

comment

“I’ll miss the camaraderie, humour, and mutual support of my ward” **DAVID OLIVER**

“What should GPs stop doing to make time to assess patients’ income?” **HELEN SALISBURY**

PLUS “Humanitarian crisis” facing UK children

THE BOTTOM LINE Partha Kar

NHS leaders must talk openly about this crisis

How big is the crisis facing the NHS? Critics can point to years, if not decades, of headlines suggesting that the NHS has “weeks to survive.” But it feels as though many things have come to a head—politics, NHS leadership, and the consequences of a pandemic.

Take emergency care and growing queues: those concerned knew these would become an issue, as social care wasn’t being supported. Yet, as a system, we’ve chosen to focus on internal processes, pathways, and initiatives such as early discharge. They’re good for a CV or an award submission, but not much use at a population level.

The growth of waiting lists for treatment isn’t new, but the pandemic pushed it into overdrive. Without consultants the waiting lists won’t get shorter—and the pension issue is the crux of the problem. The difference between that and problems with the emergency pathway is that the government has nailed its flag to sorting out doctors’ pensions, and elections aren’t that far away, so we can expect some major shifts shortly.

Which brings me to workforce. Years of below inflation pay rises haven’t helped, but let’s factor in how we as a system treat our staff. First: GPs. Sections of the media and some politicians decided to label them as work shy, lazy, a cause of trouble. And, as a system, we didn’t push back enough. Many GP colleagues have had enough.

Second: new entrants to the NHS. Our approach is stuck in the past, with a whiff of “Aren’t you lucky to work in the NHS?”—which relies on guilt tripping, gaslighting, and infantilising. Factor in a modern generation who don’t tolerate such nonsense, and we have a workforce crisis. Throw in public discussions on workforce racism and the rhetoric of a country not liking immigrants, and it’s a mass of conflicts and rota gaps.

Finally: deprivation. It’s not uncommon to equate this with ethnicity, sidestepping the fact that deprivation is far wider than a person’s ethnicity. Yet it’s linked to poorer health outcomes, and there’s a huge focus in the NHS on

closing these gaps. It’s being asked to step into areas such as poverty, fuel bills, and living costs—none of which it was built to do. No amount of zeal to do the right thing will help with the mortgage or keep the lights on.

So, here we are: social care crumbling, finance issues for consultants, a lack of workforce strategy, and inequality still widening. With the right determination and focus some things could be turned around, even if we’re looking at a decade of recovery. Otherwise we’ll be forced to prioritise emergency, maternity, and cancer care, with all else taking a back seat. It’s vital that health service leaders start talking openly about the problems, rather than talking behind closed doors because there’s “a bigger picture.”

Without this, there may be no canvas left to paint a picture on.

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With the right determination and focus some things could be turned around



OPINION Michael Marmot, Ian Sinha, and Alice Lee

Millions of children in UK face a “humanitarian crisis”

The looming fuel poverty catastrophe for families will trigger major immediate and long term child health problems

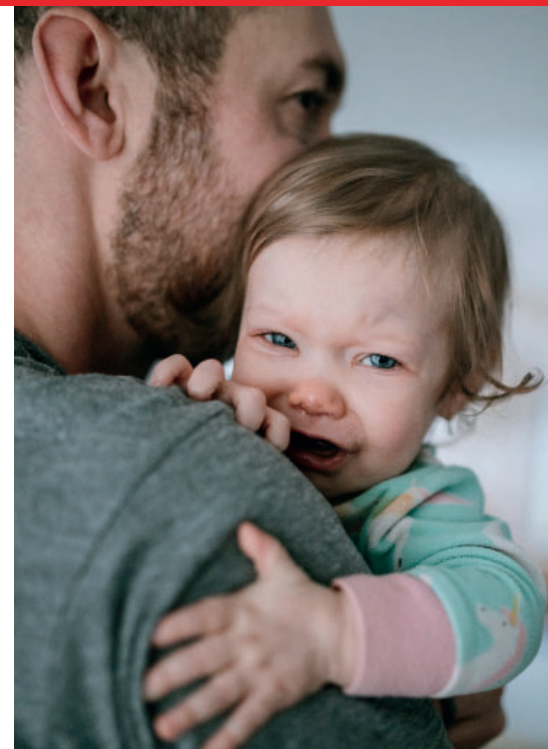
By January 2023 more than half of UK households, including millions of children, will be in fuel poverty unless effective interventions are established. Our concern is with the health effects of this crisis, in particular its effects on certain groups at risk: black and ethnic minority groups, households with children, people on low incomes, and people with disabilities. Fuel poverty is driven by the energy efficiency of a home, household income, and the cost of fuel. Substandard housing and insufficient income are deep rooted problems in the UK, and more than a third of children live in poverty. Energy prices are soaring. This winter, fuel poverty and cold homes will present a public health and humanitarian crisis.

Cold homes affect health throughout the life course. Excess winter deaths have long been a problem, with the relative

excess in the UK greater than in other, colder European countries. Cold homes cause and exacerbate respiratory and cardiovascular diseases, mental illness, and dementia. Financial insecurity can cause significant stress for households, with consequent effects on mental and physical health. Hypothermia and cold, damp, and dangerous housing cost the NHS more than £2.5bn a year.

Key risk factors

There is also a direct threat to children, in whom lifelong health inequalities take root. A person’s respiratory system, which develops in utero and in early childhood, is a key determinant of their health and longevity. Without doubt, substandard or overcrowded living circumstances are key risk factors for impaired lung development as, in addition to cold, these are associated with viruses, dust, mould, and pollution.



The picture for children is bleaker still when we add the impact of living in cold accommodation on the quality of their sleep, development, and mental health. As families make financial sacrifices to stay warm, fundamental aspects of a happy, healthy, and productive childhood—good nutrition, educational essentials, toys, birthday parties, and Christmas presents—will give way.

ACUTE PERSPECTIVE David Oliver

A bittersweet final farewell to my ward



Sooner or later I’ll have to give up working in a large hospital ward, after many years as a consultant physician and a senior doctor responsible for an inpatient ward all year round.

Doing so requires a very hands-on, accessible presence and sustained continuity. After a quarter of a century (and several more years as a registrar) in which “looking after the ward” formed a huge part of my working life, I’ll miss it terribly. It’s a big part of my professional identity. But it’s also left me increasingly tired, and it may be time for younger doctors with new ideas and more energy to inject new life into how patient care is organised and the ward team works.

