comment

“We need to create a culture of openness in end-of-life conversations” **CHARLOTTE AUGST**
“As a GP it’s not easy to disentangle the medical from the psychological” **HELEN SALISBURY**
PLUS The Grenfell Tower Inquiry

TALKING POINT John Launer

Having fun with feedback

I went on a country walk recently with two medical friends, and for some reason we started to talk about 360 degree feedback, sometimes called multisource feedback. This is an exercise that virtually all doctors have to do in one context or another, requesting comments from colleagues on our performance, teamwork, and so on.

The three of us had little positive to say about it. Maybe some people have had their lives turned around by constructive comments from other team members, but none of us owned up to such an epiphany.

From our own experience, multisource feedback in routine health service settings is largely characterised by banal questions designed to elicit vapid courtesies (“good team worker and kind to patients”) or recommendations belonging to the world of fantasy (“could benefit from more administrative support”). The exercise seems to be particularly limited when people can choose who receives their questionnaires, leading to an absurd degree of bias—and even more so when the authors of the supposedly anonymous returns can be easily identified.

We exchanged some stories about colleagues who had received venomous feedback from people planning to leave their jobs, who no longer cared about offending them. We also each confessed we usually didn’t have the courage to challenge seniors when giving feedback up the organisational food chain, except in very guarded ways. And when offering it down the hierarchy, we thought we shouldn’t have anything to add to what we’d already said face to face, if we were doing our jobs properly.

As our walk continued, we tried a thought experiment. What kinds of questions, we wondered, might yield information that we’d find genuinely helpful in an ideal world? Here are the ones we came up with:

“Describe an occasion when you’ve seen me make an idiot of myself”; “Give an example of a time when I’ve held onto an obviously wrong view or decision and refused to concede”; “When have you seen me abuse my power or bully someone without realising it?”; and “What criticisms have you heard other people make of me that they haven’t been able to say to me directly?”

As an additional twist I suggested two further instructions: “You aren’t allowed to say ‘never’ in response to more than one question” and, “Please submit your answers in the name of someone else in your team, to confuse us when we try to guess who you are.”

Before readers send emails or social media messages pointing out how preposterous this idea is, let me admit that it was meant to be. But at least we were trying to go beyond the ritual function that multisource feedback largely serves, to invent something instead involving realism and educational value—not to mention fun. Maybe our playful conversation could contribute to an intelligent debate about 360 degree feedback exercises generally.

John Launer, GP educator and writer, London johnlauner@aol.com
X @johnlauner

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We tried to invent something involving realism and educational value

OPINION Charlotte Augst

Better care at the end of life: we need to change the conversation

All stakeholders need to work towards patient autonomy

Far too many people are denied their right to autonomous decision making at the end of their lives. This stubborn reality seems hard to shift, despite years of guidance supporting professionals to elicit and respect people's wishes, and despite the best efforts of educators and campaigners to encourage better conversations about death and dying.

This is evidenced by the thousands of phone calls and emails that the charity Compassion in Dying has received in recent years. The charity analysed these responses to better understand what prevents doctors, nurses, or care home managers following the wishes of a dying person.

The report published recently makes for difficult reading. It finds that people do not understand that they need to write down their wishes for their end-of-life care in order to ensure they are followed. Relatives report that their loved ones were subjected to invasive treatments they had explicitly said no to. People are being actively discouraged by their doctors from having a conversation about their preferences at the end of life.

For years there has existed guidance about doctors needing to ensure patients fully understand the implications of interventions at the end of life. For this, dying people obviously need to understand they are terminally ill, the likely trajectory of their illness, their treatment and care options, and what decision maximises their chances of maintaining good quality of life for as long as possible—if that is their priority.

Denial of the right to be heard

Health and voluntary sector organisations have run various "let's talk about dying" weeks and charity initiatives. People have used complaints processes and Patient Advice and Liaison Service (PALS) services to try to be heard. But still, far too many people experience a denial of their right to a conversation, to be heard, and for their wishes to be followed through on. The consequence of this is concerning. Polling shows that one in four people say the last close friend or family member they know who died received medical treatment they would not have wanted.

