comment

"It's tempting to think that medical activism is new, but it isn't" **JOHN LAUNER**
"Will same day access hubs deprive GPs of opportunities to learn?" **HELEN SALISBURY**
PLUS The Safety of Rwanda Act

TAKING STOCK Rammya Mathew

We can't miss the backdrop as the UK becomes sicker

Plans by the prime minister, Rishi Sunak, to overhaul the sick note system in the UK have left me with mixed emotions. A more independent process, overseen by professionals skilled in occupational health, will hopefully lead to a more robust system, in which people are supported to get back into work as quickly as possible, when they feel able to. But I worry that removing GPs from the decision making will create a less compassionate process that's unduly stressful for patients, most of whom are genuinely struggling to cope.

Some 2.8 million people in Britain are currently signed off as unable to work, and in almost half of them the cause of ill health is depression, anxiety, or mental health problems. The volume of sick notes being issued has also risen steadily over the past decade—and, given the ramifications both for the individual and for wider society, there's a strong argument for change.

We know that being signed off sick for long periods can be life altering. Prolonged sick leave absence reduces the likelihood of returning to work, and in many cases long term absence can spiral into long term incapacity. Unemployment is itself a health hazard: it can have hugely negative consequences for a person's mental and physical health, and it's associated with an increased risk of morbidity and mortality. So, doing more to safeguard people against the ill effects of worklessness is the right thing to do, but simply tightening up on sick notes isn't a solution in itself.

We can't overlook the backdrop on which Britain is becoming a "sicker nation." Access to healthcare in the UK is at an all time low, and many patients are off work while waiting for specialist investigations and treatment. Mental health services have also become increasingly threadbare, losing opportunities to intervene early and prevent low level mental health problems from evolving into more serious illness. Add to this the cuts to drug and alcohol services, a reduction in mental health beds, and a lack of key worker provision for people with severe mental illness, and it should come as no surprise that more people are signed off work than ever before.

Be it physical or mental health, early intervention matters, in terms of reducing the burden of illness and getting people back to work. Delays can take people out of work for good. If we focus on sick notes without fixing the underlying problems in access to healthcare that are causing more people to spiral into worklessness, we'll only create a cold and punitive system for patients who have already been grossly let down.

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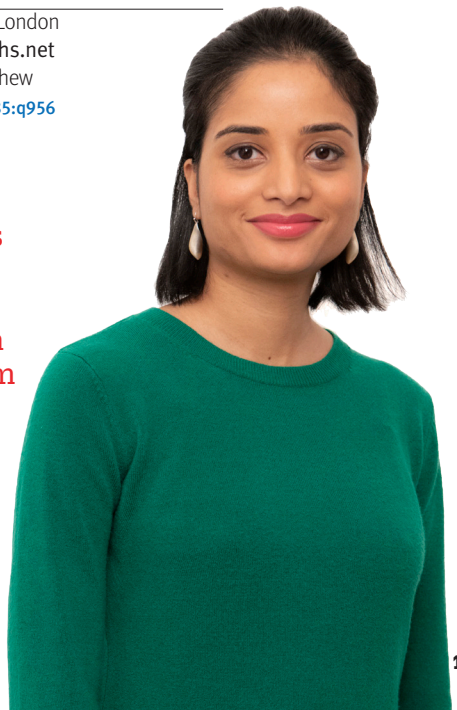
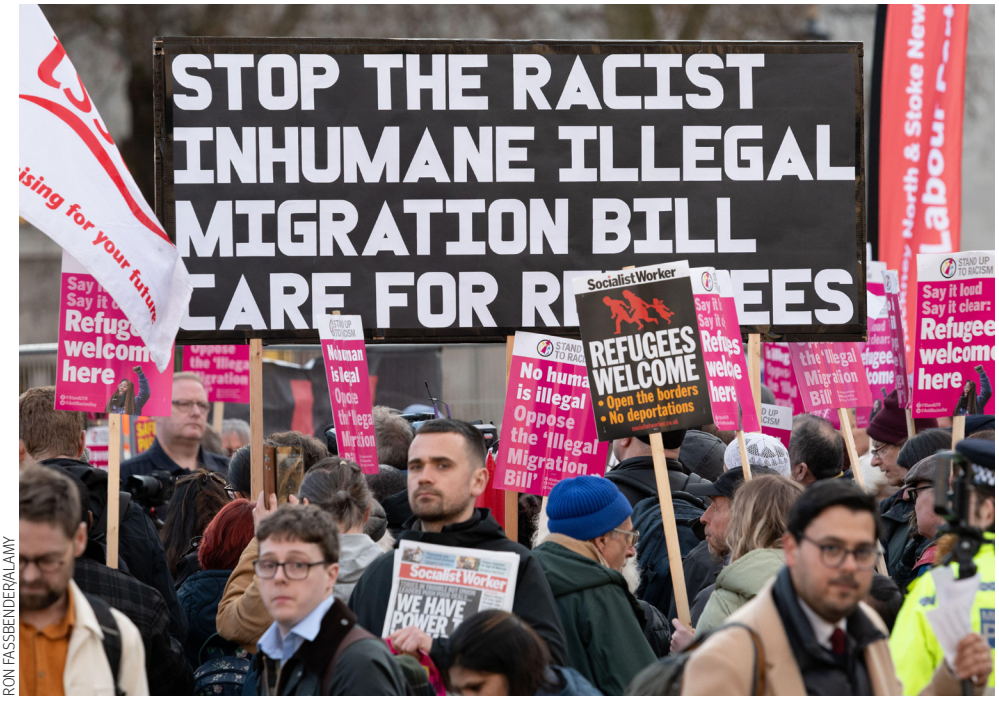
Services lose opportunities to prevent low level mental health problems from evolving into more serious illness





RON FASSBENDER/ALAMY

OPINION Martin McKee

The Safety of Rwanda Act: a pointless exercise in performative cruelty

Why do politicians have such a low opinion of British people's compassion to think this policy is a vote winner?

Those asked to facilitate removals, including doctors, would be extremely unwise to participate in this process

Late on 22 April the Safety of Rwanda (Asylum and Immigration) Bill cleared its final stages in the UK parliament. Its stated purpose is to enable the government to send migrants who have reached the UK to Rwanda.

The bill was deemed necessary because the government's previous attempts to send migrants to Rwanda were thwarted, firstly by a series of temporary blocks (Rule 39 orders) imposed by the European Court of Human Rights (ECHR), and then by the UK Supreme Court.