Since starting I’ve seen an exponential rise in the acuity and complexity of patients, pressure on acute hospital beds, imperatives to help people leave hospital ever more quickly, the range of investigations and treatments, and expectations from the public and central performance directives.

Many doctors say that working on the acute medical intake or looking after people on wards can be the least fulfilling and most frustrating part of their job. But these have always been what I enjoyed most and had the greatest aptitude for.

In my time as a consultant spanning two hospital trusts, I’ve looked after anything from 24 to 36 inpatient beds, but usually 28. My current ward has been a “hot” all covid ward for many months in the past two years. I’ve been fortunate to have largely avoided “safari ward round” models (with patients spread around various wards) and been able to have my inpatients on one home ward, save for mercifully rare excursions into covid “escalation beds.” Even in my regular duties in acute medicine, I’ve been able to spend my 12 hours in the acute medical unit and emergency department, not traipsing round the hospital finding patients. Again, I have that feeling of belonging to a home ward team and an environment I know and love.

The team atmosphere is what I’ll miss

If more than 50% of households will be affected, support to those on benefits will be insufficient

fuel poverty, with ringfenced funding to enable local authorities to plan and sustainably support their populations proportionate to need. Many national programmes that either stalled or received reduced funding prior to the pandemic (including the Energy Savings Trust, the Energy Company Obligation, and the government's pledge to offer smart meters) should be reinvigorated, and efforts to improve building insulation should be prioritised.

Vulnerable households

Urgent financial approaches are required. Vulnerable households should be protected from the catastrophic threat of having their gas and electricity supplies cut off this winter. A lower energy price cap, which kept thousands of households out of fuel poverty, should be reinstated and fixed. If the supply costs of gas and oil are increasing, these should instead be absorbed by companies that profit from these essential commodities.

Government can provide the funds to support the price cap, paid for out of a windfall tax on energy production

companies, and should reject the idea of tax cuts, which will favour the rich. If more than 50% of households will be affected, support to those on benefits will be insufficient. Our concept of proportionate universalism implies support across the social gradient with effort proportionate to need.

Local level health providers should implement NICE guidelines on the health risks of cold homes with immediate effect. Services such as Citizens Advice will be invaluable in helping households to access their entitled benefits—currently, billions of pounds are estimated to go unclaimed each year, reflecting a system that is difficult to navigate.

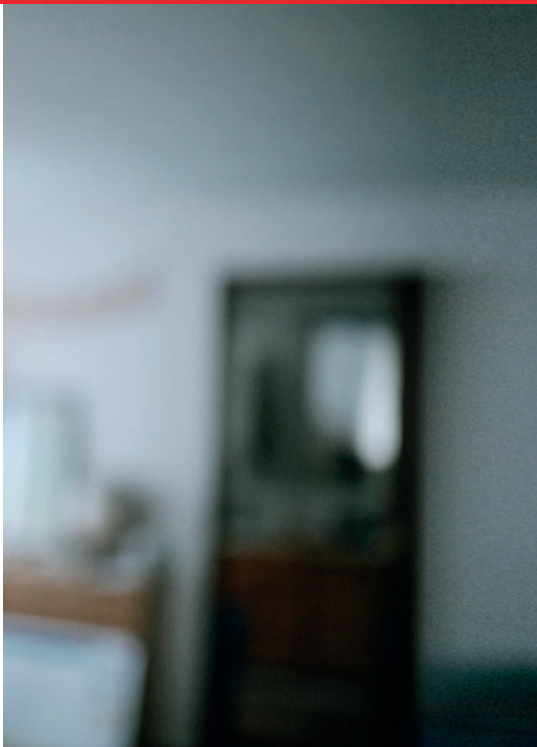
The prospect of more than half of households facing fuel poverty is a sad state of affairs in a rich country. To avoid a humanitarian crisis this winter, efforts to help households stay warm must be immediate and meaningful, with sufficient reach and accessibility.

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The crisis of fuel poverty this winter is the result of a short term problem of rising fuel prices coming on top of long term problems of housing quality, inadequate investment in sustainable energy and energy independence, and families having insufficient money to lead a healthy life. The solutions, too, must tackle these long term problems. But a priority this winter must be a national strategy to manage

most. A strong bond and a key leadership “double act” exist between the consultant and the sister or charge nurse managing the ward. I've worked with a series of brilliant colleagues: when done right, such a collaboration can set the tone for “how we do things here,” ensuring continuity even as an ever changing cast of junior doctors and allied health professionals rotate through placements. I've worked with many colleagues on the same wards for many years, through thick and thin—not least during the pandemic and growing staffing crises—and I feel fiercely loyal to them.

Allied health professionals, such as physiotherapists and occupational therapists, are crucial to my patients' team based care, and I love working with them. But healthcare assistants, ward admin, and domestic staff are also key to making it all work for patients.

I'll miss terribly the camaraderie, humour, mutual support, and working towards a common goal. I'll miss the chance

to see and help a patient and their family from arrival on the ward to leaving hospital, and sometimes to as dignified and peaceful a death as we can provide for them. I'll miss being the pet “old man” on the clinical team, helping younger clinicians develop their skills but also learning so much from them and being inspired.

But all things must pass, and the relentless pressure of getting through a multidisciplinary team meeting and a 28 patient ward round by lunchtime, with competing pressures, demands, and priorities, means that in the next few years I'll probably be ready to hand over the baton, even if it's with a mixture of happiness and regret.

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I'll miss being the pet “old man” on the clinical team, helping younger clinicians develop



A cold shoulder to the Treasury

August is famously the silly season, a slow news time with parliament in recess, when newspapers fill their pages with daft stories in the absence of serious political news. I recently returned from a two week break to find a very full inbox and a whole new range of proposed activities to keep us idle GPs busy.

Our primary care network is putting plans in place for the new extended hours requirement starting in October, which will see GP surgeries open in the evenings and at weekends. We're also gearing up for our flu vaccination programme and the next round of covid boosters, with a new bivalent vaccine that requires additional training all round. But on top of this I hear that the Treasury is considering asking GPs to assess whether patients are struggling enough financially to be eligible for a prescription for money off their fuel bills.

