 2008 financial crisis and which led to underfunded public health systems ill prepared for a pandemic.[33] The second is opposition by transnational corporations and wealthy individuals to tax increases needed to pay for government pandemic economic rescue packages, even though many of them benefited. The third is political willingness to reject the neoliberal model of capitalism that has dominated the past 40 years. Under this model governments' role in the economy has been largely confined to bailing out market failures.

Build back differently: mission economies

Mariana Mazzucato, an internationally influential economist, argues that these barriers could be overcome if governments took on more forceful leadership in mobilising public and private partners to achieve important economic, social, and environmental goal oriented "missions."[15] Rather than responding to market failures, governments should use regulations and tax policies to shape markets towards democratically decided social and environmental outcomes, especially when companies benefit from government spending and infrastructure.

Mazzucato chairs the World Health Organization's recently established Council on the Economics of Health for All. Its first mission policy brief outlined a different approach to health innovation from the flawed government responses to covid-19 vaccines that led to gross inequities in access[16] and pharmaceutical profiteering.[17] In the case of vaccines, governments could (and should) have required technology sharing by companies as a condition of the public financing that supported vaccine research and manufacture.

The council's second brief on health system financing goes further by invoking modern monetary theory. This posits that governments that have their own sovereign currency can never run out of money; they simply issue bonds to be held by their central banks.[18] Progressive and redistributive tax systems are still important, but modern monetary theory suggests that these are no longer the sole or even primary source of public financing for health, education, social protection, green growth, or climate mitigation programmes. As the economist Tim Jackson explains in an interview:

"That fundamental insight gives us the space that we need to create monetary and fiscal policies that are flexible, that are coordinated and that give government the space to manoeuvre as we navigate these huge environmental and social challenges that are facing us . . . lifting the veil of the ideology that says the government cannot afford to spend in the well-being of its citizens."[19]

To the extent that WHO has normative influence on its member states and civil society actors, the council's support of alternative economic models could help governments resist calls for post-pandemic austerity.

There are limitations. First, the trillions of new dollars created by high income countries to keep their pandemic economies afloat led to asset bubbles in financial markets and real estate. Historically, the bursting of such bubbles benefits those who are already wealthy and worsens health and living conditions for poor citizens.[6] Excess liquidity (money supply) also risks inflation, as is now being seen in rising food costs worldwide that will be hardest on the health of the poorest people.[20] Strong regulation of financial markets, targeted taxation to reduce inflation and speculative investing, and measures to restrain monopoly profiteering are all seen as companion

policies in building an economy based on modern monetary theory.[34]

Second, few low and middle income countries have sovereign reserve currencies, and most are dependent on borrowing from international lenders. This makes them particularly vulnerable to inflation, interest rate increases, and volatility in global financial markets, which risks increasing debt burdens and new imposition of austerity programmes that compromise the health and wellbeing of hundreds of millions still living in poverty. Some tax and financial policies must be reformed at global scale to prevent capital flight and redistribute wealth if all countries are to have the resources needed to improve the health of their populations.

Finally, strengthening the state's role in disciplining the market's invisible (but inequitable) hand requires governments to be less beholden to business interests and more responsive to public interests.[15] Participatory forums and progressive social movement activism are essential in the clichéd but vital task of "holding governments to account." Challenging the class based power of elite groups requires political struggle, as seen in progressive protests in many countries worldwide, from Black Lives Matter to resurging activism throughout Latin America. Protecting the public space for such struggle is now especially urgent given the rise in autocratic regimes globally and the increased suppression of opposition civil society voices.[21]

Towards an eco-just degrowth

Building back better, even if adopting a more generous mission economy approach and revitalised participatory politics, inevitably bumps up against the limits of our planetary ecosystem and a capitalist economy predicated on a continuous upward spiral of growth, (over) production, and (excess) consumption.[6] Consider the investment shift to electric vehicles, which has countries competing to produce as many or more of these as are in the fossil fuelled fleet. Vehicle generated greenhouse gas emissions will fall, but environmental damage arising from automobile manufacturing (including new emissions) and the extraction of rare metals needed for batteries will increase,[22] along with the exploitative conditions associated with their mining.[23] Structured global injustices remain, with wealthy nations continuing to inequitably consume and exhaust most of the world's natural resources, just as they did with covid-19 vaccines.

