# comment

"Instead of naming and blaming hospitals, let's try to understand the reasons" **DAVID OLIVER**
"Without more money, how are we to retain the staff leaving in droves?" **HELEN SALISBURY**
**PLUS** The rising demand for medical imaging

**CRITICAL THINKING** Matt Morgan

## Creating the option to work from home

As many health workers plan industrial action, another revolution in working life rumbles on. Millions of office staff no longer have to commute, moving only from their bedroom to another part of the house to work.

Although in many workplaces the pendulum has swung from fully home working to a hybrid model, evidence shows this new normality is good for employees. A randomised controlled trial of 1612 employees in engineering, marketing, and finance showed that working from home on Wednesdays and Fridays reduced attrition rates by 35%, improved self-satisfaction scores and communication with colleagues, and increased productivity by 8%. While great for many, however, these new ways of working may further exacerbate inequalities between jobs that can and cannot adopt such changes.

There are exceptions, but healthcare is difficult to deliver from home. And so, along with below inflation "pay rises," poor working conditions, and punitive pension taxes, many health workers will keep driving to work in rush hour traffic and living in city centres with higher rents. Those able to work from home will mainly be in non-clinical roles where retention and burnout are less problematic. So, there's a double divide: between healthcare and non-healthcare staff, and between patient facing and office based roles.

To bridge this gulf, innovative delivery models such as telemedicine may help. Even in critical care, where working from a distance has many challenges, innovation is possible. One example is Health in a Virtual Environment, a remote monitoring service in Western Australia in which clinical staff provide 24/7 monitoring for vulnerable ward patients who might otherwise need admission to intensive care.

But technology isn't the only solution. Allowing patient facing staff the flexibility to be educated and trained at home, and to deliver non-clinical roles at home, may also help. Opening hospital IT systems to secure work off site is critical, along with job planning that recognises the value of this type of working. While most doctors have recognised non-clinical components in their contracts, many staff are entirely patient facing. This is a chance to reconsider why education, leadership, and training are a critical component of a doctor's weekly hours but are not recognised in many allied health roles.

So, while it's right to criticise below inflation pay rises, this is also an opportunity to allow more health staff to benefit from the home working revolution—helping retention, efficiency, and ultimately, patient care.

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These new ways of working may further exacerbate inequalities

**OPINION** Giles Maskell

# Why does the demand for medical imaging keep rising?

Any attempt to reduce demand must look outside the profession

Demand for medical imaging is rising at a faster rate than most other aspects of healthcare and at a speed with which NHS radiology services cannot cope.

We radiologists must accept some responsibility for this ourselves—as technological advances result in ever more detailed images, we identify more and more findings of uncertain significance, and we frequently choose to resolve this uncertainty by proposing further imaging. Many of these findings will turn out to be of no consequence. The greater part of the increase in demand, however, is attributable to developments elsewhere in clinical practice.

Some specific examples come to mind. The greater range of therapeutic options now available to treat most forms of cancer and the increasing survival of patients with this condition bring a need for more frequent and more prolonged monitoring of the response to treatment, which often involves imaging. A series of national reports and guidelines in the UK have encouraged greater vigilance for conditions that are difficult to diagnose clinically and can be excluded only with imaging such as pulmonary embolism and aortic dissection.

### Anticoagulants

At the same time, the increasing use of anticoagulants in the population has led to a marked increase in the number of cranial CT studies performed for patients with minor head injuries. The desire to diagnose and treat cancer at an early stage has led to increasing enthusiasm for imaging based screening—for example, to detect cancers of the breast, lung, and prostate.

As well as these examples relating to specific clinical scenarios, however, a number of systemic factors play a part. The well documented pressures on emergency department staff in particular have fuelled an increase in demand for imaging in the acute setting. The ability

**ACUTE PERSPECTIVE** David Oliver

# Stop naming and blaming hospitals for whole system problems

HANNAH MCKAY/PA /ALAMY

In advance of the chancellor's financial statement, the UK press trailed the government's intention to protect NHS funding while pushing the health service to improve its performance and efficiency.

This is nothing new for the Treasury, and both the previous and current health secretaries have pointedly highlighted major performance variations between acute hospitals. One figure doing several rounds of news recently is that just 15 of England's 135 acute non-specialist hospital trusts account for 40% of ambulance handover delays outside emergency departments, with one large trust experiencing one in 20.

There's also nothing new in highlighting variations in data on activity and outcomes. We've had national databases on variation for several years—such as the NHS atlas of variation, focusing on local level data, and the Getting it Right First Time (GIRFT) programme, which is more concerned with hospital services.

A range of national clinical audits also show variations in processes and outcomes between trusts. The question is, having described and highlighted the variation,

**Individual hospitals are very much affected by their local context**

what do we then do to understand and improve it?

What I'm seeing at the moment from politicians and mainstream media offers more heat than light. Naming, shaming, and blaming the "poor performers" or "outliers" won't help the staff working there, or the patients using their services—but it makes politicians appear to be taking tough action, holding the NHS to account for its use of public money, and acting as patients' champions.

The Care Quality Commission has often compounded this by rating and inspecting individual hospitals as though they're autonomous islands, not affected by their local context. But they very much are. I don't doubt that there's always more an individual hospital trust can do on leadership, workforce, morale, internal systems, and priorities—so their senior managers and clinical leaders don't get a free pass. However, let's think about those wider local contexts in which they operate,

to conduct a full clinical examination in a crowded emergency department may be restricted, and imaging is increasingly used as a triage tool to help identify patients who can safely be discharged rather than admitted for observation. Overstretched staff may understandably look to imaging to provide a form of safety net.

**The rise of remote consultation has led to the use of imaging as a form of replacement for clinical examination**

Away from the emergency department, the widespread adoption of remote consultation which has been accelerated by the covid-19 pandemic has also led to the use of imaging as a form of replacement for clinical examination, an approach which has its own consequences.

### Defensive medicine

Perhaps even more significant is the societal trend towards reduced tolerance of uncertainty which in the context of healthcare is sometimes characterised as "defensive medicine."