We need to re-examine how decisions are made and communicated

Charities that work towards change have some choices to make. First, they could decide their services alone are the answer. This idea is unrealistic for all small charities, but even large ones cannot reliably provide services to patients and families at the scale that is required for near universal coverage. The solution for charities can't ever really be "just services." It has to be a service, plus influence, leverage, insight, and advocacy.

But influencing the supertanker that is the health and social care system (and sadly the report shows that it is also the care system

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OPINION Martin McKee, Isobel Braithwaite, and May CI van Schalkwyk

The Grenfell Tower Inquiry reveals fundamental weaknesses of governance

JAMES MANNING/PA/ALAMY

In 2017, one of us wrote in this journal that "it is impossible to achieve a comprehensive understanding of events such as Grenfell Tower without confronting the political determinants of health and challenging the forces that shape them." Seven years later, the inquiry's report into this tragedy, which killed 72 people, shows the extent to which this argument holds true.

When disasters occur, the media and politicians commonly focus on the immediate causes rather than the political decisions that create the conditions that allow them to happen. The 2017 editorial referred to the loss of life in hurricane Katrina in 2005. The immediate cause was the extreme weather, but it was the political failure to plan for such events that caused so many, mostly marginalised, people to die.

The Grenfell Tower report is different. While it contains much technical detail about the structural and procedural failings, it places the blame firmly on politicians and the companies whose interests they failed to challenge.

The report begins with the Westminster government. It notes how ministers were well aware of the risks of high rise fires exacerbated by flammable cladding by 2016. Indeed, a 1999 parliamentary committee drew these risks to their attention, but its recommendations were ignored. This has become the norm, with a recent report from the Levelling Up, Housing and Communities committee complaining none of its 2022-23 reports had elicited a timely response.

Another warning sign emerged in 2001 when tests on the cladding systems by the Building Research Establishment (BRE) showed a "catastrophic escalation of fire" with aluminium composite material. Established as a government research organisation, the BRE was privatised in 1997, after which it reduced its fire safety work. Its findings were never published, recalling the fate of the exercises that should have informed pandemic planning but did not.

A third warning, also ignored, came from a coroner following a similar fire in another

SERGIO AZENHA/ALAMY

which sometimes denies people their right to autonomous decision making about the end of their lives) is by no means a trivial challenge. How do you tackle "systems change" at the required level, where everything from medical education, to training of care workers, to inspection frameworks, and obligations placed on individual clinicians has to change?

There seem to be two schools of thought. One of these views the system as a machine, where if you pull the right lever, different outcomes will follow. It seems to me—and to Compassion in Dying—this theory of change has been tried and tested to destruction, and it doesn't deliver. The systems are too complex, there are too many decision makers in the process, and everyone from a care assistant to a consultant can scupper your efforts if you rely solely on mechanistic tools for change.

The other approach foregrounds "culture." It acknowledges that system change is complex, and that you need to tackle the beliefs and assumptions of the workforce and of users to effect change. Is it fair to say that far too often this approach remains entirely aspirational? It suggests that if only we talk enough about change, about "flipping the culture," and about "transformation" then it will somehow magically happen. Maybe some of the wider sector activity around death and dying falls a bit into this trap too—being too easily satisfied with having had some good conversations about dying, but not making sure people have actually documented their wishes in ways that clinical teams are then compelled to enact.

Improve education and training

Compassion in Dying adopts an approach that recognises we need both. Yes, we need to change the conversation. But we also need to re-examine how end-of-life decisions are made and communicated. So, we need to improve education and training, how we enable people to record their wishes, and introduce a duty of candour for someone reaching the end of their life. Taking the GMC's Good Medical Practice guidance as a blueprint, this would include a duty to provide clear, jargon-free information to a person about their condition, likely progression and prognosis, their options for treatment (including declining it), and the benefits and risks for each. This will help instil a greater culture of openness and transparency in end-of-life conversations, so people can fully weigh up treatment decisions and provide properly informed consent or refusal.

But we also need to enable people to see that they can—and should—tell their families what they do and don't want and record this, and clinical staff need to feel safe and confident to know when to transition from active treatment to comfort care only.