To build back differently there has to be a major reduction in and redistribution of aggregate global consumption. This is not a new argument. A half century ago the Club of Rome published *Limits to Growth*,[25] foreshadowing how the aggressively marketed consumerism of wealthier countries was not environmentally sustainable. It was also patently unjust, resting on the centuries-old and ongoing exploitation of the natural and economic capital of poorer countries.[6 26]

The path to fair consumption for all[30]

- Redistribution of material resources between rich and poor countries, and rich and poor people within countries
- Rapid transition to more resource efficient economies (from circular to regenerative material flows)
- Shift to caring economies driven by shared services and with low to no carbon intensity

More recently terms such as degrowth and postgrowth have entered the policy lexicon,[27] with calls for a democratically led downscaling of material based production and consumption worldwide. Many in poorer nations will still need to increase their level of consumption, while those in wealthier nations can make do with considerably less with no sacrifice to (and more likely improvements in) life quality, happiness, and health.[28] This planned reduction in rich world material and energy consumption would be accompanied by growth, globally, in other desperately needed areas: social care (a low resource, caring economy), green technologies, and environmentally restorative forms of "decent work."[29] An equitable reduction in consumption by humanity's wealthiest decile is essential to create space for growth in countries where livelihoods need to rise if people are to sustain good health and achieve reasonable life expectancies.

Fifty years on, the Club of Rome co-published an updated report, the *1.5-Degree Lifestyles*.[30] The report contains detailed recommendations in support of its headline policies to achieve "a fair consumption space for all" (box).

Restoring, reforming, or transforming capitalism

Our post-covid world confronts the twinned crises of gross undershoots in our social domain (inequalities in wealth as the stellar example) and overshoots in our ecosystem domain (extreme weather and climate being the most obvious ones).[31] Human and planetary health both suffer. Restoring the capitalism that preceded the pandemic, even if in stakeholder rather than shareholder form, will do little to alter this trajectory. Commitments to build back better offer some important reforms but remain too little, too late, and too prone to political capture by elite group interests.

Mission economies, if informed by a critical stance on power inequalities, afford more possibility for deeper reform without necessarily challenging the legitimacy of capitalism per se. However, they rest on the abilities of social movements and political actors to disrupt the recent rise in autocracy and to ensure more participatory governance models, from local to global scales.

A more transformative pivot would be to advance the radical degrowth policies of redistribution and avid de-consumerism. These policies draw inspiration from worker, produce, and consumer cooperatives that still do well in Europe, peasant movements worldwide, and the *buen vivir* commune based principles that pervade South American environmental activism.[32] Whatever economic model emerges: the pre-covid-19 version of rapacious capitalism is well past being fit for (human) purpose.

An equitable reduction in consumption by the wealthiest decile is essential to create space for growth in countries where livelihoods need to rise if people are to sustain good health

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Stressed systems lead to over-investigation

Oliver writes about solutions for the workforce crisis (David Oliver, 15 January). Stressed systems become inefficient, exacerbating the stress. Extra resources may not be the answer. A stressed health system must have formal and informal techniques for dealing with high demand.

The system can become more risk averse. Investigations are used to put off decisions. It's a reverse pass the parcel: the music stops when you can't think of anything else to do. Spurious diagnoses are added to the differential and get stuck there. When I have more time, I tend to investigate less, am happier to raise and dismiss serious matters, and can reassure more.

Maladaptive techniques to get through busy times can become hard wired. Stressed systems draw more resources into this maladaptive maelstrom. Guidelines then come from maladaptive coping techniques.

I have seen a shift from "doing the needful" in times of excessive demand to the paradox of busier systems being more inefficient. Productivity has plummeted. Pathway standards are higher. While often laudable, such standards may be erroneous surrogate end points. It makes you feel good when you calmly apply super-duper pathways. Patients in the waiting room, on the phone, waiting for an appointment, waiting for a 111 call back, or just giving up might take a different view. How many patients in the system are kept there, inappropriately, by us?

Often, clinicians know in their hearts that nothing useful will come from an applied pathway. As an experienced GP, I can quickly spot medically inexplicable symptoms. Even so, I often start the over-investigation, pass-the-parcel juggernaut. Strong reassurance and a social-psychological history are often all that is needed. Inappropriate, rushed indulgence of our stressed cleverness leads to scans, repeated blood measurements, repeated referrals, and incidentalomas.