Admittedly we're local, we cover almost the whole population, and we're trusted, which is a good place to start, but 30 seconds' thought is all it takes to come up with many reasons why this is a bad idea. We've no knowledge of our patients' financial situations and lack the skills to assess them.

I suspect that even the politicians or civil servants who mooted this proposal know that we're a bit short of GPs right now, so the question must always be, "What would you like us to stop doing to make time for this?"

I anticipate that our waiting room may get a bit more crowded this winter



Put diabetes reviews on hold? Call a halt to all mental health work?

On a typical day in most practices the phones ring non-stop, and reception staff work hard to find out what the patient needs and direct them to the best person to help. Can you imagine the deluge of calls on day one of a policy like this? It wouldn't surprise me if some surgeries were already receiving requests for this "money off" prescription, given the media coverage it's received.

We have a welfare system that's currently failing to provide adequate benefits to support the poorest people in our society, many in working families. We're facing a crisis that's likely to see huge numbers of people unable to heat their homes. I anticipate that our waiting room may get a bit more crowded this winter as people come for an appointment and stay for the warmth, although heating the premises is likely to prove a financial headache for general practices too. I've never seen a case of hypothermia, so I'll need to do some catch-up reading (the NHS website helpfully advises that hypothermia is more likely if you live in a cold house).

GPs have neither the ability nor the inclination to become further embroiled in the benefits system. The Treasury and the incoming government really need to sort this one out—and quickly.

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LATEST PODCAST



Deep Breath In: retention in general practice

GP shortages are getting worse instead of better, with staff retention an ongoing problem. How can we make general practice more attractive as a career? This episode of the Deep Breath In podcast hears from GPs who are trying to tackle this dilemma. Firstly, GP Pamela Curtis describes an initiative to help GPs returning to work after a break. Secondly, a group of GP trainees describe how a new platform is trying to shape the future of general practice, with Liam Loftus explaining how it works:

"We've been part of a piece of work called the Big GP Consultation, and what that aims to do is twofold. Firstly, it recognises that the next generation of GPs are very interested in the future but quite often don't have the space to discuss what that future looks like. We wanted to bring them together and give them that space. But, secondly, we also recognise that they have incredible insight into how we can build a positive future of general practice. So the second aim was to try and take all of those ideas, put them together in one place, and then have discussions with the people who can pull the levers to make that future happen."

Veena Aggarwal explains some of the key findings that have come out of the project:

"We found some really great ideas about how GP training can be modernised to fit the challenges of 2022 as opposed to the past. People wanted a lot of support; they wanted coaching and mentoring and peer support to cope with the challenges. They wanted teaching on social determinants of health, on health inequalities, on climate change in health, and how to practise more sustainably. They wanted training on leadership and management, and they wanted to be more involved in shaping the future."



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

Role of scientific advice in covid-19 policy

Holly Jarman and colleagues discuss why science and medical advisers must be separate from government decisions and evaluate the autonomy and transparency of the UK's system

The use, non-use, and misuse of advice from natural, medical, and social scientists during the pandemic is highly controversial. Governments generally claim that they are “following the science” when discussing their policy choices. Introducing the UK government’s covid-19 response plan in spring 2020, the then health secretary, Matt Hancock, claimed it was “driven by the science” and expressed confidence in the UK’s “world-class expertise to make sense of the emerging data” on the virus.¹ Announcing the UK government’s plans to relax restrictions in summer 2021, the prime minister appeared at the press conference flanked by the chief medical officer and chief scientific adviser.

Critics of the government’s covid policies said the claim to be “following the science” was political theatre, designed to support its desired policy positions rather than evidence informed policy making.² Others pointed out that science is not a monolith, so it is close to meaningless to claim to follow science without specifying what kind of science is supporting which decisions.³ To claim to follow science only raises questions such as “which science?” and “according to whom?”

Moreover, holding advisers responsible for government decisions is tricky. Advisers do not compel politicians to do anything. Politicians have interests of their own and abundant sources of advice, including special advisers, friends, lobbyists, backbenchers,

KEY MESSAGE

- Governments claimed to be following scientific advice during the pandemic to legitimise decisions
- Advice should be autonomous to ensure that governments do not simply seek advice that aligns with what they want to hear
- Transparency is also essential to know who gave the advice and what the government did with it
- The UK’s advice system was not autonomous, being designed to answer questions posed by government with advisers appointed by government
- The system became more transparent as a result of political pressure

Arguing about advice often amounts to arguing about policy decisions by proxy

media, private consultants, civil servants, and other ministries.

Advisers are often blamed to deflect responsibility from the politicians who selected the advisers and made the decisions, and attacking advisers is a way to get at their political employers. The result is that arguing about advice often amounts to arguing about policy decisions by proxy. An inquiry into the quality of scientific advice to government has to begin with an appreciation that governments, not advisers, balance priorities and make decisions, and so it is never clear that good advice will lead to good policy.

We examine the structure that, on paper, was supposed to shape and legitimise policy in England and compare it with systems in Northern Ireland, Scotland, and Wales (which relied on much the same scientific advice) and those in France and Germany (to show how governments in similarly large countries with strong scientific establishments sought advice). These comparators help us to understand how the UK government solicited and used science.

Role of advice systems

The first potential contribution of an advice system is giving government access to credible advice that can shape its decisions. Although some governments elsewhere gave prominence to fringe figures, the UK’s science advisers were clearly experts in relevant fields. Rather, the risk was that government selection of experts created an echo chamber.

Minutes from the UK’s Scientific Advisory Group on Emergencies (SAGE) and parliamentary reports show the UK government primarily wanted to know the likely effect of different policies on the spread of the virus and the consequences of spread for healthcare.⁴ It was uninterested in broader advice from social sciences about, for example, health behaviour or the trade-offs of different policies. The advisory committees produced credible, if not always consensual, models drawing on policy

QUESTIONS FOR THE INQUIRY

- Why did it take so long to increase the transparency of SAGE and other government scientific advice bodies?
- SAGE answered questions set by ministers. Did omissions and assumptions in those questions shape outcomes?
- Where, if anywhere, did government get advice about trade-offs and broader policy implications of public health measures?
- Why do UK science advisers have so little autonomy from the government?

options and questions set by the government.