The Supreme Court ruled ministers had failed to show that refugees sent to Rwanda would be safe and would not be sent on to another country and that its plans were incompatible with the UK's obligations under international agreements, in particular, the 1951 Refugee Convention.

These decisions created two problems. First, should the government want to proceed, it had to show that Rwanda was indeed safe. Second, it would have to prevent last minute orders by the ECHR halting the removal of refugees from the UK.

The solutions were, superficially, simple. First, the government declared that Rwanda is indeed safe, and will remain so unless it decides otherwise. The government rejected a role for the Independent Monitoring Committee that it established to give its policy a veneer of respectability. The idea that a country will remain "safe" regardless of what happens there is clearly ludicrous, as was pointed out in parliamentary debates.

Second, the act allows ministers to instruct civil servants to disregard any orders by the ECHR. However, as the president of the court has pointed out, the UK has a "clear legal obligation" to follow these orders, a position that the UK's attorney general has stated is "beyond doubt," with "no respectable argument" to the contrary.

The claim there is no money for the NHS seems implausible given a willingness to spend in excess of £370m on the scheme

Understandably, the body representing civil servants has threatened legal action given how the act forces them to choose between obeying ministers and breaking international law.

All of these points and more were made as the bill moved through the parliamentary process—entering what is termed "ping pong"—as unworkable, illegal, or immoral components passed by the House of Commons were rejected by the House of Lords, with many of the government's own peers voting against them. Eventually the Lords were worn down and the bill was passed.

This does not, however, mean that anyone will ever be sent to Rwanda. Unusually, ministers have stated, on the face of the bill, that they cannot say that it is compatible with the European Convention on Human Rights. Consequently, those asked to facilitate removals, including doctors, would be extremely unwise to participate in this "inhumane and unconscionable" process. Given the low threshold for acting against doctors breaking the law—even in climate protests when many might view it as justified—one must assume that the GMC would take a dim view of such transgressions.

Outside scrutiny

Although the government has legislated to remove as many possible defences against removal as it can, leading the UN High Commissioners for Human Rights and for Refugees to express severe concerns, it has been unable to remove ministerial decisions entirely outside the scrutiny of the UK's courts.

Thus, those subject to removal orders can challenge them if their individual circumstances place them at particular risk. This could place a substantial burden on a struggling justice system. The government has responded by saying it will deploy

150 additional judges with 5000 extra sitting days, although without explaining where they will come from. Meanwhile, the lady chief justice has pointed out that this is an attack on the independence of the judiciary's right to decide how to deploy resources.

The government claims to have found an airline willing to transport those people subject to removal, but UN Special Rapporteurs have noted that any that do could be "complicit in violating internationally protected human rights and court orders by facilitating removals to Rwanda."

RwandAir, the national carrier, and AirTanker, which operates the Royal Air Force's long range transport fleet, have both refused to do so. Furthermore, it seems unlikely that military lawyers would advise service personnel to breach international humanitarian law given the wider implications.

Finally, even if a handful of people were sent to Rwanda, a future Labour government, now a virtual certainty within months, will stop the programme.

Wider implications

There are, however, some wider issues. The government's claim that it has no money for the NHS or many of the other pressing issues facing the country seems implausible given its willingness to spend in excess of £370m on a plan that the Home Office's own impact assessment was unable to conclude would work.

The inability of the House of Lords to prevent passage of what the Law Society has described as a "defective, constitutionally improper piece of legislation,"—despite the strenuous efforts of some peers such as Lords Hope and Anderson—strengthens the case for constitutional reform. But perhaps the most important question is why any politician would have such a low opinion of the compassion and humanity of the British public that they believe such an exercise in performative cruelty would actually attract large numbers of votes?

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TALKING POINT John Launer

Doctors as activists

Doctor activists are in the news. Sarah Benn, a former GP from Birmingham, has had her medical licence suspended for five months after being arrested for taking part in peaceful protests by Just Stop Oil.

Medical members of the Extinction Rebellion movement have served jail sentences for taking part in peaceful protests about the climate emergency: they now face disciplinary hearings to determine whether they'll be struck off.

It's tempting to think that medical activism is new, but it isn't. There's a distinguished history of doctors, some of them eminent, putting their medical careers and reputations at risk by making social action a priority.

As it happens, two books I've just finished recount the stories of such doctors and provide examples for us all. *Chekhov's Sakhalin Journey* by Jonathan Cole describes a journey made by the great Russian dramatist and doctor to investigate a penal colony set up in the 19th century on the island of Sakhalin, off the east coast of Siberia. Cole is a professor of neurophysiology who has clearly been mesmerised by this episode, visiting Sakhalin twice himself in collaboration with an actor who produced a theatrical piece based on Chekhov's mission.

Cole writes that Chekhov expected his plays and short stories to be forgotten within a few years, but what he hoped would endure was the work he did to improve the lot of the millions of peasants, exiles, and convicts who populated the Russian empire. Chekhov's account of Sakhalin conveys a harrowing impression of squalor, degradation, crime, corruption, disease, child prostitution, and much else—matching testimonies from British penal colonies in Australia. Partly through his ironic and detached writing style, Chekhov seems to have evaded reprisals, a significant risk in tsarist Russia. But, as Cole writes, "To have made the trip—and survived—marked Chekhov forever."

The second book—Richard Stone's *Hidden Stories of the Stephen Lawrence Inquiry*—is from closer to home, but it attests to the same kind of moral commitment. Richard was a prominent London GP, an activist in race relations, a personal friend, and a panel member of the public inquiry into London's policing in the 1990s. This arose from the murder of Stephen Lawrence, a black teenager killed by a gang of white fascists. The findings led to accusations of institutional racism in the police. Richard's fight for racial justice wasn't his only campaign: he uncovered a "homes for votes" scandal in Westminster, which forced its council leader to refund £12m.

Richard's recent death prompted me to read his book about his experiences on the Lawrence inquiry, intentionally breaching a convention that activities behind the scenes should be veiled in silence. In his book he expressed his belief that racism, accompanied by deceit, corruption, and obfuscation, had pervaded not only the murder investigation but also the inquiry itself, as well as police and government behaviour for years afterwards. Seemingly, this still continues.

I suspect many doctors, like me, have never been bold enough to act like these people or the doctors now facing GMC tribunals, but we are in awe of their courage in taking personal and professional risks for such causes.