This often manifests as rigid adherence to guidelines and protocols. In imaging, as elsewhere, these are generally drawn up with the objective of ensuring that any patient who might benefit from a particular test gets that opportunity. A by-product of this approach is that some patients who may not benefit will still get the test.

All good guidelines allow for a clinical decision that the test may not be appropriate in certain circumstances, but the decision to image is often delegated to a member of staff—medical or non-medical—who lacks the experience, the confidence, or the authority to override the guideline or depart from protocol. The result is increasing deployment of imaging and other interventions in patients who stand very little chance of receiving any benefit from them.

I fully accept that this is the personal view of a radiologist and that others with other perspectives will have their own opinions as to why demand for imaging keeps rising, but my contention is that the rise is an inevitable result of our current model of patient care. I believe that it is an unintended consequence of a series of developments in clinical practice as well as changing societal attitudes which have become embedded over recent years.

It follows that any attempt to curb or control this demand will require something much more radical than a new set of guidelines and will need to take into account the views of patients as well as healthcare professionals.

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which give them very limited control over demand for care and put serious constraints on its supply.

Those factors include a local population's growth, age structure, deprivation, inequalities, ethnicity, nationality, first language, education, housing and employment status, and help seeking behaviour, as well as proximity and access to the nearest acute hospital.

They include the funding of local government services, public health teams, alcohol and addiction support, and social care; the capacity and workforce in ambulance trusts, local social care, care homes, and primary and community health services; and alternative types of emergency care centre outside major departments—all of which are hugely variable around the country, with many gaps. They also include the proximity and behaviour of neighbouring acute trusts in urban areas, or a hospital's status as a standalone provider many miles from the nearest alternative healthcare centre.

And they include the ability to recruit staff from the local community, against competing sectors, or to attract clinical staff from other regions or from overseas. Housing, rental costs, and transport links all play a part. Coastal communities with lots of retirees or seasonal holidaymakers, as well as rural hospitals with geographically large, low density catchment areas and long travel times, face particular challenges, as do hospitals in medium sized towns close to bigger conurbations with teaching hospitals. Progressive major reductions in general and acute hospital beds over the past 30 years, with newbuild hospitals often smaller than those they replaced, also mean major variations in bed capacity between localities.

None of these wider explanatory variables directly mirrors local needs and demands for healthcare. And it should come as no surprise that some acute hospital trusts have been on the "underperforming" or regulatory radar for decades despite numerous reviews, reports, special measures, and changes at board level. If these things weren't easy to fix when the going was better, they won't be fixable in the current context.

So, instead of naming and blaming hospitals for factors beyond their gift, let's consider what would help us understand the reasons and allow them to improve, in terms of targeted resources and support. And let's accept that this is a whole system and population problem. Soundbites and slogans won't fix it.

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**PRIMARY COLOUR** Helen Salisbury

# An unfit country

Back in 2010, in a move reminiscent of George Orwell's Newspeak, sick notes were renamed "fit notes." These are forms for employers or benefits agencies, generated by GPs (and sometimes hospitals) to verify that a patient is currently not well enough to work. Doctors have scope to advise amended hours or limited duties, and when I see recovering patients who are impatient to be back at work we can have a useful conversation about what they can realistically manage as they build up their strength.

The old concept of convalescence—giving your body enough time to recover properly—has faded from popular consciousness, and these days employers and employees often seem keen to jump straight back into full time work. But I also work with patients who have lost all their confidence (particularly common after taking time away from work with a mental health problem), and the option of a phased return is useful to help people ease back into the world of work, which is often an essential part of recovery.

The most depressing fit notes are the ones I repeatedly write where, beneath the headline problem, I put "awaiting hospital investigation" or "on waiting list for surgery." There are currently 7.1 million people on waiting lists, many of whom would be back at work if they'd received the treatment they needed. Instead, they're stuck at home, often in pain, with deteriorating mental health and worsening finances, instead of easing our labour shortage and paying taxes. Further resources are squandered as GPs spend time not just rewriting fit notes but also seeing these frustrated patients to adjust their medications and explain that, however many letters we write, we're unlikely to be able to expedite more definitive treatment.

Most countries took an economic hit during the height of the pandemic, but the UK stands out as being the only country where the number of working age people outside the workforce has continued to rise—a problem attributable to chronic pain, unresolved mental health problems, and long covid. I fear the chancellor's autumn statement this week will, once again, paint NHS spending as a cost that must be cut, rather than a vital investment.

The health secretary, Steve Barclay, has apparently stated that the NHS doesn't need more money, which leads me to have serious misgivings about his knowledge of, and intentions towards, the service. Without more money, how are we to retain the staff leaving in droves for better paid jobs? We need investment in training. We still don't have a workforce plan, but it's clear we're not training enough doctors and nurses. Even though we're poaching trained staff from countries that can't spare them, we're understaffed to the tune of 106 000 people.

Investing in health would be good for the economy, but it's also necessary if we're to end avoidable suffering and premature deaths. I'd like to be reassured this is high on our government's agenda.

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I fear NHS spending will be painted as a cost to be cut, rather than a vital investment

## LATEST PODCAST

### Compassionate medical schools

Throughout medical school, students are taught how eventually to become a compassionate doctor, but do medical schools show compassion towards students? In this episode of the Sharp Scratch podcast, the team discusses the impact that compassion (or a lack of it) can have on students, and the struggle that ensues when you have compassionate individuals but not compassionate systems.

Special guest Rob Jarvis, lead for student support at Dundee Medical School and for the ScotGEM (graduate entry) programme, starts by explaining what is meant by a compassionate organisation:

"I like the definition of 'empathy, but with action.' So we're interested in people and individuals—the ones that work for us, our students—but we try and recognise when there are issues and then do something about it. Compassionate organisations tend to be more productive, nicer places to work. Compassion within medical schools is sometimes seen as the sum of the compassion of the individuals who work within the schools. There is a lot of compassion out there among staff and peer-to-peer compassion between students. What I worry about is that the systems we have in place sometimes work against that. It's nobody's intention, but I think that, through historical and cultural norms, we've created systems that sometimes can even be harmful to our students."