Graeme Mackenzie, GP, Twickenham

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SOLUTIONS FOR WORKFORCE CRISIS

Don't leave overseas doctors in limbo

Oliver discusses action on the current NHS workforce crisis (David Oliver, 15 January). "Let's allow more staff from overseas, and treat them better," is the new war cry. "Treat them better" because reports from the past 20 years clearly show evidence of poor induction, support, and career progression, as well as differential attainment and bullying. These reports lead to written guidance and social media discussion, but not the dedicated resources and coordinated measures needed for systematic change.

Health Education England's role is to work with NHS partners to plan, recruit, educate, and train the health workforce. Should Health Education England take responsibility for the learning and training environment of newly recruited overseas doctors? Does it have enough financial resources to provide the direct support needed to deliver this remit? This needs to be made clear so that overseas doctors and the trusts employing them are not left in limbo.

Sujesh Bansal, consultant anaesthetist, Manchester

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IS THE NHS OVERWHELMED?

Something is going to crack

Alderwick's editorial explores the current overwhelmed state of the NHS (Editorial, 15 January). The only thing to add is that, drawing on a parallel from the mountaineering world, most accidents occur on the way down after an arduous climb.

The pandemic was a long, steep climb that has been emotionally and physically challenging. The descent is tiring and is getting colder and darker. In healthcare, sympathy has been replaced by hostility. Dark are the times when fear, anxiety, and exhaustion among those with patient facing roles are palpable. When the pandemic wanes, the sense of victory and relief is likely to be overshadowed by the pressures of increased demand as a result of the backlog and the ongoing mismatch between resources and societal expectations.

Something is going to crack. And, like in the mountains when the avalanche or crevasse fall destroys dreams, the dream of the NHS might shatter irreversibly.

Piotr Szawarski, consultant in intensive care medicine, Slough

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Patients ignore withheld numbers

As Alderwick points out, the NHS is not providing the level of care expected by UK citizens. Remote consultations have allowed services to continue, enabling clinicians to consult from home when isolating and reducing the number of patients in waiting areas. Patients benefit from not having to commute; many prefer to have quicker remote engagement.

But most NHS calls are from withheld numbers, and people receive far too many nuisance calls. Patients might say they have not been contacted when they have had calls from withheld numbers and presumed that they were not relevant. What if the calls were not anonymous? If, for example, all NHS hospitals were to be identified as 113 and primary care as 114, patients could easily identify the call. They would be more likely to answer and be able to contact the service in return.

Clinicians need to identify themselves to patients better when working remotely.

Pablo Millares Martin, GP, Leeds

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A LIVING WHO GUIDELINE ON DRUGS FOR COVID-19

Reconsider using convalescent plasma

In December WHO recommended against using covid-19 convalescent plasma (CCP) to treat covid-19 based on a statistical summary of selected randomised controlled trials (RCTs). Unfortunately, WHO didn't ask critical questions about treatment timing, study populations, and antibody titre of CCP in the reviewed RCTs.

Nearly all the RCTs considered were conducted in patients in hospital who had progressed to the inflammatory phase of covid-19, when CCP is unlikely to work; signals of CCP efficacy were found in subgroups of patients treated early or in less severe stages of illness. Some RCTs used CCP with an insufficient amount of SARS-CoV-2-specific antibody (Rapid Recommendations, 11 December). New RCTs in outpatients have shown that CCP reduced covid-19 progression and hospital admissions by half.

We urge WHO to revisit its recommendation by reviewing all the evidence supporting benefit, considering the pandemic conditions and RCT design features that affected the findings of most large RCTs.

Nigel Paneth, university distinguished professor emeritus, Michigan; Arturo Casadevall, Bloomberg distinguished professor, Maryland; Liise-anne Pirofski, Mitrani professor of biomedical research, New York; Jeffrey P Henderson, associate professor of medicine and molecular microbiology, Missouri; Brenda J Grossman, professor, Missouri; Shmuel Shoham, associate professor, Maryland; Michael J Joyner, Frank R and Shari Caywood professor of anaesthesiology, Minnesota, on behalf of the National Covid-19 Convalescent Plasma Project (ccpp19.org)

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PAROXYSMAL ATRIAL FIBRILLATION

CPAP for atrial fibrillation

We were delighted to see obstructive sleep apnoea (OSA) flagged as a common risk factor for development of atrial fibrillation (AF) (Easily Missed? 8 January). Patients with AF may not have OSA symptoms, so routine referral for sleep studies should be considered.