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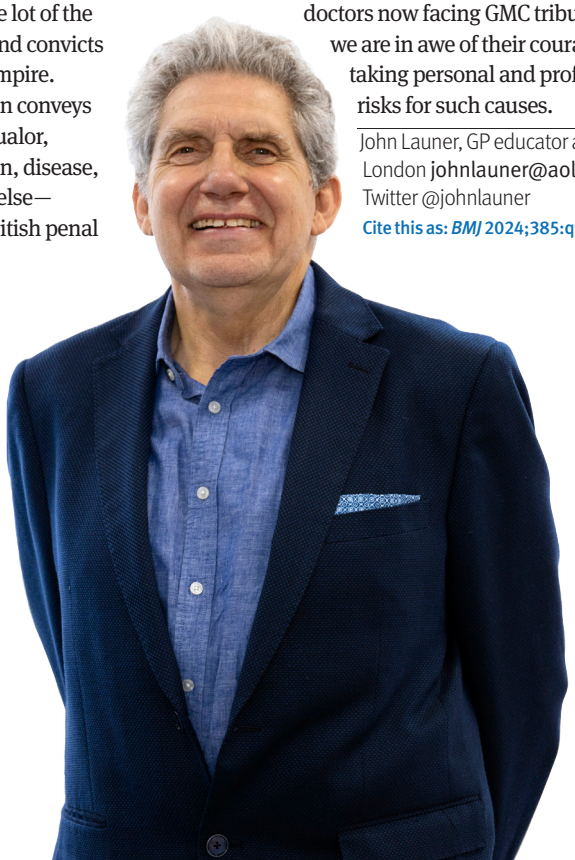

There's a distinguished history of doctor putting their careers and reputations at risk by making social action a priority

Continuity and experiential learning

Continuity of care—seeing the same GP over time—reduces the need for emergency care and increases longevity in patients. It leads to better patient satisfaction and improved quality of care. It also has the potential to make GPs into better doctors—not just for the individual patient in front of us, as we learn more about their life and gain their trust, but by deepening our understanding of medicine.

Although I was technically ready for practice when I completed my training, I know that I'm a better GP now than I was then. Some of my new knowledge comes from update courses and formal ongoing education, but much of what I now know I've learnt from patients.

As a medical student I had a head full of clearly defined sets of symptoms and signs that led to solid diagnoses, but once I entered practice I rapidly discovered that the real world is much messier and more complicated than that. The patient has a rash that looks like nothing you've seen before and matches none of the images you find online. The ex-smoker with swollen ankles and shortness of breath could have COPD, heart failure, or lung cancer, or they may just be unfit.

To learn from experience we need feedback: we need the patient to come back and tell us that the treatment worked, or that it gave them side effects, or that new symptoms have arisen that throw a whole new light on the diagnosis.

This feedback also comes in the form of test results and hospital clinic letters. Even in these late years of my career I still want and need to know whether I got the diagnosis and management right—and the answer may make me a better doctor for the next patient I meet.

I stay late in the evenings at my practice, checking results and reading the letters in Docman. There may be more efficient ways to process the data, but then I wouldn't learn, or I'd do so only when something went seriously wrong.

I worry that the direction of travel for general practice, with the fragmentation and loss of continuity implied by the "same day access hub" model of care, will deprive us all of these opportunities to learn and grow as doctors.

If GPs are busy supervising other non-medical staff who see all the patients requesting same day access, giving them no time to see their own patients, it's difficult to know how we'll produce the experienced GPs of the future.

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To learn from experience we need feedback

LATEST PODCAST

Fixing healthcare's workforce problems

In this episode of *The BMJ* podcast we hear from Amy Edmundson, whose work on psychological safety in the workplace has underpinned lots of quality improvement efforts in healthcare. She talks about how people and organisations have become more psychologically literate, and what the evolution of the psychological safety movement may look like:

"There's been more awareness, but that awareness is at risk of expanding to everything, so that psychological safety starts to mean to people that I get all my needs met at all times. But we have to be realistic about the complexity of human interactions, which will always be somewhat fraught. So my aspiration is that we get greater clarity about what psychological safety is and what it isn't. And with that clarity we are better able to ensure that relevant ideas, questions, concerns, and mistakes are always heard, while also keeping in mind realistic expectations about what work is."

This episode also caught up with the authors of one of the papers in *The BMJ*'s Commission on the Future of the NHS. Mary Dixon-Woods, director of THIS institute at the University of Cambridge, talks about how the NHS needs to become a more people centred employer:

"Some of the issues are quite mundane and unglamorous. They're to do with basic conditions of having fridges, lockers, somewhere to put your bike safely. All that sort of stuff is really important to people's day-to-day experience of work and should be a priority for NHS organisations. A second thing is the issue of workplace conduct and behaviour. NHS staff are exposed to unacceptable levels of bullying and discriminatory and racist behaviour. There needs to be a strong emphasis on dealing with that at policy level all the way through to individual trusts."

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

ANALYSIS

Can today's crises spark structural and policy choices needed for healthy societies

Kumanan Rasanathan and colleagues argue governments and others, including the health sector, must use current global crises to enhance social, economic, and environmental equity and sustainability

The world faces multiple interlinked crises, with severe and long lasting impacts on health and health equity[1]: covid-19, climate change, cost of living, and increasing conflict and inability to protect human rights. These crises were not inevitable; they reflect political, structural, and policy choices that drive an overarching crisis of social and intergenerational inequality. They also reflect the systematic failures in governance across countries that exacerbate inequities in health and imperil achievement of the 2030 sustainable development goals.

These failures are increasingly untenable. Current crises offer an opportunity for governments, societies, and individuals to make the structural and policy choices needed to co-create societies that maximise health and wellbeing. There is no singular understanding of what constitutes such a society. Healthy societies vary by culture, politics, and history,[2] but some broad commonalities can be identified.

The proliferation of global crises and the lack of countries meeting all requirements for a healthy society need not inspire fatalism about the possibility of healthy societies. Instead, current crises provide urgent impetus to transcend what is currently thought to be possible; an inflection point to reverse this course and make the structural and policy choices that create and build healthy societies.

Without reorienting societies towards health and health equity there will be insufficient trust, solidarity, and cooperation to ameliorate crises

Without reorienting societies towards health and health equity there will be insufficient trust, solidarity, and cooperation to ameliorate today's crises—and to prevent and manage the crises of tomorrow.