The second potential contribution of an advice system is broader democratic accountability. Knowledge of what politicians asked and heard, and inferring how they incorporated that advice into their decisions, can allow the media and voters to evaluate politicians’ decisions and hold them accountable. That requires transparency: public knowledge of advisory bodies, including their composition, members’ interests, agendas, and advice given.⁵ It also requires autonomy: the ability to go beyond answering questions posed by government in order to identify potential problems that the government did not anticipate.

The UK civil service and government agencies are traditionally not very transparent or autonomous of the central executive, and government’s ability to influence them has been increased over decades by every party.^{6,7} UK science advice is no exception. Adapted to the preferences of strong governments, it has a long tradition of opacity, informality, and “safe pairs of hands.”⁸ The result is a characteristic string of UK policy failures in which decisions were made too quickly, by too few people, and with weak and unchallenged justifications.^{6,9}

Advising governments in a pandemic

What scientific advice informed policy makers? Table 1 (overleaf) shows the bodies with official advisory roles in different countries. In England these included pre-existing committees (eg, SAGE and its subcommittees), committees within the executive (eg, the civil contingencies

committee), agencies (eg, Public Health England), and ad hoc advisory committees configured specifically for covid. Table 2 (right) shows the extent to which they were public about their composition, activities, and the advice they gave and that information when it was available.

Transparency

Among the countries we compared, France's approach was most opaque; Scotland and Wales were somewhat more transparent than the UK government about their use of advice, and Germany was the most transparent. In both France and the UK, high ranking bureaucrats, advisers, and politicians shaped advice by using consultancy firms, sidelining public health experts and agencies, and relying on special advisers.

France has maintained partial control over public availability of its advice. Publication of recommendations from the scientific council and the vaccines strategy council were sometimes delayed, and the proceedings of the National Defence Council were kept confidential.¹⁰ The vaccines strategy council's recommendations were published by the health ministry rather than the council, and some were never made public.

In theory, secrecy can enable civil servants and advisers to offer unpalatable advice to leaders and can prevent lobbying; civil servants and advisers stay in the shadows and politicians get both credit and blame. This bargain, which was clearly the basis for the structure of SAGE and other committees at the start of the pandemic, has been eroding for decades as politicians try to shift blame on to others and outsiders demand transparency.⁷

The UK advice system did become more transparent, with the names of SAGE members and meeting minutes eventually published. The key questions that government was asking science advisers and the basis of their answers became clearer. This allowed better

external scrutiny. For example, outsiders pointed out that issues such as shielding vulnerable populations and integration of economic, educational, and other outcomes with epidemiological modelling were not considered, the attendance of people such as special adviser Dominic Cummings (not a scientific expert) at meetings, and the gaps when SAGE was not asked to meet.⁴⁻²¹

However, delays in disclosure meant that information about advisers and the evidence base for decision making were not available in time to support effective outside scrutiny, especially in the early stages of the pandemic.⁶

Autonomy

If the transparency of the UK system improved during the pandemic, autonomy did not. SAGE provides advice in the shadow of government authority. Although SAGE's ramifying subgroups gave it access to a wide base of experts, giving its views credibility, these experts were centred within committees that had their terms of reference and membership controlled by government, had their secretariat provided by the government, and were chaired by government's chief scientific adviser, Patrick Vallance. As Freedman notes, "By necessity SAGE can be said to provide 'policy aware scientific advice.' This can be seen in the objectives it set for itself and the means chosen to meet those objectives."¹¹ Or, as SAGE member Graham Medley succinctly put it on Twitter, "Since models always have a policy assumption in them (do nothing is a policy option), it makes perfect sense for policy to tell modellers what will most help them decide what to do."¹² The question of autonomy is whether the advisers are able to do more than this.

Advice from SAGE has sometimes seemed to anticipate government objections, particularly relating to the framing of lockdown measures in the early stage of the pandemic. In its early meetings, SAGE concluded that immediately

The government used the advice in ways that did not necessarily reflect its text or apparent intent

going into lockdown was not a viable option because the UK public would not tolerate it. The social science underpinning that decision was not well specified. Both Vallance and SAGE member Neil Ferguson subsequently stated that a decision not to lock down earlier in spring 2020 was a mistake that probably cost lives.¹³

UK advisory committees lacked autonomy. SAGE and the other committees have no consistent membership or regular meeting requirement. SAGE did not meet for large periods of 2021, supposedly because the UK government was not seeking its advice. The UK also acted against advice from its own committees, as with the decision not to adopt a circuit breaker in October 2020 or the choice to adopt less stringent rules on masking in schools in May 2021.

The government used the advice received in ways that did not necessarily reflect its text or apparent intent.²⁻¹⁴ For instance, few who read the SAGE advice on the lifting of public health measures or the provision of home testing from the 10 February 2022 meeting would have regarded it as a clear mandate for what the government did a few days later, which was to announce the end of almost all restrictions and a massive scaling back in the testing regime. In fact, since the documents behind that advice are public, it is clear that the government was not following the science it had solicited from its advisers.

The lack of autonomy for the government advice system was made especially clear by the UK government's mid-2020 decision to abolish Public Health England. Public health agencies around the world did not always get the influence they sought during the pandemic, but it seems only the UK went so far as to abolish and replace its public health agency during the pandemic.

Table 1 | Who advised governments on covid-19?

| | Established advisory committee | Ad hoc advisory committee | Public health agencies advising on pandemic | Prominent figures |
|------------------|---|--|---|--|
| UK and England | SAGE and subcommittees; New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) | None | Public Health England, to April 2021, UK Health Security Agency (UKHSA), from August 2021 | Chief medical officer for England; government chief scientific adviser; special advisers; external consultants |
| Northern Ireland | SAGE and subcommittees | None | Public Health Agency | Chief medical officer; chief scientific adviser |
| Wales | SAGE and subcommittees | Technical Advisory Group (TAG) | Public Health Wales | Chief medical officer; chief scientific adviser; TAG chair |
| Scotland | SAGE and subcommittees | Scottish Government Covid-19 Advisory Group (SGAG) | Public Health Scotland | Chief medical officer; chief scientific adviser for Scotland; SGAG chair |
| France | High Council of Public Health; High Authority of Health | At least 4 ad hoc scientific councils advising the president | Multiple, notably Santé Publique France and the French Agency for Food, Environmental, Occupational Health and Safety (ANSES) | Extensive use of National Defence Council; external consultants |
| Germany | Commission for Pandemic Research, German Research Foundation (DFG) | Network of university medical centres | Multiple, notably Robert Koch Institute and Federal Centre for Health Education | Lothar Wieler, president of Robert Koch Institute; Christian Drosten, head of Institute of Virology, Charité, Berlin; National Academy of Sciences |