Jarvis discusses the evolving role of welfare teams:

"There's been an organic movement towards trying to set up structures to help students, and that's mostly been in response to an increased recognition that there are students who struggle and we owe it to them to help. My fear—a little bit—is that student support is there to pick up the pieces, which they do pretty damn well a lot of the time. But is there anything that we can do to stop the pieces having to be picked up in the first place?"

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

ANALYSIS

# Changing the perspective on low birth rates: why simplistic solutions won't work

**Stuart Gietel-Basten**, **Anna Rotkirch**, and **Tomáš Sobotka** argue that policies responding to population decline and ageing should enable reproductive choice and maximise the potential of all citizens

The news that birth rates hit record low levels in many countries in Europe, Asia, and the Americas in the past decade was met with some alarm globally. More than half of the world's population lives in countries with a total fertility rate below two children per woman. The rate is below 1.5 in 46 countries (fig 1), and ranges from 1.3 to 1.8 in many middle income countries such as Brazil, Iran, China, Turkey, and India.[1]

Countries that, until recently, had fertility rates around 1.8-2.0 such as France, US, UK, and those in the Nordic region also now have declining birth rates. In South Korea the rate fell to 0.81 children per woman in 2021, an unprecedented low for any country in peacetime. Adversities and anxieties linked to the pandemic, Russia's invasion of Ukraine, and climate change may further contribute to fertility declines.[2]

As a primary engine of population ageing and stagnation, low birth rates are often viewed as a threat to welfare systems, healthcare, and the economy. The concern is that lower birth rates imply that, in several decades, there will be fewer economically active people to fund health and welfare systems as well as increasing demands on these systems. Rather than reforming such stressed systems through, for example, altering the pension age or raising taxes (which may be politically unpopular), many governments have sought to find a demographic solution by pursuing target driven policies to encourage childbearing. Such policy responses have questionable justifications, limited effect on fertility, and potentially harmful effects on sexual and reproductive health, human rights, and gender equality.

People in countries with low fertility rates desire, on average, to have more children.[3] Adopting a person centred, inclusive, rights based, and gender sensitive approach to fertility, following principles set out at the 1994 International Conference of Population and Development (ICPD; box),[6] is more likely to deliver a sustainable response to low fertility.

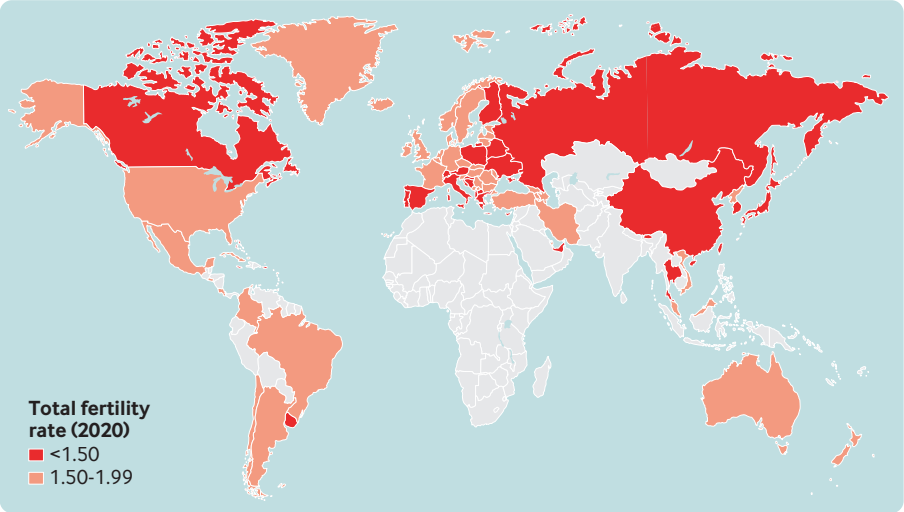



Fig 1 | Countries with a total fertility rate below 2 in 2020[1]

## 1994 UN International Conference of Population and Development

Big changes in health and longevity drove an increase in global population from 2.5 billion in 1950 to 5.3 billion by 1990.[1] This perceived unrestrained demographic growth resulted in fears of resource scarcity, environmental collapse, and overcrowding,[4] leading stakeholders to advocate reducing fertility, sometimes through coercive and draconian measures such as China's one child policy.[5]

The 1994 International Conference of Population and Development (ICPD) affirmed that sustainable demographic change was key to shaping macroeconomic prospects.[6] However, its programme of action marked a paradigm shift by focusing on reproductive health, gender equality, and individual wellbeing rather than governmental needs or demographic targets.[7]

Implementation of the ICPD programme has not been without controversy. The voluntary family planning it espoused has been linked to an overarching narrative of fertility reduction and presented as a way to resolve development problems.[8] There was also disagreement over funding, integration, and the right to induced abortion and its role in health services.[9-11]

Still, the core principles remain valid: individuals should be empowered to realise their reproductive goals on the basis of human rights, dignity, and gender equity within the context of sexual and reproductive health and rights.[12]

## KEY MESSAGES

- Low birth rates, linked to population ageing and stagnation, are a source of concern in many countries of the world
- Many governments have introduced target driven policies to spur the birth rate
- These policies often negatively affect gender equity, reproductive health, and sexual rights and are unlikely to be successful in their stated aims
- Other governments have focused on family friendly policies and increasing the wellbeing of all children
- Governments, civil society, and other stakeholders should concentrate on tackling the key institutional challenges associated with population ageing, enabling all citizens to reach their full potential, and supporting reproductive empowerment