KEY MESSAGES

- The current multiple interlinked crises provide opportunities for transformative action to enact healthy societies and improve social, economic, and environmental equity
- While the understanding of what constitutes a healthy society varies, common features can be identified drawing on existing concepts related to health equity
- Key structural and policy choices to realise healthy societies will require action across all sectors, not just health
- Evidence, research, and learning should frame and interpret the current crises in ways that support these choices

Systems and governance failures

The covid-19 pandemic caused at least 15 million deaths worldwide,[3] with egregious inequities between and within countries.[4] Lack of preparation and poor response illustrate the dysfunction in systems and governance that undermine health and health equity. Among the countries that have seen the greatest impacts, or the worst inequities, many are high income countries that were thought to be well prepared for a pandemic.[5]

Failures in systems and governance are further elucidated by the world's inability to mount an effective response to mitigate climate change, even though it poses an existential threat and despite over 30 years' evidence of the problem and remediation required.

The health co-benefits of key measures to mitigate climate change, including less air pollution, better diet, and enabling more physical activity, could prevent millions of deaths.[6] Yet progress in action to realise these co-benefits is slow. Instead, the scale of these injustices shows how current policies have failed on equity and the urgency of choices to change direction. The world's wealthiest 1% of people generate double the carbon emissions of the poorest 50%.[7] Countries that provide the healthiest conditions for children currently have the greatest carbon emissions, compromising the futures not only of these children but also of those in countries that often have contributed least to climate change.[8]

Costs of poor choices

Societies' failure to make the structural and policy choices needed imposes steep and unnecessary costs on all countries. A "toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics"[9] enable tobacco and alcohol use, unhealthy diets, air pollution, and insufficient physical exercise to contribute to 72% of all global deaths from non-communicable diseases.[10]

In the past decade, many countries have seen widening inequities and stagnation or reductions in life expectancy.[11 12] The increasing numbers of wars and conflicts have created unprecedented numbers of refugees, many of whom lack basic protection including access to health and social services. The groups with the worst health status globally are those in settings of chronic conflict or who face structural discrimination within their societies.

The economic and social costs of policy failure are also high. Since 1995, the wealthiest 1% of people globally have amassed almost 20 times more global wealth than the poorest 50%.[13] The failure to tackle social determinants of health (living conditions and relative access to power, money, and other resources) and economic inequality drives increasing health inequities but also leads to reduced societal cohesion.[14] This reduces solidarity and ability to act together in crises. The covid-19 pandemic has shown how societies with lower trust in government and within communities, often driven by greater inequality, performed worse in mitigating the pandemic's impact.[15]

Globally, modelling analyses through to 2040 estimate that investment now in measures to tackle the social determinants

Box 1 | Features of healthy societies

Healthy societies make structural and policy choices to produce health as a "resource for living"[25] for all people in their boundaries, irrespective of ethnicity, gender, sexual orientation, disability, caste, religion, place of residence, immigration, wealth, or educational status. Governments and politicians understand and execute their primary stewardship role and invest in the foundational economy[26] to ensure high quality physical and social environments, tackling the determinants of health and providing universal health coverage.

Health is understood as a public good in itself and as the prerequisite for individual empowerment, and economies are structured to realise the right to health.[27] Global governance supports national and local governments to fulfil this role.

Healthy societies look at the past, present, and future, considering all aspects of health equity, including intergenerational inequity. As a result, healthy societies stay within planetary constraints to mitigate climate change and environmental degradation—crucial for ensuring that future generations have the same right to health as present generations.

Healthy societies consider carefully positive and negative consequences of all their actions (and inactions) in terms of health, social, economic, and environmental outcomes, changing course to avert negative results, maximising co-benefits, and managing trade-offs.

Government and non-state sectors (both not-for-profit and for-profit) work together with communities in a social compact to ensure that no one is left behind and that everyone can achieve their full potential. The state embraces its role to regulate the commercial determinants of health, including through fiscal measures, holding the private sector to account for actions that undermine health.

Health equity underlies social stability and conflict prevention, economic development, and environmental sustainability. Healthy societies prioritise health equity as a fundamental value and measure of their success. They recognise that enabling people to be free to lead flourishing lives—equalising and transcending the circumstances in which they are born—is a part of fundamental infrastructure, like water and sanitation, housing, communication, and rail and road networks, for a healthy and successful society that is cohesive, inclusive, and unified.

Poverty and economic inequality and the intersectional and persisting nature of structural discrimination (such as racism, sexism, casteism, ableism, ageism, and homophobia) are understood as key barriers to healthy societies and confronted as priorities. Only by building such healthy societies is it possible to build the resilience and social cohesion required to navigate and minimise the impact of crises of whatever cause.

of health and reduce health inequities could add $12tn (£9.4tn; €11tn) or 8% to total gross domestic product in 2040, through increased productivity of workers; improvements in their health and reductions in mortality, and would add 0.3% to global employment growth.[16]

How to create healthy societies

Drawing on previous discourse on primary healthcare, health promotion, and social determinants of health, and extensive discussions during the Wilton Park dialogues, we have identified broad features that healthy societies share (box 1).

Effective public health functions are necessary but not sufficient to enact all these features; healthy societies require contributions and actions involving all sectors. Unhealthy societies are not natural or inevitable but result from inadequate and inappropriate structural and policy choices at global, national, and subnational levels of governance, including inadequate responses to commercial determinants of health.

The covid-19 pandemic has shown that governments can make unprecedented, rapid, and effective transformations in crises. For example, the US implemented a child tax credit that reduced child poverty by 41%.[17] South Africa put in place comprehensive alcohol control measures. Such measures have proved difficult to sustain, showing the challenges in making permanent the transformations needed.

Current crises have also intensified discussions on how to measure what is valuable to societies and what structures and policies are most important for health. In India and South Africa, concepts of wellness and wellbeing have been made central to the aims and functions of health ministries. There are calls and proposals to make more use of measures of societal progress other than gross domestic product, such as development and wellbeing indices.[18]

The importance to health of broader factors, beyond the remit of the health sector and healthcare, and the need for multisectoral action have long been understood.[19] The covid-19 and climate crises have brought this to the attention of politicians and the public, although countervailing political and commercial interests and siloes in governance continue to obstruct action.