Table 2 | What do we know about the advice given*?

| Structure | Members public? | Composition | Advice public? | Form of advice |
|---|-----------------|---|----------------|---|
| UK: SAGE and subgroups; NERVTAG | Not initially | Interdisciplinary membership for SAGE; more specialists in particular groups | Not initially | Summaries of literature and research; emphasis on modelling effects of new developments or policies |
| Wales: TAG | Yes | Government officials, NHS Wales, academics with public health, medical, biomedical, social scientific expertise | Yes | From May 2020, summaries of advice from the technical advisory cell, which supports TAG; modelling results; special issue reports; TAG consensus statements |
| Scotland: Scottish Government Covid-19 Advisory Group and subgroups | Yes | Government officials, academics in data science, epidemiology, medicine, nursing, global public health, social sciences | Yes | From April 2020, summaries of literature and research, select academic articles, memorandums from government and academics |
| France: High Council of Public Health, Santé Publique France | Yes | Medicine, health fields including public health; limited behavioural science | Yes | Scientific reports and extensive guidelines on particular practical issues |
| France: ad hoc committees and National Defence Council | No | Unknown | No | Unknown |
| Germany: Robert Koch Institute | Yes | Public health and medicine | Yes | Press conferences, status reports, situational reports, Covid dashboard, FAQs, risk assessments, daily surveillance reports |

*Authors' compilation from government documents. Excludes executive-only coordinating groups—eg, special cabinet formations or interdepartmental civil service meetings.

How to improve

The science of covid progressed extremely quickly. Compared with past pandemics such as HIV (in which even identifying the virus took years) researchers started to understand the epidemiology, virology, and treatment of covid-19 with remarkable speed. Useful knowledge about topics such as transmission, masking, vaccination, and treatment was becoming available at a tremendous pace. The stakes for scientific advice were therefore particularly high.

The weaknesses in the UK system are a lack of autonomy among advisers—they are selected by government and answer questions posed by government—and poor overall transparency. Although transparency improved as the pandemic progressed, the initial lack of openness, combined with advisers' lack of autonomy, robbed the process of its legitimacy and might have enabled damaging government decisions.

What lessons could we draw from the UK's experience? First, governments tend to get the advice they want. This can be through informal routes, and the abundant informal connections with government are well documented (eg, in UK contracts for personal protective equipment).¹⁵ It can also come through private consultancy firms, which gave extensive and expensive advice in France, Germany, and the UK about which the public knows very little.

The French government, for example, contracted with several consulting firms to design their vaccines strategy. McKinsey received €11.6m between 4 December 2020 and 4 February 2022 to monitor the delivery and administering of the Pfizer and Moderna vaccines, track shipments, create indicators and monitoring tools for the ministry of health, and produce thematic analyses on specific subjects at the request of the government.¹⁶

McKinsey's mission far exceeded its initial contractual duration: it was initially to focus on the first three weeks of the vaccination campaign but ended up providing support to the government for 14 months.

Voters can judge the overall performance of their governments, but it is hard for them to learn whether governments asked the right questions or received valid responses from private consultancy companies. Nor can we rely on post hoc scrutiny to deter poor decision making, at least in the UK.

Government dominance extends to inquiries in the centralised UK system, where it tends to commission and choose the membership and terms for inquiry.¹⁷ The weakness of scrutiny makes independent inquiries and civil society or professional pressure (such as the work of Independent SAGE) more important.

Second, transparent and independent advice can enable democratic accountability even if governments do not want it. It is rightly the task of elected politicians, not science advisers, to balance and represent interests, so a good science advice system for the UK should make it easier to see how they have incorporated advice as they do that. This would allow observers and ultimately voters to judge the competence and priorities of politicians. For example, the UK government's decision not to require masks in English schools, taken against SAGE advice in May 2021, was clearly the government's decision. That increased transparency means that voters can draw their own conclusions.¹⁴

By contrast, more autonomous German institutions were able to provide more diverse advice. The explicit separation between advice and political decisions, contributed

Transparent and independent advice can enable democratic accountability even if governments do not want it

to public trust in pandemic response by communicating that government leaders were not misrepresenting science.¹⁸

Third, transparent and competent scientific advice can also improve intergovernmental coordination, as in Germany and the UK. The devolved administrations looked, to various degrees, to SAGE for advice and when SAGE's advice convinced them of the appropriateness of a particular course of action, this eased coordinated action. When the devolved administrations were not convinced by SAGE's advice, they were less likely to follow the UK's lead. In this, the UK can learn from Germany, where trust in advice from federal institutions reduced intergovernmental conflict.¹⁹

Finally, we should recognise the limits of reforming scientific advice systems. Advising is not decision making. Good advice systems preserve the autonomy and credibility of the advisers and scientists by separating their advice from actual decisions. Understanding the UK government's actions might require understanding its scientific and public health advice, but it must also include its internal arguments and its political and economic understandings and motivations.

Perhaps the pandemic teaches us that the best we can hope for is scientific advice that is useful to well intentioned governments and allows others to hold governments accountable when they make specious claims about following the science. The political role of transparent scientific advice is not just to enable policy making; it is also to enable accountability for failures, such as the ones we saw in the covid-19 pandemic.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Shifting focus from access to population health



Paddison and Fuller, in their editorial on tackling the crisis in primary care (Editorial, 9 July), and Fuller, in her stocktake report for NHS England on integrating primary care, recognise that the current status quo is unsustainable. They do not, however, go far enough in flagging how policy needs to change.

Nobody, including me, is against access, but too much of the resource for the health service is focused on access rather than outcomes—ensuring that the available resource does the most possible to improve the health of populations. Over time we, as a society, have put more effort into dealing with the apparently urgent than into dealing with what might be most important. Inevitably this leaves less resource for other care that we might provide.