Effective treatment of OSA with continuous positive airway pressure (CPAP) has been shown in non-randomised studies to help maintain sinus rhythm after electrical cardioversion and catheter ablation in patients with AF and to prevent progression to more permanent forms of AF. Robust randomised clinical trials are needed to confirm this and to establish whether early CPAP could be sufficient as a therapy for AF and paroxysmal AF. NICE guidelines advise prioritisation of OSA assessment and treatment in patients with unstable cardiovascular disease and poorly controlled arrhythmia. This should be considered before electrical cardioversion and catheter ablation in patients with AF, alongside the assessment of other risk factors.

Sophie D West, consultant respiratory physician; Alexandra Thompson, consultant cardiologist, Newcastle upon Tyne

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REPOSITORY OF CONSULTANT DETAILS

Unintended consequences of a consultant repository

Creating a public repository that sets out consultants' practising privileges "including how many times they have done a procedure and how recently" (This Week, 8 January) is unlikely to have detected and stopped Ian Paterson. It would have enhanced his profile, as he was registered as a breast surgeon and would have had plenty of recent procedures—they happened to be inappropriate procedures.

Once again we are drifting into a response that is inappropriate for the original problem: identifying a rogue clinician. Just as the introduction of revalidation after the Shipman inquiry would not have identified Harold Shipman, the introduction of a repository is unlikely to identify a future Paterson. It will, however, almost certainly decrease the variety of procedures that a clinician is prepared to perform, resulting in even further specialisation and narrowing of experience causing the need for even more clinicians to manage the same number of patients.

D W J McCreadie, retired emergency consultant, Warwick

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HEALTH, POVERTY, AND STIGMA

Paying attention to fuel poverty

Salisbury eloquently writes about the challenges of health, poverty, and stigma in primary care (Helen Salisbury, 22 January).

The MECC Link website has contact details for a range of services based on local authority area and wider determinants of health. We are promoting this resource in West Yorkshire, particularly for affordable warmth and housing services. The website also provides questions and phrases for clinicians to use when having difficult conversations.

The West Yorkshire Health and Care Partnership is investing £1m to help keep people warm this winter. It has produced an infographic that includes signs that might indicate someone is living in fuel poverty, such as wearing lots of clothes indoors and staying in bed to keep warm, as well as leaflets summarising some of the affordable warmth services available.

We all need to pay more attention to poverty as inequalities widen and the cost of living and fuel goes up.

Claire Gilbert, public health registrar and former GP, West Yorkshire Health and Care Partnership

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VICTIMISATION OF WHISTLEBLOWER

The NHS is still shooting the messenger

I am impressed with the *The BMJ*'s honest coverage of whistleblowing and by the continued commitment of UK anaesthetists to the safety of patients who could be harmed (This Week, 8 January). It is disheartening that the NHS is still unable to investigate and manage these complaints without resorting to "shooting the messenger."

As a previous "messenger," I agree that the bullying and harassment that an NHS trust can inflict on a consultant are so extreme that life in that trust can become unbearable. Being proved right by subsequent inquiries provides little solace. The Royal College of Anaesthetists awarded me the Frederic Hewitt medal for patient safety, which should be considered for others.

I continue to work in the field of patient safety, in Australia, for a non-profit healthcare provider. We are using specialty registry data to identify "high reliability teams," thus expanding the measurement of clinical excellence in healthcare.

Stephen Bolsin, director of medical services and clinical governance, Perth

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OBITUARIES

John Wagget

Consultant paediatric surgeon Newcastle (b 1938; q Durham 1961; FRCS; FRCPCH), died from pulmonary fibrosis on 13 December 2021

John Wagget trained as a paediatric surgeon, including a Fulbright scholarship in Philadelphia, and was appointed as the second full time consultant paediatric surgeon in Newcastle in 1970. He worked at the Fleming Memorial Children's Hospital and was a regular star of the Christmas show. An inability to learn lines or hold a tune in his head were matched by his enthusiasm, which carried the day. He was an excellent surgeon, very supportive of nurses as equal partners. He was in the first wave of medical managers and for six years he was clinical director of paediatrics, laying the foundations to bring together all children's care in Newcastle on to one site, in the Great North Children's Hospital. He leaves Ina, his wife of 58 years, and three daughters.