Perhaps most compellingly, the current interlinked crises have accelerated transformations in society, with impacts that are beginning to be understood—in particular, decarbonisation and digitalisation. Covid-19 has prompted advances in digital health including in telemedicine and systems rapidly to analyse, synthesise, and report data. The increasing pace of decarbonisation in Europe—for example, due to climate change and the war in Ukraine—shows that change is possible. However, digitalisation and decarbonisation will not necessarily improve health equity; indeed, inequities could worsen. Yet these transformations present opportunities to reduce air pollution and energy poverty and improve access to health and social services. Structural and policy choices are needed that capitalise on resultant changes in governance and society and ensure these transitions increase equity.

Implementing the policy choices needed

Creating healthy societies requires structural and policy choices to co-create systems for health and health equity (box 2).[20] Implementing these policies is resisted by powerful interests that benefit from the status quo. These interests can be overcome only by principled political leadership and social mobilisation.

Building healthy societies is therefore not an abstract initiative. Instead, it needs to be communicated and developed in ways that make sense to people's lives, to stimulate popular demand for social change. Crucial to success is co-creating healthy societies with communities that have local and indigenous knowledge,[21] including learning lessons from existing community led initiatives.

Healthy societies depend on economic, social, and environmental stability and, most fundamentally, social justice so that social goods and services are distributed fairly. Healthy societies are not possible without all societal actors making substantial efforts to end inequities by tackling the inequitable distribution of power, money, and other resources and upholding human rights.

Box 2 | Selected key policies and interventions for healthy societies

Climate change: Tackling energy poverty and ending fossil fuel subsidies as key priorities of decarbonising energy supply (in the broader context of carbon budgets for spending to optimise health equity)

Economic systems: Implement progressive and equitable global and national taxation systems

Food systems: Promote public procurement of healthy and sustainable foods

Digital economy: Reduce the digital divide in expanding health and social services to marginalised groups

Commercial determinants of health: Steward transnational commercial impacts on health and health inequity

Structural discrimination: Tackle intersectional discriminations through governance, legislation, and reparations

Conflict and forced migration: Ensure human rights in war settings, and refugees' access to health and social services

Employment and social protection: Provide universal paid sick and parental leave

Human development: Provide quality early childhood education, including child protection and poverty prevention, with priority for marginalised groups

Intellectual property: Enact intellectual property waivers, technology transfer, and production capacity to ensure equitable access to health commodities

Health security: Implement a social determinants of health approach (that is, multisectoral and equity focused) to pandemic prevention, preparedness, response, and recovery

Health sector: Implement a primary healthcare approach to provide health services for all (universal health coverage)

More than utopian ideals

The concept of healthy societies in box 1 may seem utopian. Can societies overcome the failures that have led to current crises? Can crises be catalysts for change? Consider the creation of welfare states after the great depression and the second world war or the mass provision of antiretroviral drugs in the HIV and AIDS crisis in response to the demands of an indomitable social movement.

Crises do not necessarily lead to societal transformation, however. They often lead to a focus on reactive measures that can make building or reinforcing systems conducive to health more challenging. The global financial crisis of 2007-09 did not lead to transformation of global financing or the dominance of neoliberal economic management. Instead, in many countries it led to austerity measures and a reduction in state functions.[22] In the current crises, World Bank estimates show alarming reductions in fiscal space for health in many low and middle income countries.[23] Austerity measures are again being introduced, with budget cuts in health and social services.

A vision of the right to health driving multisectoral efforts has been articulated before. Most famously, the codification of primary healthcare in Alma-Ata, 1978; the drafting of the first charter on health promotion in Ottawa, 1986; and the final report of the WHO Commission on Social Determinants of Health, 2008. Despite the progress each movement has engendered, it is fair to ask why success in realising these visions is any more likely now.

It is also fair to ask why the health sector itself may be any more successful now in advocating for and contributing to multisectoral action than it has been in the past. The focus of the health sector on healthcare, particularly, curative care, has proved stubbornly resistant to change. The capacity of health ministries to push for multisectoral action remains limited. In the covid-19 pandemic, health ministries have had unprecedented visibility but have routinely been bypassed in coordination of the multisectoral response.

Progress is possible

Progress now is possible because of the scale of the crises and severity of the threats faced; the magnitude of social inequality, particularly intergenerational inequality; and the consequent discontent, including in the dominant paradigms of our economic systems.

Also, the effects of the climate crisis will only intensify, forcing more and more people to demand action from their leaders. The level and shifting pattern of global inequality, with inequality within countries predominating, are already destabilising governance in many countries. Increasing misinformation and the polarisation of societies are difficult to counteract. The impact of the degree of societal transformation needed, and other shifts such as demographic change, is unknown but will have profound effects on societal organisation and geopolitics.

Analyses of the outcomes of past crises show that reforms to increase equity afterwards are not inevitable.[24] A reversion to the status quo can occur, or crises can instead be used by vested interests to concentrate their power and increase inequities. Whether or not crises lead to improvements in equity is substantially determined by how the meaning of crises is framed and interpreted—that is, how the causes are understood, who is perceived to be responsible, and whether the crisis is considered to have been avoidable.[24]

For healthy societies to be an outcome of current crises, proponents of health equity should provide evidence to guide this framing of the causes and accountability for crises. They also should support social movements to demand action to influence policy outcomes, minimise indifference to the root causes of crises among communities, and direct blame for crises in ways that increase rather than detract from health equity.

Building healthy societies will require coalitions within countries and globally of governments, civil society, academia, and the private sector to present credibly what each part of government, each part of society, and each person can contribute, and to foster social mobilisation to support the improvements needed in systems and governance. We need to reach a consensus in our societies on the causes of current crises and what needs to be done. The health sector must urgently improve its capacity and performance to play its part, even though it is only one contributor, and often a minor one, in many of the required transformations. It will take humility and sensitivity to avoid being seen as using the resources of people and other sectors for narrow technocratic public health ends. Instead, the health sector will need to engage with the public's interests and priorities and be willing to make trade-offs and persuade, generously and credibly with evidence and a spirit of solidarity, to get support for creation and preservation of healthy societies.