US President Dwight D Eisenhower is reported to have quoted J Roscoe Miller in 1954, saying: “I have two kinds of problems: the urgent and the important. The urgent are not important, and the important are never urgent.” I wonder whether we have got ourselves into a policy trap that breaks this Eisenhower principle?

The widely accepted aims of healthcare systems include patient experience, population health, and reducing costs but not access in the way that it has become such a focus in the English NHS. Population health would include a greater focus, for example, on improving cancer survival.

Resources are currently squeezed, and there are many vacancies for and falling numbers of GPs and practice nurses, with the numbers of these healthcare professionals unlikely to improve in the next decade. It seems time to be much more focused on prioritising activities that improve population health even if that means being more selective in triaging who should have urgent access.

Simon de Lusignan, general practitioner and professor of primary care and clinical informatics, Oxford

Cite this as: *BMJ* 2022;378:o2105

REMIFENTANIL USE AND INHALED ANAESTHESIA

Opioid-free anaesthesia can be administered safely

Lewin mentions the effects of national disruption to the supply of remifentanyl used in total intravenous anaesthesia (Letter, 23 July). Contingency plans propose using volatile anaesthesia instead, which implies that total intravenous anaesthesia is not easily implemented without remifentanyl. But anaesthesia can be delivered by total intravenous anaesthesia techniques without intravenous remifentanyl (or any other opioid).

Recent systematic reviews and meta-analyses showed not only that opioid-free anaesthesia can be administered safely but also that it may improve postoperative pain management. Remifentanyl has been consistently associated with impaired pain management, suggesting that its potential benefit during anaesthesia might not compensate for its disadvantages after surgery, as in, for example, acute opioid tolerance and opioid induced hyperalgesia.

As any new technique requires learning, implementing opioid-free anaesthesia must undoubtedly be guided by experienced practitioners. Such learning could eventually be incorporated into educational programmes and, in reducing the need for remifentanyl, could benefit patients.

Patrice Forget, clinical chair in anaesthesia and honorary consultant, Aberdeen

Cite this as: *BMJ* 2022;378:o2071

BURNOUT AMONG TRAINEE DOCTORS

Better pay could improve burnout

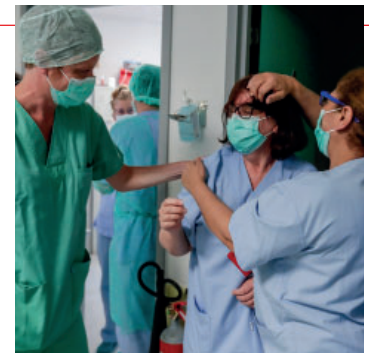
“Burnout” is now as much a part of my medical vocabulary as the language taught throughout medical school. Results from GMC surveys focus on what we already know (Seven Days in Medicine, 30 July), but the reaction will be what matters. The solution seems to be improving working conditions, but what about increasing pay?

Burnout is a state of physical, emotional, and mental exhaustion caused by long term involvement in demanding situations. If I spent less time worrying about paying rent or affording petrol, I would have more emotional and mental reserve. Perhaps I would be less likely to pick up a locum shift on my annual leave and more inclined to catch up on sleep after working 58 hours the previous week.

Burnout will continue until the workforce crisis is tackled. But better pay could be implemented comparatively quickly, and I would be intrigued to see the results.

Adam Darnley, foundation year 2 doctor, Manchester

Cite this as: *BMJ* 2022;378:o2118



Lack of empowerment harms trainees

The GMC's national training survey 2022 shows that, of the 76% of trainees who responded, 63% were at moderate or high risk of burnout. In addition, just over a quarter of trainees did not rate their training as good or very good (around a third in some specialities). These findings are related.

In our survey of 80 trainees in the Severn Deanery, the lack of empowerment caused by consultants making decisions without involving trainees (only a third had their findings verified regularly) meant that they did not have the opportunity to problem solve and get feedback on their clinical decisions. This harms team building, communication skills, and confidence building and increases burnout. Involving trainees and teaching at the bedside will reduce burnout because the task becomes relevant and purposeful. It will also reduce wastage of NHS resources because critical thinking reduces the blanket ordering of expensive and duplicate tests.

Parag Singhal, consultant endocrinologist, Weston-super-Mare; Davinder Sandhu, chair and associate dean, Antigua

Cite this as: *BMJ* 2022;378:o2120

HISTORICALLY OFFENSIVE CONTENT IN BMJ's ARCHIVE

Harmful science can be hard to recognise

Ragavooloo and colleagues' editorial on historically offensive content in BMJ's archive is timely and relevant (Editorial, 30 July).

Slavery, colonisation, genocide, racism, casteism, and fascism are condemned today, yet some people still admire Hitler. So, BMJ's action is more of a mission initiative to spread awareness about past wrongs and develop a system against their perpetuation and damaging effects.

BMJ's classification of harmful content into four categories—offensive language; offensive views; harmful science (research that harms certain groups); and misused content (to support a harmful agenda)—would be clearer if a couple of examples were included for each category. This would help readers to report offences in future.

The first two categories are easy to decipher. But "harmful science" is hard to crack, particularly when the outcome

of research is just a suggestion but might be mischievously shown as a conclusion, which could then be quoted to support harmful agendas.

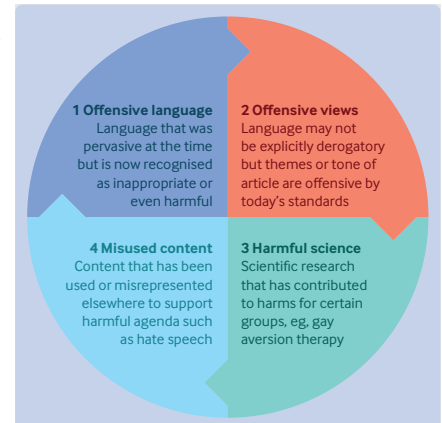
Lakshiram Murmu, medical superintendent; Sushmita Murmu, assistant professor psychiatry, Faridabad
Cite this as: [BMJ 2022;378:o2097](#)

The past was once the present

How might today's authors feel to have their language, motives, and attitudes condemned or corrected, to be judged and found wanting by perhaps more enlightened successors?

Past authors who have striven to choose the best way to express ideas in the language of their day might justly feel aggrieved. How can we judge progression (or regression) if publications are altered? Past editorial boards should take responsibility for what they published, as should today's.