Laurie Rangecroft
Alan Craft

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Madan R Bahl

Consultant in public health and infectious diseases (b 1935; q Baroda, India, 1961; DPH, DCH, FFCM, FFPHM, FFPHMI), died from a blood clot on the lungs on 15 December 2021

Madan R Bahl spent his career working in Kenya, Zambia, and England. As a consultant, he worked at Guy's, St Thomas', University College London, and the Royal Free hospitals. The last position Madan held was that of a consultant for communicable disease control for Camden and Islington Health Authority from 1992 until his retirement in 2004. After retiring at the age of 69, Madan continued to keep his medical knowledge and continuing professional development up to date by reading his medical journals and completing the BMA online modules. He was also a regular attendee at the BMA library in London. Madan leaves Pratibha, his wife of 58 years; two children; and two grandsons.

Bela Bahl

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John Gwynfor Evans

GP (b 1956; q St Mary's Hospital Medical School, London, 1979; FRCS, MRCGP, DRCOG, LLB), died from pulmonary arterial hypertension, secondary to sarcoidosis, on 12 November 2021

John Gwynfor Evans ("Gwyn" or "Gwynfor") initially trained in surgery, but became ill with sarcoidosis, leading to pulmonary fibrosis and to severe osteoporosis. He retrained in general practice and became a principal in Gateshead. While working he completed a law degree and became an accomplished watercolour painter. In 1993 Gwynfor took over a singlehanded practice at Gyffin in Conwy, converting a dilapidated chapel into a modern medical centre and taking on partners. After 22 years, his illness caught up with him, and in 2015 he took early retirement. He then worked as a locum across north Wales. He leaves his wife, Marie (née Rapson); three children; and his brother.

Martin Duerden

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David Bruce Donaldson

GP (b 1920; q Glasgow, 1942; FRCGP), died from hospital acquired pneumonia on 26 September 2021

After graduating David Bruce Donaldson ("Bruce") spent some months at Dundee Royal Infirmary before being called up for the Royal Army Medical Corps. On discharge he worked at Ballochmyle Hospital in Ayrshire, where he met his future wife, Anne, a nursing sister. Bruce entered general practice after assistantships in New Cumnock and Arbroath. He was a GP at Connel and Taynuilt, Argyll, where he was also an anaesthetist at the then West Highland Hospital. In 1968 he moved to north Edinburgh and, in addition to general practice, developed an interest in occupational medicine. Bruce had many sporting interests including sailing and water skiing in Argyll, but his main love was golf. Predeceased by his wife, Anne, he leaves a son, a daughter, and grandchildren.

Nick Hastie

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Peter Campion

Professor of general practice University of Hull (b 1946; q Oxford/London, 1970; PhD (sociology), FRCGP), died from progressive supranuclear palsy on 28 December 2021

In 1968 when Peter Campion was a medical student at Oxford his first paper appeared in *Nature*. Over the subsequent 50 years his clinical academic outputs were wide ranging, covering general practice, communication skills, chronic fatigue, dementia, and community pharmacy. While a lecturer at Dundee, he researched consultation issues. As foundation chair in general practice at the University of Hull, he focused on the establishment and development of the new Hull York Medical School. He became a reader in the Church of England. His last years were marred by the premature death of this wife, Janet, and the development of progressive supranuclear palsy. He leaves four children and eight grandchildren.

Una Macleod, Nicholas Summerton

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Hameeduddin Siddiqui

Consultant psychiatrist (b 1932; q Liaquat Medical College, Hyderabad, Sindh, Pakistan, 1958; DTM&H, DPH, DPM), died from pneumonia, congestive heart failure, and kidney failure on 31 December 2021

Hameeduddin Siddiqui arrived in England in 1964 and completed his postgraduate studies at the London School of Hygiene and Tropical Medicine. From 1966 to 1970 he concentrated on general medicine. During this period, he specialised in infectious diseases and gained his diploma in public health. It was also in this phase of his career that he met a nurse, Philomena, whom he married in 1967. In 1970 Hameeduddin moved into psychiatry and the Royal Preston Hospital welcomed him as a locum consultant psychiatrist in 1995. He retired officially in 1998, although he undertook some further locum work until 2002. Hameeduddin leaves Philomena, three children, and four grandchildren.