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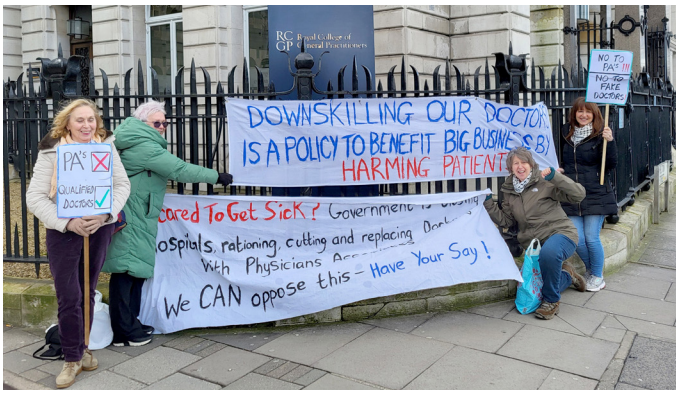
OPINION Margaret McCartney

Why the fuss about physician associates?



Features of the debate around physician associates (PAs) have crystallised a range of underlying problems in the NHS into a lightning rod. This now has serious implications for the future of general practice and the medical profession itself. Unless we look back and understand why we have medical royal colleges and regulation we risk further alienating doctors—current and future.

To be clear: my argument is not with the many individual PAs who have, with good faith, engaged in their training and work, with high aspirations for patient care. The current crisis is not their fault. The same cannot be said for the medical and political leaders who have led us here. Nor can we blame every current leader: this crisis has been drip fed for years, with those expressing concerns or asking questions urged to "be kind or be quiet." But we should really be looking further back to understand what is at risk in general practice and the wider medical profession.

Team working is well established in healthcare, but it is possible to increase activity while adding little value for patients. Skilled practitioners can do much, but doctors who ultimately retain responsibility for patient care need the power to discharge their leadership effectively. This requires enough staff working in systems that enable clinical safety. Doctors being given more responsibility to supervise less skilled staff, all while having little control, is a recipe for burnout and disaster.

Formation of the RCGP

In 1950 the *Lancet* published the investigation of a doctor called Joe Collings into general practice in England and Scotland. Practices were overwhelmed, premises were unfit, and there was no coherent training or standards in practice.

This debate has revealed an existential crisis in medicine

"The overall state of general practice is bad and still deteriorating," he wrote. This "will continue until such time as the province and function of the general practitioner is clearly defined, objective standards of practice are established, and steps are taken to see that these standards are attained and maintained."

The Royal College of General Practitioners was subsequently formed in 1952 by a collective of GPs who defined their work and organised training, research, and postgraduate education. It was recognised that the management of undifferentiated symptoms was risky and needed particular skill. This is of critical importance and yet seems to have been lost in the decades since.

When Collings wrote his report, general practitioners were overwhelmed with work. We still are, and supervising less skilled people who will not end up autonomous practitioners—in the way that trainee GPs will—is a false economy. Rather than concentrating resources on supporting doctors to do their jobs—for example, with doctors' assistants, by putting serious effort into retaining doctors, or enabling them to work more clinical hours—the training of PAs is focused on producing staff more quickly, but with a shallower skill set.

Newly qualified doctors are rebelling, quite rightly, because they have been sold an expensive degree and left in massive debt only to be starkly underpaid, while also being expected to take responsibility for lesser trained but better paid PAs. Neither is this just about money. It is about the lack of respect and autonomy doctors experience, the sources of stress at work, and what might actually alleviate it.

The question of what training is needed to do what work is critical. Either all staff in general practice seeing undifferentiated patients adhere to the set standards of medical school, vocational training, traineeship, and exams or none of us do. Holding doctors to a different set of standards is illogical. General practice made itself an evidence based specialty because it was prepared to set standards and call out bad practice by setting up training, examinations, certification, and long term educational commitment.

The establishment of an independent Royal College of General Practitioners faced much opposition "by ridicule and by pressure," including from the other medical colleges. We now risk undermining the efforts that developed general practice into what it is today.

GPs' raison d'être

Usually we keep our most trained and skilled people for the most difficult and important jobs that require higher expertise. But we have got it bizarrely inverted. Highly skilled GPs can end up doing purely administrative or non-medical work—which should either be delisted or given to an assistant—while the tasks that require most training get done by someone with less training, such as a PA. Direct patient care is the raison d'être of GPs, and the system should be designed to support it.

If doctors aren't willing to do the hours—as clinical NHS work is so stressful that it becomes intolerable—that is the problem that needs to be tackled. Adding more, less well qualified staff to do the most difficult jobs may make doctors' stress worse, as they take responsibility for others' decisions.

This debate has revealed an existential crisis in medicine. It will not take long before school leavers look at medicine and then look elsewhere. There have been examples of strong leadership from some colleges, and we need more. The value of general practice cannot be understated. If continuity of care was a drug it would be a blockbuster. Yet care has been deliberately fragmented, allowing the NHS to spiral downhill. By adding more PAs to help, I predict that costs and activity will increase, efficiency will decrease, and a government minister will eventually invite a review, which will likely report, like Collings did, that the overall state of general practice is bad and still deteriorating.

Margaret McCartney, GP, Glasgow

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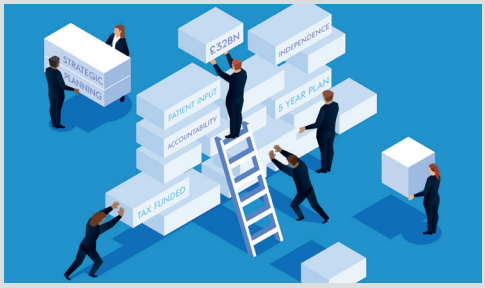
LETTERS Selected from rapid responses on bmj.com



LETTER OF THE WEEK

Reduce waste in the NHS to deliver population health

A cash injection of £32bn to the NHS might be what *The BMJ* wants (Cover, 23 March), but it is not what England needs. The people of England need *The BMJ* to work with the Department of Health and Social Care and the NHS to identify and disinvest from unnecessary and often harmful prescriptions, tests, and treatments on which vast amounts of finite taxpayers' money are being wasted. In 2017, the OECD estimated that about 20% of activity in healthcare services added no value; interestingly, 20% of the current NHS budget is over £32bn.

To support the move away from wasteful activities, *The BMJ*'s Too Much Medicine campaign (last updated in 2018) should be revived. Since then, *The BMJ* has published several articles about waste in healthcare, but more needs to be done to identify and disinvest from wasteful activities and to reinvest resources to higher value activities that can help to reduce the backlog, improve health, and prevent disease.

England also needs *The BMJ* to advocate strongly for initiatives that promote health and deliver primary prevention of disease, such as expanding the evidence based and effective diabetes prevention programme and providing healthy, delicious, sustainable school meals for all children in England.