CS Lewis's view was that "the study of the past helps us to appreciate that the



ideas and values of our own age are just as provisional and transient as those of bygone ages." He said that "reading texts from the past makes it clear that what we now term 'the past' was once 'the present,' which proudly yet falsely regarded itself as having found the right intellectual answers and moral values that eluded its predecessors."

Hazel Thornton, independent citizen advocate for quality in research and healthcare, Colchester
Cite this as: [BMJ 2022;378:o2125](#)

HISTORICAL RISE OF "OVERDIAGNOSIS"

Is there a "just right" amount of diagnosis?

Podolsky reminds us that diagnosis, like any medical intervention, can produce harms as well as benefits (Essay, 30 July). But "overdiagnosis" implies that there is a "just right" amount of diagnosis, and this depends on value judgments. "Just right" is meaningful only in the specific context of decisions about populations taken by health economists and politicians.

The difficulty in shared decision making conversations is that thinking about a terrible but unlikely thing such as cancer or a stroke is easier than thinking about less dramatic but much likelier things such as the potential harms of diagnosis. The concept of "overdiagnosis" has never helped me overcome this difficulty.

I used to emphasise that there was no right answer. My task was to help "the patient" reach an evidence informed decision that reflected their own values; my own personal enthusiasms and scepticisms constituted obstacles to be recognised and circumnavigated, as Podolsky recommends.

Louisa Polak, retired GP and visiting researcher, Cambridge
Cite this as: [BMJ 2022;378:o2089](#)

FAILING NHS DENTISTRY AND GENERAL PRACTICE

NHS dentistry is at breaking point

Alger-Green and colleagues report the effect of the crisis in NHS dentistry on dental training (Letters, 9 July). Dentists are quitting or radically scaling down their commitment, exhausted and fed up with a system that does not work. Morale has hit rock bottom. No dentist should have to provide NHS care at a loss.

NHS England's recent modest, marginal changes to the discredited

NHS contract go nowhere near tackling the systemic problems the service faces. Sustained investment is needed. We need to see ambition and commitment: real reform, backed up by sustainable investment.

We are dealing with a preventable disease, and prevention must be at the heart of any new dental contract. Urgent change is needed now, and only this will help to tip the scales and end the growing oral health inequalities we are seeing across the UK.

We cannot have NHS dentistry without NHS dentists.
C Albert Yeung, consultant in dental public health, Bothwell
Cite this as: [BMJ 2022;378:o2135](#)

WELCOME TO YOUR NEW HOSPITAL

Mentorship goes beyond supervision

Changing hospital is stressful for anyone (Opinion, 6-13 August). Part of Boyle's narrative is what I consider "mentorship"—developing an appropriate outlook, honing organisation and time management skills, and making the most out of any situation. It's staying sane in a system where the rules often don't make sense.

The best mentors are often not clinical supervisors. Rather, they tend to be experienced (not necessarily older) colleagues willing to take others under their wing, to help differentiate what matters, to guide decision making, and to provide tips even "locals" are unaware of. It could be where to get the best coffee in a hurry, whom to ask to expedite tests, or where to look for parking. A mentor is someone you can ask "stupid" questions without fear of judgment or consequences.

I hope mentorship is available to those who want it. Those who have received its benefits should pay it forward.
Shyan Goh, orthopaedic surgeon, Sydney
Cite this as: [BMJ 2022;378:o2138](#)

OBITUARIES

Barbara Elizabeth Cresswell

GP (b 1956; q Bristol, 1979; MRCP), died from metastatic adenocarcinoma of the rectum on 6 April 2022



Barbara Elizabeth Felton undertook house jobs at Bristol hospitals. She married and became Barbara Cresswell, before moving to London to start as an inner city GP. After her divorce in 1992 she increased her GP hours and in 1996 became a full time partner at Myatts Field Medical Practice. Barbara retired in 2014. On 1 October 2020, she was diagnosed with advanced bowel cancer. The testing was delayed by six months, because of covid. She had an anterior resection and chemotherapy through to May 2021. After a second operation in July 2021 she made a good recovery but discovered in January 2022 that she had developed secondaries. Barbara leaves her second husband, John Wheen; a son; and two stepchildren.

John Charles Wheen

Cite this as: *BMJ* 2022;378:o1991

Donald Charles Jackson

Diagnostic radiology specialist Coastal Radiology, New Bern, North Carolina (b 1932; q Sheffield, 1954; MD, MRCP, FRCR), died from a stroke on 15 March 2022, after having had dementia for a number of years



Donald Charles Jackson ("Don") took a post at St Bartholomew's Hospital in London, before emigrating to Winnipeg, Canada, with his second wife, Margo, in 1964. He practised academic radiology at the University of Manitoba and then moved to Duke University, Durham, North Carolina, where he was a tenured professor and joint director of the radiology department. On retiring from academic radiology in 1979, he became a founding partner of Coastal Radiology in New Bern, North Carolina, where he lived with his third wife, Adrienne. At work he met his fourth wife, Brenda; they married in 1998. Predeceased by a son, Don leaves Brenda, four daughters, three stepchildren, eight grandchildren, and four great grandchildren.

Emma Jackson, Charles Gallaher

Cite this as: *BMJ* 2022;378:o1987

John Henry Nelson Ferris

Consultant obstetrician and gynaecologist Ards Hospital (b 1932; q Trinity College Dublin, Ireland, 1955), died from a myocardial infarction 16 August 2021



John Henry Nelson Ferris ("Harry") was appointed to a consultant post in Ards Hospital in 1967, where he worked until his retirement in 1993. Harry was the 28th president of the Ulster Obstetrical and Gynaecological Society. However, what distinguished him as a doctor even more than his clinical ability were his communication skills and affinity with his patients and staff. Boating, where he couldn't be contacted, was Harry's only real escape from work. Golf was his other lifelong passion. Harry met his future wife, Lorna, in 1959 when she was a final year medical student at Queen's University. They were married in 1964. He leaves Lorna, three children, and eight grandchildren.