This change can't be led just by "the state," or just by "society." Because the organisation paying for care, and regulating and inspecting it, is probably not the right one to lead a hearts and minds communications campaign on changing the conversation about death and dying. And the organisation supporting professionals in how to engage in better conversations can't be the one that then inspects them. We need partnerships that enable all the actors to lean into their assets and strengths, and to coalesce around a shared mission of autonomy for people at the end of their lives.

The new government's commitment to giving power to patients is refreshing, but as encouraging as these noises are, we need cross sector and multilevel collaboration to ensure it becomes reality.

Charlotte Augst, freelance consultant, London

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tower block eight years earlier. The coroner's *Report to Prevent Future Deaths* included recommendations to strengthen building safety standards and review emergency responses.

These failings were exacerbated by weaknesses in the then Department for Communities and Local Government (DCLG), which the inquiry describes as "poorly run." While certain individuals were heavily criticised, these failings occurred when the civil service had experienced severe cuts and morale was falling, with the greatest decline in DCLG.

The inquiry is especially critical of the system for regulating the construction of high rise buildings, describing it as "seriously defective."

A particular concern is the apparent extent of corporate capture of the myriad systems in place to regulate the construction sector. The inquiry describes many examples of manufacturers and service providers manipulating or misrepresenting information on their products' safety, in some cases with apparent complicity by regulators.

The inquiry thus represents an important case study of the commercial determinants of health. Their intertwining with political determinants is aptly captured by a description by Peter Apps, contributing editor at *Inside Housing*, of political actors who "deliberately ran down, neglected and privatised arms of the state," acting in concert with various corporations' "almost psychopathic disregard for human life."

> **The report raises questions about how and for whom the UK is governed**

The inquiry also examines the legislative framework for management of disasters, in particular, the 2004 Civil Contingencies Act. This confers wide ranging powers on ministers, who need only declare they perceive a threat to exist and cannot be challenged in the courts. Yet, as in the pandemic, this act was not used. The inquiry identified many failings in its implementation and helpfully recommends that the act be reviewed.

The inquiry is also highly critical of the local government, the Royal Borough of Kensington and Chelsea. Its failings contributed to the disaster occurring in the first place, repeatedly ignoring tenants' concerns and comprehensively letting survivors down.

We have only been able to scratch the surface of the inquiry's 1700 page report. However, one thing is clear. While the Grenfell disaster represents a culmination of failures by many individuals and organisations, the inquiry report raises fundamental questions about how and for whom the UK is governed.

How can we achieve the transformational changes needed to ensure the voices of ordinary people are heard and not, as with the Grenfell Tower residents, ignored? How can we hold ministers and corporate executives to account? How can we deliver justice for all those who died unnecessarily? And how can we end the need for future inquiries by preventing such devastating events from happening in the first place?

Martin McKee, professor of European public health

Isobel Braithwaite, housing and health research fellow, University College London

May CI van Schalkwyk, honorary research fellow, London School of Hygiene & Tropical Medicine

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PRIMARY COLOUR Helen Salisbury

Resisting the temptation to advise

When people consult their GP they often arrive with a clearly defined medical problem—a pain, a lump, breathlessness, a rash—and what they're asking for is a diagnosis, treatment, and, if necessary, a referral.

However, the solution to a problem isn't always obvious or simple: a patient may present with back pain and insomnia, but further discussion may reveal relationship problems, stresses at work, or self-medication with alcohol in an attempt to deal with isolation and low mood.

When patients come asking for help because they can no longer cope alone, it's not easy to disentangle the strictly medical from the social, the psychiatric from the psychological. After investigating the physical symptoms a referral for talking therapy may be useful (or ideally a link so that patients can self-refer), but it will be several weeks at best before help arrives by that route. Reaching for an antidepressant prescription is also an option, but it often feels as though we're treating bleak lives and bad luck rather than depression.

In that moment, when it seems we have little to offer in the face of suffering and the solution is beyond the scope of our medicine, the only thing we have left is to listen. We shouldn't underestimate the power of making a space in which the patient can examine and explore problems—talking out loud, without interruption, to an empathetic listener. "Doctor, I feel better after talking to you" is always a compliment to be treasured.