## Target driven pronatalism risks health

Almost all countries with a total fertility rate below 1.5 have policies in place to raise fertility (fig 2).[13] Many governments have launched policies intended as a quick, politically expedient demographic fix to the challenges of population ageing and stagnation.[14] Rather than follow ICPD principles, countries such as Belarus, Japan, Republic of Korea, Hungary, Turkey, Poland, and Russia have adopted pronatalist policies that use narrowly oriented interventions to encourage or pressure women to have more children to reach a target fertility rate (usually around two children) and population size.[15] Although financial support for new parents is common in welfare systems around the world,[16] in target driven pronatalism payments are intended to encourage marriage and larger families. Some examples include the "baby bonuses" in Singapore, which pay out more for couples with three or more children; interest-free loans to prospective parents in Hungary that do not have to be repaid if a couple has at least three children within five years; and the "maternity capital" in Russia, a one-off benefit that has been provided to mothers of second or third children since 2007.[17]


Of equal importance to the actual policies is the rhetoric surrounding them, which often combines the "mission" to raise birth rates with a promotion of conservative family values, where women have a duty and responsibility to bear children and thus secure the future of the nation.[16] By promoting the childrearing role of mothers while ignoring men's contribution, top-down pronatalist policies and discourses tend to reimpose conservative family and gender roles and reverse progress on gender equity and rights for sexual and gender minorities.[18 19] Access to abortion, contraception, and sexual education is often curbed. In Poland, for example, restrictions on abortion were further tightened in January 2021, shortly before the government presented its demographic strategy, which aims to "get out of the trap of low fertility rate."[20] In Iran, as a part of the push to increase fertility, a law enacted in November 2021 curbs access to abortion, eliminates free provision of contraception, prohibits voluntary sterilisation, restricts prenatal screening, and broadens surveillance on access to family planning services.[21] In China, the latest round of policies designed to achieve "an appropriate childbearing level" includes provisions to "reduce abortions that are not medically necessary."[22] Certain groups (eg, unmarried parents, sexual and gender minorities, and couples without children) can be stigmatised and penalised.

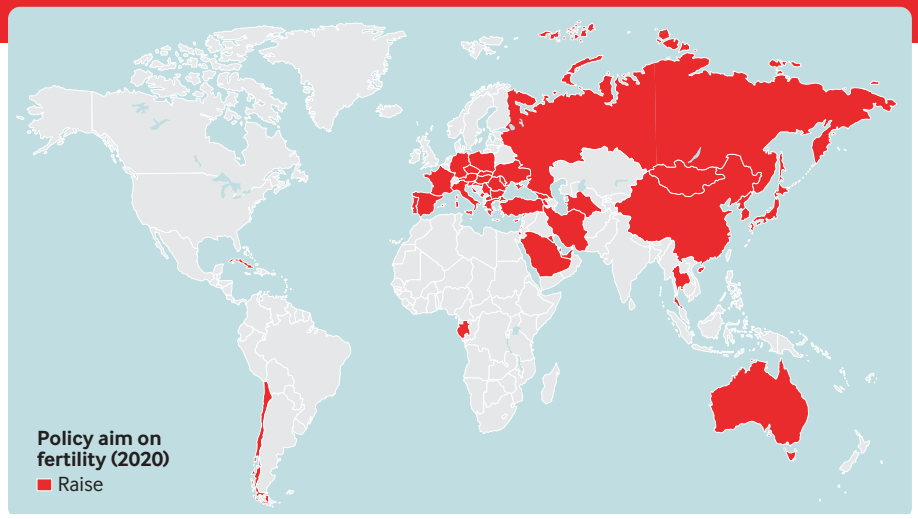


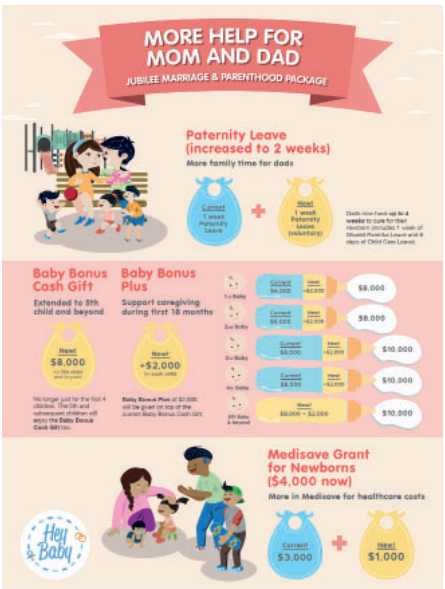

Fig 2 | Countries with a stated policy aim to raise fertility, 2015[13]

Target driven policies are often embedded within an authoritarian and ethnonationalist propagandist discourse. The "general population policies" announced by the supreme leader of Iran, Ayatollah Khamenei, in 2014 called for "promoting and establishing an Islamic-Iranian lifestyle and confronting the negative aspects of the western lifestyle."[23] In Turkey, President Erdoğan has declared that all families should have at least three children.[24] Russia's president Vladimir Putin reintroduced the Soviet era medal (inset above) for "mother heroines" with 10 or more children in 2022,[25] and deputies of the Russian State Duma introduced a bill banning information promoting the "foreign child-free ideology."[26]

Ethnonationalism becomes explicit in discussions of differential fertility rates by ethnic groups, as exemplified in the discourses about perceived high fertility among the Roma ethnic group in central and eastern Europe, including Bulgaria.[27] Although immigration can slow the pace of population ageing and counter fertility decline, it contradicts ethnonationalist goals. Hungary's prime minister, Viktor Orbán, has emphasised that government population policies aimed at increasing the number of Hungarian children are a fight against "a suicidal attempt to replace the lack of European, Christian children with adults from other civilisations—migrants."[28]

## Miscalculated approach

Target based pronatalist policies often rest on a questionable assessment of demographic measures and change and are thus unlikely to achieve their objectives. Firstly, pronatalist policies often affect the timing and spacing of births rather than the total number born to a particular cohort of women—for example, the short lived baby booms in Russia in the 1980s and 2000s following more generous family benefits.[29] Restrictions to abortion have historically led to a rise in illegal abortions and worse health for women and children, without long term fertility gains.[30] Secondly, population decline in many low fertility settings, especially in central, southeastern, and eastern Europe, has been exacerbated by emigration brought about through poor employment opportunities.[31] Simply put, if babies that are born because of pronatalist policy move away to work elsewhere at the earliest opportunity, the net population impact is zero.