Nadeem Siddiqui

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Kristin Henry

Eminent pathologist who was known as "the Joan Collins of medicine"

Diana Kristin Henry (b 1932; q St Thomas' Hospital, London, 1956; FRCP, FRCPath), died from complications arising from vascular disease on 11 October 2021

At the age of 86, Kristin Henry flew to San Francisco, USA, after doctors at the children's hospital had struggled to diagnose the cause of diarrhoea in a 2 year old relative. They suspected, among other things, coeliac disease or lactose intolerance, but the symptoms had persisted for six months.

Henry's arrival in California surprised her US colleagues. But she amazed them by diagnosing a rare condition she had not seen in 40 years. Her San Francisco trip was probably life saving. The child's refractory diarrhoea was associated with a rare paraneoplastic syndrome of neuroblastoma. Recognising the syndrome as a "blind spot" among fellow histopathologists, Henry later ran an IAP symposium based on the theme in Jordan.

Henry was at the forefront of the international drive that identified more than 70 forms of lymphoma.

Art and glamour

Like other leading pathologists said to have "the eye," Henry could have been an artist. She had a great talent for decoration and drew cartoons of animals for her children. Stylish and elegant, "the Joan Collins of medicine" also had a predilection for Butler & Wilson necklaces, Elnett hairspray, and Rive Gauche perfume.

She did not like her image to slip. Unexpectedly in hospital overnight after day surgery, she rang her histopathologist colleague and friend Ann Sandison, saying: "SOS Ann. SOS. I need hairspray." Her party guest lists included her hairdresser.

Her daughter, the artist Georgea Blakey, recalled, "Her typical Saturday morning would start with a much deserved lie-in, a perusal of the papers, and breakfast in bed. But by noon she was dressed up in Jaeger's finest threads, John Denver was on the record player, and she would be waltzing one of our five cats around an imaginary dance floor, usually with a Butler & Wilson necklace around its neck."

Henry and her husband, George, were a dashing couple. George, who died eight years ago, modelled for Terence Donovan, the fashion photographer and film director. A stockbroker, financial historian, and author of *A History of the London Stock Market*, he helped to oversee the financial viability of the British division of the IAP while his wife was treasurer. He objected to his celebrated wife shopping in Harrods instead of Sainsbury's.

Many women protest if a male colleague puts their appearance before their professional accomplishments, but Henry "loved it," according to Sandison, when a distinguished surgeon recalled her as "a very glamorous pathologist."

She added, "She used her appearance to get her own way and found her glamour very useful. People did not expect her to have negotiating skills."

Although Henry loved the high life and holding court with a champagne cocktail in hand at Annabel's nightclub in Berkeley Square, she frequently worked 14 hour days. Due to retire from Charing Cross Hospital in 2000, she never did so. After finally vacating her office, the octogenarian astonished staff by hot desking on the 11th floor.

Like other leading pathologists said to have "the eye," Henry could have been an artist

Life and career

The daughter of a British civil servant, born in India near the Pakistan border, she did not like being told what to wear and do at boarding school in Malvern, England. Told by her headmistress that medicine was not for women, Henry played truant in her school uniform to attend an interview at St Thomas' Hospital medical school, London. She started there at the age of 17, despite an official age limit of 18.

She seemed an unlikely pathologist but was intrigued by the roots and development of disease and had an outstanding scientific mind. In 1970 she became a lecturer and honorary consultant in pathology at the Royal Postgraduate Medical School and Hammersmith Hospital.

In 1974 she moved to the Westminster Hospital and the Westminster Children's Hospital, where she joined the bone marrow transplant team and became lead pathologist in the melanoma unit. After Westminster Hospital closed in 1987, she took up the London University chair of pathology at Charing Cross and Westminster Medical School. In 1998 she was appointed emeritus professor of pathology at Imperial College London.

Henry was the impetus behind the formation of the Arab British School of Pathology, which is to be renamed after her.

She founded the British Lymphoma Group and co-founded the European Bone Marrow Working Group. She served as a council member and treasurer of the British division of the International Academy of Pathology and became its president in 1995 and of the IAP in 2010.

She leaves two children.

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