In such cases, perhaps the hardest thing is guarding ourselves against the temptation to offer advice. When our opinion is needed about which analgesic would be best for a particular pain, we have the expertise to offer one. However, when it comes to relationship problems or work stresses, we're unlikely to arrive at a solution that the patient hasn't thought of already. Even if we know the patient and their circumstances well, we probably won't have new ideas that they, living with their problems every day, haven't explored in detail. The best we can do is to ask questions and offer prompts: "Have you thought about your options? What are the pros and cons of each course of action? Can you think of anything that would help you move forward?"

Each year, as new specialist registrars arrive in our practice, I have a chance to share once more why I enjoy my job so much and derive such satisfaction from it. I love the medicine, making diagnoses, and solving puzzles—but more than that I relish the complexity, discovering how I can help this patient with these physical problems and these particular familial and social circumstances. Sometimes, just listening is the best help we can offer.

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

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When it seems we have little to offer the only thing we have left is to listen

LATEST PODCAST

MICKAEL CHAVET/ZUMA

Caring for elite athletes

In the latest episode of *The BMJ* podcast, we talk to Jonathan Finnoff, chief medical officer of the US Olympic and Paralympic Committee. Now that the games have drawn to a close, Finnoff describes the provision of healthcare for these elite athletes outside the global sporting competition:

"Top tier athletes in the US—and there are roughly 1500 people that qualify—receive elite athlete health insurance from the US Olympic and Paralympic Committee. This allows them to access healthcare at any hospital or with any provider in the country. However, we also have medical network partners, which gives us access to world class, comprehensive care for our athletes at those locations. We also have three medical clinics located in the Olympic and Paralympic training centres, where we predominantly provide rehabilitation services, but some medical services on top of that.

"We have our psychological services team that help people from a mental health and mental performance standpoint throughout their careers. That includes the ramp up to the games, people who don't make it to the games and helping them with that transition, getting athletes through the games, and then also the post-games blues, which are very real, whether you're retiring after the games and have achieved your goals or whether you're going on with your career. The Olympic and Paralympic games are this big thing and then it's over, leaving people thinking, 'Well, what's the next thing I need to do with my life?' And so we have a very robust psychological services programme.

"I'd say the area that is a limitation is what we do after somebody retires, because we don't have a lot of services after they leave the Olympic and Paralympic movement and that's something we need to work on."

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

ANALYSIS

Holistic modelling as a catalyst for effective obesity policy

Reducing the prevalence of obesity requires multifaceted intervention, and system-wide modelling would support a move away from current piecemeal policy making towards an equitable and cost effective strategy, argue **Joanna McLaughlin and colleagues**

Despite longstanding government rhetoric of a commitment to tackling obesity, UK policies have not provided an adequate and coherent response. A 2021 analysis of 14 key obesity policy documents since 1992 identified repeated inadequacies in policy design, implementation, and evaluation.[1] The 2023 Institute for Government report on tackling obesity concluded that the government had no serious plan to meet the aim of tackling obesity and called for learning from past mistakes.[2]

Obesity is one of the biggest health challenges of our age; prevalence in England continues to rise and reached 26% in 2021 (32% of those aged 55-74), one of the highest rates worldwide, and shows stark inequalities by deprivation.[3] It is well established that population obesity is not going to be solved through treatment or simplistic encouragement for individuals to eat less and move more.[2] As a report from the UK Government Office for Science concluded in 2007, obesity is a system level problem that requires simultaneous action on multiple fronts.[4]

> **A 2021 analysis of 14 key obesity policy documents since 1992 identified repeated inadequacies in policy design implementation, and evaluation**

KEY MESSAGES

- UK policy making to reduce obesity prevalence is hindered by evaluation of interventions in isolation
- Holistic, systems-wide modelling of policy strategy would highlight the combinations of policies required to meet targets and help counter barriers to action
- Modelling would support scrutiny of the cost effectiveness and health inequality impacts of policy choices