Ralph Roberts, John Ferris

Cite this as: *BMJ* 2022;378:o1996

Donald Harry Short

Anaesthetist (b 1930; q London Hospital, 1954; FFA), died from old age and frailty on 28 December 2021



Donald Harry Short was appointed consultant anaesthetist at Bristol Royal Infirmary in 1968, joining a young team in developing the intensive care unit and cardiothoracic anaesthetic areas. His work in the wider service included examining for the faculty of anaesthesia and working for the British Standards Institute on anaesthetic equipment, chairing international committees. After graduating he did a three year short service commission in the navy. He later returned to naval reserve duties at HMS *Flying Fox* in Bristol, rising to the rank of surgeon captain. Outside work he had a lifelong interest in Hornby model railways and supported Bristol Rugby club. He was regarded as a true gentleman by all who knew him. He leaves his wife, Pamela; two children; six grandchildren; and a great grandchild.

Peter Short

Cite this as: *BMJ* 2022;378:o1985

Mary Gillies

GP and author (b 1952; q Edinburgh, 1976; MRCP (CH), MFHom, DTM&H), died at home from disseminated breast cancer on 12 April 2022



Elizabeth Mary Gillies (née Gunn) was interested in paediatrics but decided on general practice. She spent three years working with her husband in rural Malawi in the 1980s, then worked as a GP in Galloway and the Scottish Borders. Her clinical work was curtailed by secondary breast cancer, with which she lived for 12 years. Mary loved travelling and continued this throughout her life. She developed a profound understanding of the principles and practices of Buddhism, as reflected in her 2017 book, *Well*. Mary had a unique combination of sparkle, warmth, intelligence, and humour. Sometimes she was called Mary Giggles. She leaves her sister, Donella; her husband, John; two children; and four grandchildren.

John Gillies

Cite this as: *BMJ* 2022;378:o1988

Albert Kenneth Woodward

General practitioner Codsall, Staffordshire (b 1934; q Birmingham, 1957), died from old age on 24 February 2022



Albert Kenneth Woodward ("Ken") joined an established general practice in Codsall in 1962. He became senior partner in 1987, and in 1989 led the design of new practice premises. As a traditional GP living and working in the same village he was an integral part of the community until he reluctantly retired in 1997. He had many interests and chaired the village's civic society. He needed quadruple coronary artery bypasses aged 63, and subsequently had an intracranial haemorrhage, recurrent coronary vascular disease, and bilateral hip replacements. Having lived in the Wolverhampton area for almost all of his life, he and his wife, Joan, moved to a retirement village in Exeter nearer to one of their daughters in 2020. He leaves Joan, three children, seven grandchildren, and three great grandchildren.

Stephen W Millar

Cite this as: *BMJ* 2022;378:o1984

Awani Kumar Choudhary

Orthopaedic surgeon and medical activist

Awani Kumar Choudhary (b 1950; q Darbhanga Medical College, Darbhanga, Bihar, India, 1977; MS, FRCS), died from gastric cancer on 28 April 2022

Awani Choudhary, orthopaedic surgeon, medical activist, president of the British Orthopaedic Specialists Society, co-founder of the BMA's staff, associate specialist, and specialty doctors (SAS) committee (SASC), and mentor of many junior doctors has died at the age of 72.

Choudhary grew up, qualified, and gained his masters in India. In 1979 he followed his brother to the UK, undergoing and completing further medical training in Edinburgh. He specialised in orthopaedics, with a focus on trauma management and spinal

surgery. It was in Edinburgh that Choudhary met his future wife, Fiona, a teacher, who helped improve his grammar. They were one of the first couples to be married at the Royal College of Surgeons in Edinburgh in 2004.

He worked for many years at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, where he mentored many junior doctors and acted as an appraiser.

BMA activist

Choudhary became interested in medicopolitics when he encountered problems on his way to becoming an associate specialist in orthopaedics.

To improve the working lives of his colleagues, he joined the BMA and served on the association's consultants committee as a non-consultant

career grade representative. In 2002 he became the co-founder and inaugural deputy chair of SASC. The committee works on matters affecting SAS doctors, such as contracts, development, recognition, and autonomy.

Choudhary tackled matters affecting NHS hospital doctors, including achieving a secure working environment with enough space to preserve patient confidentiality. In June 2005 he told a reporter from the *Guardian*: "We have to write letters to patients in other people's offices, in the doctors' mess rooms, in the operating theatre, at home, or even in the corridor. That's pretty worrying when you consider how sensitive the information we're dealing with is."

Bus bomb

Choudhary was at a meeting negotiating new SAS contracts at BMA headquarters in London on 7 July 2005 when he heard a loud bang outside the building. A suicide bomber had blown up the number 30 bus outside the building. Choudhary and other BMA colleagues worked tirelessly to provide emergency treatment and care for badly injured people at the scene, as fears grew that there was a second bomb on the bus.

After a controlled explosion was carried out on a suspect package, patients could be carried into the building, using tables covered in curtains. According to the later inquest, as there was no medical equipment in BMA House the doctors improvised using jackets and ties as bandages for the wounded, some of whom had massive internal and spinal injuries. Choudhary told the hearing he would have required an orthopaedic stretcher to

carry patients but the double decker bus window "was the best alternative."

In his role as the first president of the British Orthopaedic Specialists Society, affiliated to the British Orthopaedic Association, Choudhary campaigned tirelessly to improve local health and reduce inequalities. He was also a member of the SAS committees for the Royal College of Surgeons of both England and Edinburgh.

He was awarded a BMA fellowship in 2018 and trained as a mediator for the Civil Mediation Council, but he was unable to pursue this role because of the pandemic.

He was a fellow of AO (a global network of orthopaedic surgeons) and completed his AO fellowship in Switzerland, Vienna, and Toronto. Later, in Sheffield, he was named an honorary orthopaedic clinical fellow. He regularly published in medical journals and presented on a range of orthopaedic subjects at conferences, both nationally and internationally.

Diagnosed with gastric cancer in 2020, Choudhary continued to work at Bassetlaw Hospital, with Vaziri, one day a week, while undergoing chemotherapy.

Happily married to Fiona for 18 years, he enjoyed playing chess, opera, ballet, theatre, cooking traditional Indian food, and adventurous travelling. He was charged by a rhino when on safari, pursued by sharks, and survived a severe earthquake in Peru.

Choudhary leaves Fiona, two of his three brothers, and nieces and nephews.

Rebecca Wallersteiner, London
wallersteiner@hotmail.com

Cite this as: *BMJ* 2022;378:e1804