The Singapore government introduced the Jubilee package in 2015 to encourage families to have more children and improve support during the child's first 18 months

## Reproductive empowerment

The international and moral consensus against target driven birth policies was settled at the ICPD (box 1).[6] It affirmed a health and human rights approach that prioritises empowering individuals to realise their reproductive goals as the mechanism by which to influence fertility rates. The ICPD principles, which aim to reduce the gap between desired and actual fertility, were successful in lowering high birth rates and can now also help governments to avoid very low birth rates. This consensus has been restated in various follow-on summits, such as ICPD+25 Nairobi 2019, and with target 3.7 of the sustainable development goals calling for universal access to sexual and reproductive healthcare services, and the integration of reproductive health into national strategies and programmes.

In countries with low fertility rates, many people aspire to have more children than they end up with.[3] The gap between fertility aspirations and actual family size—combined, in some countries, with high rates of emigration—are often symptoms of societal and economic dysfunction, including discrimination, imbalanced labour market, gender inequality, an unsustainably work oriented culture, and inadequate social support for families and young adults.[19] Countries with low fertility rates need comprehensive policies to support the healthy growth and development of families.[32] These include, for example, high quality and affordable childcare provision, flexible and well paid parental leave, work flexibility, job protection for parents, and policies supporting both partners' involvement in child rearing.

Some middle and higher income countries, including Estonia, Moldova, and Uruguay, have recently adopted such inclusive family policies while also broadening access to health and social policies.[33 34] Financial transfers provided in many higher income countries (such as monthly child allowances, paid maternity and parental leave schemes, subsidised early childhood education, and dedicated marriage or housing loans) also offset some direct costs of childbearing and reduce poverty among families with children.[35]

Gender sensitive family policies can offset some of the indirect costs of family formation, which are disproportionately shouldered by women, while also addressing men's wishes and challenges related to childbearing. Currently, access to sexual and reproductive health services is highly unequal both between and within countries.[36 37] Single women and gender and sexual minorities are often unable to access fertility treatment.[38 39] Demand for assisted reproductive technology and (in)fertility counselling is growing—not least because of rising parental ages and involuntary childlessness.[40 41]

**Focusing on the wellbeing of children and families should be the first priority of ageing societies**

KIM KYUNG-HOON/REUTERS/ALAMY

In South Korea the birth rate fell to 0.81 children per woman in 2021

Historically, generous family policies in France, Germany, and Estonia, for instance, have been partly linked with stated pronatalist goals. However, family friendly policies in these countries today are aligned with human and reproductive rights and support families to maximise social and economic wellbeing rather than arbitrary goals of the state. Hence, governments concerned about demographic trends should give more priority to initiatives to prevent infertility and involuntary childlessness and raise fertility awareness and reproductive empowerment. Young adults should be provided with the skills and services needed for planning their family life, just as they plan their work careers. Such educational and medical services need to be sensitive to the needs and wishes of different families, without stigmatising child-free lifestyles. These policies should be built on a strong grounding of sexual and reproductive health and rights and enhance family and children's wellbeing.

## Beyond birth rates

Even if slightly higher birth rates can be achieved, major societal changes need to be tackled now, irrespective of future birth trends. Urgent reform of health and welfare systems is required to meet the demands of an ageing population.[42] Other dimensions of population change, especially education and health, contribute to increased wellbeing and productivity and could offset many of the challenges linked with population ageing.[43]

Countries with smaller, older populations need to realise the full social and economic potential of all citizens, including migrants and their families. This involves continued investment in maintaining wellbeing and good health from infancy into old age, which is lagging in many countries, including the UK.[44] Countries with recent target driven policies such as Iran and Turkey often have much potential to maximise their existing human capital, not least through lowering child poverty and youth unemployment and increasing female participation in the labour force.[45]

Focusing on the wellbeing of children and their families and caregivers should be the first priority of every ageing society. Countries in the early stages of population ageing can also learn lessons from demographically older countries and create sustainable institutions that are resilient to continued demographic changes. This requires working with civil society, the private sector, and families to adopt holistic policies for healthy and active ageing, labour market and pension reform, family friendliness, and better immigration as well as promoting reproductive rights and empowerment.

Securing political support to bring about such reforms is not easy, as shown by the slow progress since the ICPD programme of action. However, we must learn from history and push back against attempts to fix the problem by telling women how many babies they should have.

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# LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

## Formula milk: a new regulatory system is needed


The failure of the International Code of Marketing of Breastmilk Substitutes to prevent industry violations has created a blame culture that has led to widespread dysfunctional behaviour across the key infant feeding stakeholders. This is illustrated in Coombes's article (Feature, 22 October). After 40 years, the concept of the code clearly needs to be reviewed.

The code's purpose is to prevent inappropriate marketing and promotion of infant formula by industry, and, in practice, violations present as breaches of trading standards. A key action should be to confirm trading standards for the industry and for these standards to be managed and regulated by trading authorities. The new approach should be set out in a revised code that is industry focused.

The new regulatory system should have global reach using digital technologies and should be developed so that all products and their related texts and advertising materials are fully evaluated and registered before entering the open market. All data will be held online and regulated by a specialist trading authority. The product should have digital codes to allow monitoring groups, policy makers, national authorities, and consumers to check the authenticity of the product by gaining access to the registered evaluation data. If violation is detected, trading standards authorities will place sanctions on the relevant manufacturer or retailer.

If the WHO is responsible for setting global policy, it is inappropriate that it should assume regulatory and judicial functions of the industry oriented code, as it will have an inherent conflict of interest. Independent regulatory and governance systems should be in place. Codex Alimentarius—which is part of the United Nations family, is already affiliated with the World Trade Organization, and also has responsibility for protecting consumer health and ensuring fair practices in the food trade—should provide governance oversight.

**Stewart Forsyth, retired medical director and consultant paediatrician, NHS Tayside**

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REDUCING UNNECESSARY PREOPERATIVE TESTING

## Avoid unnecessary tests

Dossett and colleagues reveal that unnecessary preoperative tests have become a traditional culture in medical practice, despite voluminous evidence against their continuation (Practice, 22 October). A couple of barriers to change are not mentioned.