The BMJ needs to look again inside the NHS to identify and reduce wasteful activities and recommend more high value options to promote population health. Even £1bn could be used to improve health and prevent disease in a sustainable way. It could provide all primary state school pupils in England with a free school meal, for example, and extending this to all secondary school pupils would be an additional £1.5bn.

Funnelling more finite taxpayer money into the NHS is not the best way to deliver population health given the state of the country right now.

Muir Gray, director; Anant Jani, senior adviser; Alf Collins, senior adviser, Oxford Value and Stewardship Programme

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AI AS KEY TO TRIAGE IN GENERAL PRACTICE

AI cannot offer the crucial human touch…

Mathew discusses the use of artificial intelligence (AI) to help triage in general practice (Rammya Mathew, 23 March).

We use a human GP to do this. Having the most senior member of the team assess and assign management of every clinical problem that presents to general practice seems sensible. This system takes clinical responsibility away from non-clinical team members and gives it to those who are trained to make decisions.

But—here's the catch—you need GPs to make the decisions. Their clinical experience and training allows for assessment of the whole clinical picture, including the patient's medical and social history, and an understanding of the skills of the practice team. This improves efficiency, allocates appointments to the right person at the right time, and helps with continuity of care. I'm not sure how AI could improve on this—the human touch is built into this process, something AI cannot offer.

Anna Wake, GP partner, Towcester

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…or be used unsupervised

Mathew has great hopes for the use of AI in GP triage. Is she willing to rely on it unsupervised?

The practice I work at has AI embedded in triage through the large language model platform. But every form submitted is also read by a human in case the model has missed key information or reacted with unnecessary alarm to an innocuous history. If every form is reviewed by a human, the benefit of AI is modest—it just chooses the order in which forms are looked at.

For large language model AI to be "transformative," we would have to use it unsupervised. I'd be interested to know if other practices are doing so, as I think this would be taking a considerable medicolegal risk.

Large language model technology is not currently able to operate unsupervised in such a high stakes scenario as medical triage, and I doubt it ever will be.

Dylan Summers, GP, York

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INTERVENTIONS TO SUSTAIN INDEPENDENCE IN OLDER PEOPLE

Patient centred outcomes should be the focus

Crocker and colleagues investigated which components of community based complex interventions were most likely to sustain independence in older people (Research, 23 March). Few of the estimates were significant, and the authors' interpretations might have been overly enthusiastic.

Many intervention trials have tested the effectiveness of complex, preventive approaches in older people's care, but reviews often report effects according to what is thought to be the intervention's active ingredient. This raises questions for those involved in programme planning or designing new trials—for example, will adding another active ingredient to a complex intervention improve the likelihood of positive health outcomes? Crocker and colleagues contribute to answering such questions.

The outcomes of reducing costly hospital admissions and delaying placement in residential care are often prioritised, but neither is impacted with high certainty in this review. We advocate for person centred outcomes to be given more importance in future implementation research.

Leah A Palapar, research fellow; Ngaire Kerse, Joyce Cook chair in ageing well, Auckland

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Anthony Epstein

Pathologist and virologist who jointly discovered the Epstein-Barr virus

Michael Anthony Epstein (b 1921; q Cambridge/ London, 1949; CBE, FMedSci, FRS, MA Cantab, MD, PhD, DSc, FCPath), d 6 February 2024

In March 1961 a lunchtime talk by Irish "bush surgeon" Dennis Burkitt at the Middlesex Hospital, London, left young pathologist Anthony Epstein "hopping up and down" in excitement. He decided then to abandon all other work to hunt for what became known as the Epstein-Barr virus (EBV). It was the first human virus shown to cause cancer.

Based in Uganda, Burkitt speculated that a virus might cause the cancer later named after him. The distribution of Burkitt's lymphoma (BL), Africa's commonest childhood cancer, seemed to be related to the high temperatures and heavy, year round rainfall in the malarial belt. The idea that a virus could cause cancer was controversial in the 1960s—even though viruses are now estimated to account for 15-20% of human cancers.

Epstein immediately suspected a biological agent after his several years of research with cancer-causing viruses in chickens. He arranged for BL tumour samples to be flown from Uganda to his laboratory at the Bland-Sutton Institute of Pathology in London. After two years of failing to extract virus from samples, he became worried. "I had no letter of appointment, no terms and conditions of service, and I didn't know from one year to the next if the head of department would reappoint me."

Stroke of luck

He then had an "extraordinary stroke of luck." A flight carrying a specimen from the upper jaw of a 9 year old Ugandan girl was diverted 200 miles to Manchester from London because of fog. When the specimen finally reached his laboratory late on 5 December 1963, the fluid in which it was suspended was cloudy, suggesting that it had been contaminated.

His team thought they should bin it. Epstein decided otherwise. Expecting to gaze on a mass of multiplying bacteria, Epstein was amazed to see a huge number of free floating, healthy looking tumour cells that had shaken free from the tumour on their long journey from Kampala.

This reminded him that mouse lymphomas would only grow in a suspension of free floating single cells, rather than on the usual glass surfaces. He and graduate student Yvonne Barr finally managed to grow and study the free

Epstein had a strong independent streak and paid little attention to critics

floating BL cells in what was the first culture of any human lymphocytic cell—a pivotal point in medical history.

But the usual tests for identifying viruses did not work. Here again luck favoured Epstein. A fortuitous death gave him priceless access at a critical time to one of the first electron microscopes. He was an expert in using this new and powerful tool after a year as a visiting investigator at the Rockefeller Institute in New York in 1956. He had anticipated how important electron microscopy would become.

In a BBC interview in 2014 marking the 50th anniversary of his co-discovery, he recalled, "The very first grid square I looked at had a cell with virus particles. I was first of all exhilarated and then extremely frightened in case the electron beam burnt the specimen up.

"So I switched it off and walked round the block in the snow. I had no coat on. When I came back calmer, I recorded what I had seen. I recognised it at once as a member of the herpes family of viruses. But which was impossible to tell. There were then about five human herpes viruses known. There are now nine.

"The curious thing was that any of the then known ones would have wiped the culture out as they were replicating, but this wasn't happening, so I had the feeling that this was something new and special."

But had the virus caused the cancer? It could have been "a wild goose," Epstein conceded, but it was one "that had to be chased." A report announcing his team's findings in the *Lancet* in 1964 was greeted with great scepticism, even though they went on to show that EBV could cause cancer in monkeys. It was not until 1977 that the International Agency for Research on Cancer finally classified EBV as a group one carcinogen, formally acknowledging its role in a variety of cancers.