Firstly, a battery of unnecessary tests might give doctors a sense of assurance—if they missed something in the history and examination, it will be picked up by the tests. And if not, they could defend themselves by showing their proactive approach of getting the tests done. Secondly, in developing countries, these tests could be the first a patient has had in their lifetime, so they are more willing to undergo them to know for sure that they do not have any other illnesses. But if a patient has to bear the cost of tests, which is known to push households to poverty, it is neither legal nor ethical for doctors to get the unnecessary tests done.

**Lakhiram Murmu, medical superintendent; Sushimta Murmu, assistant professor psychiatry, Faridabad, India**

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## Ask doctors to do their own phlebotomy

Reducing unnecessary preoperative testing remains a pressing concern for general practitioners in the UK, and their practices, which often host this activity.

A universal constant that I discuss with GPs in training is that a doctor will request fewer blood tests if they are asked to do their own phlebotomy. Is it now economically and ecologically reasonable for the general practice to decline requests to host this work if only to prompt some quality reflection from the clinical team requesting the tests?

**Will Howe, GP, Lostwithiel**

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SEROTONIN HYPOTHESIS OF DEPRESSION

## Molecular action of antidepressants is irrelevant

For many years I have told patients that the molecular action of antidepressants is ultimately irrelevant to their clinical application. When patients ask me, "Does this mean I have a serotonin deficit?" I tell them that our success gluing a broken chair leg does not mean the chair had a "glue deficit." We prescribe these drugs because they are often helpful.

Moncrieff and Horowitz's notion that the serotonin hypothesis could be "a rationale for why people should take antidepressants" (Letters, 8 October) overlooks the practical fact that clinicians continue to prescribe them not because they block the serotonin reuptake pump but because clinical experience repeatedly validates their clinical effectiveness.

This is not to say that clinical experience is a very reliable guide to what works; we need "drug companies and academics" to provide reliable evidence. Debunking the serotonin hypothesis has nothing to do with whether we should prescribe selective serotonin reuptake inhibitors.


**John Wynn, psychiatrist and clinical professor, Seattle**

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## IMPLEMENTATION OF COVID-19 VACCINATION IN THE UK

### The JCVI needs resources

Did the Joint Committee on Vaccination and Immunisation (JCVI) shout early for additional administrative help during the pandemic? If it did, was anyone listening?

Majeed and colleagues write, "Publication of JCVI meeting minutes is laudable but insufficient for the widespread communication of decisions, particularly during times of national crisis" (Covid Inquiry, 8 October). But the JCVI did not publish timely minutes of its meetings, particularly in the first 12 months of the pandemic. NICE's technology appraisal guidance, for example, is published promptly online as an appraisal consultation document, next there is a consultation period, and then a final appraisal determination is produced.

I suspect the JCVI does not have anything like the administrative infrastructure available to a NICE technology appraisal committee. Shouldn't the JCVI ask for and be given the resources that it needs? We should all be grateful for that committee's largely unpaid, under-resourced, and ongoing work on the nation's behalf.

**Mark N Upton, retired GP, Thirsk**

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### Authors' reply

We agree that the JCVI needs to operate in a transparent manner with a suitable level of administrative and financial support to carry out its work effectively. NICE provides good examples of transparent working, partnerships with patients and the public, and publication of timely reports on its work and guidance for health professionals.

The JCVI was working under difficult circumstances, aiming to produce guidance on covid-19 vaccination during the biggest public health crisis to face the UK since the second world war. This guidance had to be produced while evidence on the risks and benefits of covid-19 vaccines was still emerging and often incomplete. The JCVI should, nonetheless, be aiming to emulate the high standards set by NICE. The government must provide the JCVI with the support to make this possible.


The UK should be leading the world in work to improve confidence in vaccines and increase vaccine uptake.

**Azeem Majeed, professor of primary care and public health; Katrina Pollock, senior clinical research fellow in vaccinology, London; Simon Hodes, NHS GP trainer, Watford; Marisa Papaluca, visiting professor, London**

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## FACIAL PARALYSIS AND WEAKNESS

### Leprosy and HIV have to be ruled out

Thirupathirajan and Thinakararajan discuss the differential diagnosis of recurrent facial palsy (Endgames, 15 October). A few important differentials, such as those between leprosy and HIV, are left out.

Leprosy, especially tuberculoid type, is an important contributor to bilateral and occasionally unilateral lower motor neurone type facial palsy. The diagnosis is mainly clinical and detection of PGL-1 by enzyme-linked immunosorbent assay (ELISA) is used as serological diagnosis of leprosy, although it is positive in 60% of tuberculoid leprosy cases.

HIV serology should be performed to rule out HIV infection. HIV infection can cause facial palsy at any stage.

**Ranjan Kumar Singh, chief medical officer cum superintendent, JPN Hospital, India**

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## SPECIALTY AND ASSOCIATE SPECIALIST DOCTORS IN GENERAL PRACTICE

### Fresh thinking for workforce solutions

The fastest growing group of doctors—specialty and associate specialist and locally employed doctors—are being constrained from working where they are most needed (This Week, 22 October). To be clear, these doctors should not substitute for the highly skilled, specialised work that GPs do. But they could have a crucial supportive role.

Over 40 000 additional specialty and associate specialist and locally employed doctors are estimated to join the workforce by 2030. Only a small proportion of these choosing to work in primary care would make a huge difference in making workloads more sustainable and reducing the risk of burnout.

If we can help primary care get the workforce it needs, more conditions can be managed effectively out of hospital, reducing demand on secondary care and ultimately benefiting patients. We are calling for fresh thinking from governments and health services to relax the rules on who can work in primary care.

**Charlie Massey, chief executive, GMC**

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### A shortened GP training programme

As a specialty and associate specialist doctor who recently joined the GP training scheme, I want to emphasise the virtues of the "combined pathway" certificate of completion of training (CCT), which the Royal College of General Practitioners has adapted to allow doctors to have up to one year of experience counted towards any future hospital posts in training.

This can reduce the CCT to two years full time if there is rigorous evidence of previously achieved competencies. Many doctors who apply to specialty jobs have competencies that can legitimately count towards a CCT in general practice—simplifying this process might help with recruitment.

Many doctors are unaware that this pathway exists. Although the process could be further ameliorated to suit senior career grade doctors, it still represents a good (and shorter) pathway on to the GP register that might attract any experienced doctor looking for a new adventure.

**David Lyness, GP associate in training, Belfast**

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## OBITUARIES

### Colin William Thomas Keen

**Medical director Mid-Kent Cancer Centre (b 1934; q London Hospital, 1958; DMRT Eng, MRACR, FRCPC, FRCR, MA Wales, LMCC), died from prostate cancer on 23 September 2022**

Colin William Thomas Keen served for three years in the Royal Air Force, with a posting to Hong Kong. On returning to the UK he qualified as a radiation oncologist before working in Australia from 1965 to 1971 and in Canada from 1971. In 1980 Colin and his family returned to the UK, where he worked as a consultant in clinical oncology at Velindre Hospital near Cardiff, Wales. In 1991 he was appointed medical director at the new Mid-Kent Oncology Centre, which opened in 1993. Colin continued to take charge of running the facility and worked towards the establishment of the Kent Cancer Centre. He was clinical director, clinical sciences at Maidstone Hospital (1993-96) and later medical director (1996-99). Colin leaves Jean, five children, and nine grandchildren.

**Fiona M Browning**

Cite this as: *BMJ* 2022;379:o2657

### Stuart Mucklow

**Consultant haematologist Royal Berkshire Hospital, Reading (b 1968; q Oxford, 1997), took his own life on 12 October 2022**

Stuart Mucklow gained one of the top firsts in his year and embarked on an intercalated PhD. He moved to the North London Deanery to train in haematology, but in the immediate post-Calman era, there was no academic pathway for clinician scientists. The modern consultant life of red tape, form filling, and lack of independence interfered with what he perceived to be the best course for patients. After wrestling for several years with a darkness that few suspected, he ended his own life. At his memorial service, family members, old school buddies, college friends, his rowing crew, and half of Dorchester-on-Thames found that he had touched them all with the same unforgettable gentleness and generosity. He leaves his wife, Lisa Walker, and their son, Alistair.

**Matthew Collin**

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### Michael Fenner Hermann Nelki

**GP (b 1944; q St George's Medical School, London, 1969), died from complications of secondaries from a grade 1 renal cancer on 27 October 2022**

Michael Fenner Hermann Nelki graduated in 1969 and married Jo, a Jewish American nurse from New York. They travelled across Africa in their Land Rover to Tanzania, where they worked for two years. He then held a GP partnership in Yatton group practice for 32 years and retired in 2006. Michael was a family doctor as the term was envisaged, with continuity of care and knowing your patients. For many years he wrote medicolegal reports for Freedom from Torture, the Helen Bamber Foundation, and Medical Justice. He later supported doctors in Bristol to continue the work. He and Jo moved to Bristol in 2001. In retirement he volunteered for Legs4Africa and the Clifton Rocks Railway. Michael leaves Jo, three children, and four grandchildren.

**Julia Nelki**

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### John Nelson Norman

**Consultant surgeon and remote medicine specialist, Aberdeen (b 1932; q Glasgow, 1957; MD, PhD, DSc, FRCS (Edin), FRCS (Glas), FFOM, CBiol, FIBiol, FRSB), died from old age on 27 September 2022**

John Nelson Norman's lifelong passion for remote healthcare started during national service with the Royal Army Medical Corps in Antarctica. He studied emperor penguin embryos and returned to academic surgery in Glasgow and then Aberdeen. He founded the Institute of Offshore and Environmental Medicine at the University of Aberdeen while he was a consultant surgeon. He led the academic support for the new oil and diving industry with a personal chair and developed supporting medical services. At Robert Gordon University he was medical director for the British Antarctic Survey and was awarded the coveted Polar Medal. He never "retired" from his passion. Predeceased by Morag, his wife of 57 years, he leaves their daughter and a grandson.

**James Douglas**

Cite this as: *BMJ* 2022;379:o2626

### Kurt Schwarz

**Professor of preventive and community medicine (b 1928; q University of the Witwatersrand, South Africa, 1951; DPH, MRCP, FFCM), died from carcinoma of the prostate and Alzheimer's disease on 20 August 2022**

Kurt Schwarz was appointed lecturer in public health at the University of Liverpool in 1957. In 1964 he became a senior lecturer at Leeds. In 1974 the family moved to New Zealand to establish the new department of preventive and community medicine at Christchurch Clinical School, University of Otago. After a spell as visiting professor at Flinders University, he returned to the UK in 1979 as a visiting professor at the University of Nottingham Medical School before serving as a specialist in community medicine in two London boroughs and at the East Hertfordshire Health Authority. In the 1990s Kurt became principal medical officer at Remploy. He leaves his wife, Elsa; two daughters; and two grandchildren.

**Gillian Seigal, Judith West**

Cite this as: *BMJ* 2022;379:o2627

### Edmund Tapp

**Consultant pathologist (b 1934; q Liverpool, 1959; MD, FRCP Path), died from long term effects of lymphoma of the spinal cord on 29 March 2022**

Edmund Tapp ("Eddie") worked in training posts in Liverpool and Manchester and was appointed consultant pathologist to the Preston and District Health Authority in 1976. Additionally he acted as Home Office pathologist for Lancashire and Cumbria from 1986. During his career Eddie published numerous scientific papers, but his work in palaeopathology will be best remembered for his performing televised autopsies on Egyptian mummies, and for his professional involvement in the "Lady in the Lake" case. He retired to Worcestershire in 1999 and continued to work as a local Home Office pathologist for 10 years. In retirement he proved a genial host and enjoyed golf and bowls. Predeceased by his wife, Joan, he leaves a son, a daughter, and three grandchildren.