In the mid-1960s, Epstein set up a joint project with Werner and Gertrude Henle, a US husband and wife team and a prodigious force in viral oncology. The Henles confirmed in 1965 that Epstein and Barr had identified a new human virus. They went on to establish EBV as the cause of mononucleosis and showed a link between EBV and certain cancers, including nasopharyngeal carcinoma.

After his discovery Epstein investigated why 95% of people are unaffected by EBV infection, while others develop cancer. A co-factor, he explained, interfered with the "host-virus balance." The BL co-factor was endemic hypermalaria. "It produces cells that are susceptible to virus," he explained.

Early life and career

The younger son of Mortimer Epstein, a writer and editor of *The Statesman's Year Book*, and his wife, Olga, a charity worker, young Anthony attended St Paul's School, London.

Epstein won an exhibition to read medicine at Trinity College, Cambridge. After clinical training at the Middlesex, he completed national service in India with the Royal Army Medical Corps. He returned to the Middlesex Hospital in 1948 as an assistant pathologist.

Renowned for perseverance and scientific rigour, Epstein had a strong independent streak and paid little attention to critics. He believed, for example, that his work with the Rous sarcoma virus in chickens in the early 1960s would eventually be relevant to human cancers, although colleagues derided it as eccentric.

In 1968 he became professor and head of Bristol University's pathology department, where he stayed until retiring in 1985. In 1986 he went to Oxford as a fellow of Wolfson College, becoming an honorary fellow in 2001. He was knighted in 2001.

A patron of Humanists UK, Epstein leaves his partner, Kate Ward, a medical virologist, and three children from his marriage to Lisbeth Knight; they separated in 1965.

John Illman, London john@jicmedia.org

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Colin Walker

Early pioneer of neonatal intensive care who developed national database for newborn infants

Colin Herriott Macdonald Walker (b 1923; q Edinburgh, 1946; MD, FRCP Edin, FRCPCH), died from natural causes on 9 January 2024

When paediatrician Colin Walker began his career, the care of frail newborns consisted of little more than keeping them warm and offering fluids.

Walker, who has died aged 100, was instrumental in a sea change in neonatal care. He pioneered an intensive care service in Tayside, establishing the special care unit at Dundee Royal Infirmary, and he set up a computerised clinical data collection service for babies—initially in Scotland and then serving the whole of the UK.

While training at Great Ormond Street Hospital for Children in London in the 1950s, Walker became interested in cardiology. He was very methodical and deft at carrying out practical procedures such as cardiac catheterisation to detect abnormalities of the heart. In 1957, he was offered a secondment for a year to the Princess Margaret Hospital for Children in Perth, Australia, where he set up the hospital's first cardiac catheterisation unit.

He was then invited to become a paediatric cardiologist at the University of Colorado in Denver. Here he developed a pioneering technique to help babies who were short of oxygen because their hearts were not pumping blood adequately to the lungs. He found a way to pass blood from the baby through an oxygenator and return it to the baby. It was an early prototype of extracorporeal membrane oxygenation and gave a baby's lungs, heart, and kidneys some respite and a chance to recover.

In 1964 Walker returned to Scotland, taking up an appointment as a consultant neonatal paediatrician in Dundee, with a brief to develop neonatal services in Tayside. He established a special care baby unit at Dundee Royal Infirmary, which was then relocated to Ninewells Hospital. It was here that the first baby in Scotland was treated with artificial ventilation. Walker was quick to bring in a range of practices, including intravenous nutrition to improve survival rates.

As well as his work in Scotland, Walker also travelled to Korea and Doha to advise on setting up special care baby units.

Walker was a founding member of the British Association of Perinatal Medicine

Perinatal association and database

For some years, Walker was the only consultant working in neonatal special care in Tayside. Other parts of the UK, notably Bristol and Oxford, were developing the specialty, but only 20 paediatricians were identified as spending 60% of their time or more with newborns and they were scattered around the country. A body to champion research and discussion was urgently needed and in 1976 the British Association of Perinatal Medicine was inaugurated, with Walker as a founding member.

In the 1970s, Walker wanted to collect information on newborn babies, such as their gestation, weight, and whether they had spent time in special care. This, at the time, was recorded only in the mother's notes. He began to keep records, at first on paper, and then set up a database which would become part of the Scottish Morbidity Record. Beginning in 1975, maternity hospitals across Scotland sent information to the Information Services (Scotland), which is part of the NHS.

The database facilitated research and it was possible to see which babies had been in special care and what the outcome was. Walker spearheaded the initiative and then, commissioned by the Department of Health and Social Security, became chair of the UK-wide Child Health Computing Committee. It ran the British Child Health Computer System, which was complete by 1984 and included comprehensive information on babies across the UK, including details of vaccinations and immunisations.

Early life

Colin Herriott Macdonald Walker was born in Edinburgh. He was the middle child with an older brother, Macdonald, and a younger sister, Pamela. His father, James, had won the Distinguished Flying Cross in the first world war and worked in medical publishing and his mother, Alison (née Richie), drove trucks during the war and was very musical.

As a child Walker had severe respiratory illness. This interrupted his primary education but inspired him to emulate the doctors caring for him and take up a career in medicine. After schooling at Melville College in Edinburgh, where he became head boy, he studied medicine at Edinburgh University. Interested in paediatrics, he moved south to take up a post at Great Ormond Street Hospital.

In 1948 Walker met Anne Gillieson at a ball held at the Chartered Society of Physiotherapy in London. She had been a decoder at Bletchley Park during the second world war and was training as a physiotherapist. The pair married in 1949 and had two children: Hilary in 1953 and Huntly in 1959.

When he retired in 1986, Walker felt he had more to give. His autobiography, *I Also Ran*, had a modest message: he said his was a story of an ordinary doctor who might have achieved more. However, he continued to live a full life in Broughty Ferry, near Dundee, where he was an elder in the church. He lectured at Tayside preretirement courses, arriving immaculately turned out to instruct people on maintaining their health in retirement. He enjoyed sport, especially curling, bowls, and golf, and was pleased to achieve a score of 83 on the Broomfield golf course on his 90th birthday.

Walker was predeceased by Anne in 2021. He leaves their two children, six grandchildren, four great grandchildren, and his sister.

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