**David Brownridge**

Cite this as: *BMJ* 2022;379:o2629

# John Marks

Outspoken former chair of the BMA, campaigner, and moderniser

**John Marks (b 1922; q Edinburgh, 1948; FRCP, DObst RCOG), died from frailty in old age on 20 September 2022**

There is, it is reported, a convention to bestow honours on BMA chairs. John Marks, with a record six years in office from 1984, might have been tipped for a knighthood. But his outspoken clashes with high profile figures, especially his arch enemy, the then health secretary Kenneth Clarke, did not endear him to Westminster.

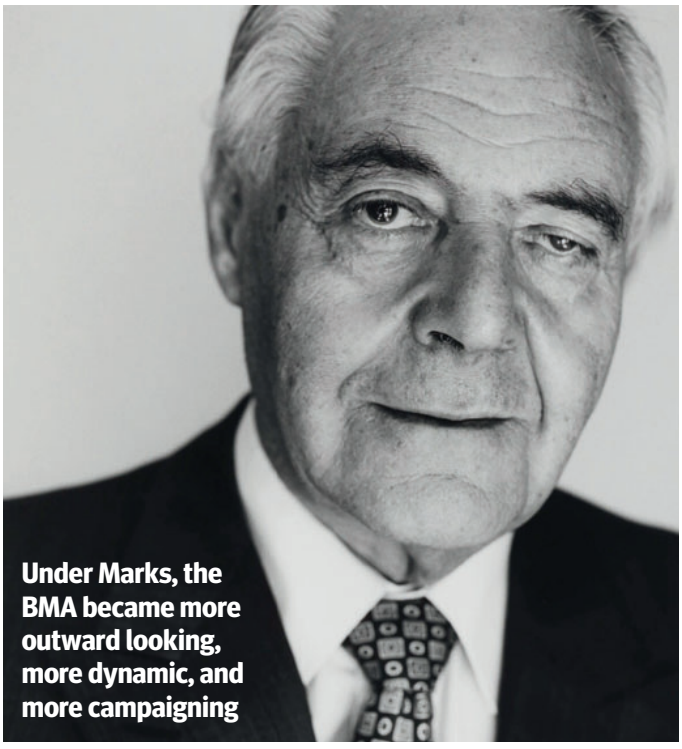
## Clashes

Marks led the profession against Clarke's reforming plans to introduce to the NHS the untried concept of an internal market to promote competition. More than 30 years later, Marks declared, "He bloody well helped to introduce the internal market into the NHS and that will spell its end." Marks lived just long enough to see the announcement in July of the introduction of integrated care systems, with their new mantra—collaboration not competition.

He delivered another stinging rebuke against the health secretary at a London seminar, when Clarke listed many of the NHS's achievements. Marks, stressing how cataract operations were being rationed and hearing aids were in short supply, barked, "And if that shows a healthy and buoyant NHS, my name is Kenneth Clarke."

Standing up to the seemingly affable, avuncular Clarke was no mean achievement. The health secretary was set on "knocking the BMA off its pedestal."

Marks showed a more diplomatic side in his off-the-cuff riposte to Prince Charles's inaugural speech as BMA president in 1982. Astonishingly, the prince cited a letter that "reminded him that the initials BMA 'stand for bigoted, moribund, and apathetic.'"



NICK SINCLAIR

**Under Marks, the BMA became more outward looking, more dynamic, and more campaigning**

In his autobiography, *The NHS: Beginning, Middle and End?* Marks recalled, "Sitting beside the prince I could see the audience of about 2000 people looking horrified. I knew I had a very difficult situation. I had to defend the reputation of the association without offending our new president."

Marks replied that any body electing a Cockney Jewish grammar school boy to its highest political office could not possibly be bigoted. He assured the prince that B stood for British and that BMA members were proud of that. Next, he pointed out that M stood for membership as well as medical, and that the recent rise in members showed the BMA was by no means moribund. Finally, to loud cheers, he told the new president he would soon learn the BMA was far from apathetic.

Arguably, the prince got his timing wrong. The BMA had cast aside its old image, becoming far more than a doctor's trade union. Under Marks, it became more outward looking, more dynamic, and more campaigning—with a firm commitment to public health—albeit not always with the full support of its members.

Its booklet, *AIDS and You*, published in 1987, provoked outrage among what Marks dismissed as "the more reactionary and bigoted members of the profession." With simple words, explicit cartoons, and pictures of condoms, it spoke about how HIV was spread and how to avoid it—and won a Plain English award.

Marks and other BMA leaders were also accused by MPs such as Nicholas Winterton of being "promoters of promiscuity," not because of their attitudes to AIDS but because of BMA policy about prescribing the contraceptive pill to girls under the age of 16.

Marks also played a major part in defending the Abortion Act 1967 against prominent pro-lifers like Victoria Gillick after the death of one of his patients. "Betty" died on a bathroom floor after attempting a self-induced termination. Tragically, Marks recalled, the act did not become law until 28 April 1968, too late for Betty.

Marks's strong support of the campaign to make car seatbelts mandatory also provoked fierce parliamentary opposition. The seatbelt law was finally passed in 1983 after 13 failed attempts. Never afraid to court controversy, he called for "the obscenity" of professional boxing to be banned in 1991, when the boxer Michael Watson was seriously injured fighting Chris Eubank.

He also joined fellow GP Sam Everington in a highly publicised protest in 1992, accusing the newly ennobled Baroness Thatcher of promoting death when she became a consultant to Philip Morris, the world's biggest tobacco company.

He qualified as a doctor on the day the NHS was formed in 1948. Having seen the effects of poverty on health, he was a passionate believer in the new health service and could not understand why so many senior doctors opposed it.

He was chosen out of 120 applicants for a post in a pioneering group practice in Borehamwood, Hertfordshire. (Most GPs at that time worked alone.) It was at this time that he met his future wife, Shirley, later one of his GP partners. The best thing he ever did, he said, was to marry her. He leaves Shirley, their children, and eight grandchildren.

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