The World Health Organization's 2022 plan for obesity further highlights the range of settings and approaches where action must be taken, including fiscal, regulatory, and lived environment interventions.[5] Nevertheless, UK obesity policy includes minimal population level interventions and continues to rely on short term, individual level, treatment focused approaches[1,2] that only a small percentage of the eligible population can access.[6] The problems in policy making on obesity are symptomatic of inadequacies across many public health policy areas,[7,8] but obesity provides a good example of the problematic influence of "nanny statism" political concerns.[1]

Current siloed and fragmented approaches to appraising policy interventions limit policy makers' understanding of the gap between the potential effect of current policy choices and stated government aims. Economic modelling capable of comparing individual policies and combinations of policies would help identify policy strategy with sufficient breadth and depth to make a difference.

Current appraisals are siloed and fragmented

Health economic modelling enables extrapolation of measured short term cost and outcome data of interventions and controls in specific settings to predict longer term effects and associated costs and to estimate their value for money (cost effectiveness).[9] Modelling is already commonly used to evaluate all types of obesity interventions, from individual treatments to population-wide policies, including assessment of impact in hypothetical scenarios.[10,11] However, current approaches use a fragmentary assessment of single interventions (typically making comparisons with usual care), rather than making a more holistic assessment of a comprehensive strategy. This disconnected approach gives policy makers only limited evidence of the opportunity costs of their decisions.

For example, use of obesity drugs in England is guided by the National Institute for Health and Care Excellence (NICE), which carries out technology appraisals to assess value for money. If a medicine is recommended in a NICE technology appraisal, the NHS in England is required to provide it to patients.[12] This appraisal system can drive scarce resources towards short term use of well defined treatment options deemed cost effective, such as novel expensive drugs, without consideration of the opportunity cost for other wider services. Multidisciplinary specialist (tier 3) weight management services remain unassessed for effectiveness or cost effectiveness and are underfunded.[13]

Glucagon-like peptide-1 agonists such as semaglutide are a case in point. Expectations are high for these novel injectable drugs since NICE approved their short term use for obesity. However, their effect on weight is assumed to be lost within three years of stopping treatment, and modelling of treatment for longer than the two years currently approved has

Holistic modelling that compares obesity policies individually and in combination is needed to quantify the overall effect of any policy

not been undertaken.[14] This short term perspective echoes the wider challenge that specialist services, if available, can also usually be accessed only for up to two years.

Another problem with current modelling is that the valuation of health and wider benefits in appraisals is inconsistent. A lack of coordination across government departments has resulted in a higher monetary value attached to quality adjusted life years (QALYs) in the Treasury's guidance on policy appraisal (£70 000) [15] than that used as NICE's threshold for cost effectiveness (£20 000-£30 000).[16] While in theory, these monetary values represent different measures,[17] in practice they are used for the same purpose and there is no level playing field when assessing the value for money of interventions that affect quality of life. For example, an analysis of Transport for London's fast food advertising ban used a monetary value for a QALY of £20 000 whereas modelling of the sugar levy on soft drinks used £60 000.[18,19]

Current obesity strategy reflects political timidity

A fragmented and siloed policy appraisal approach allows UK governments to repeatedly present a commitment to tackling obesity while advocating an ineffectual range of policies. Lobbying pressures and short term election cycles result in the recurring advocacy of politically palatable, yet inadequate, treatment focused measures that avoid the perception of an over-reaching "nanny" state.[1,2]

Consequently, UK legislation for population level benefits has been rare and had limited effects. A ban on television advertising of high fat, salt, and sugar foods in or around programmes for children was introduced in 2007. However, half the television advertising seen by children in 2015 was still for such foods or related food outlets.[20] Further advertising regulation was proposed in 2022 but is yet to be implemented after being delayed twice.[21]

A second piece of legislation was the soft drinks industry levy in 2018, which introduced tiered tariffs on drinks with 5 g or more of total sugars per 100 mL.[22] Economic modelling using drink purchasing data from before and after the levy was introduced estimated that the combined prevalence of overweight and obesity in children and adolescents would be reduced by a maximum of 0.7 percentage points over 10 years.[22]

While these examples are important and show that it is possible to introduce bold policies, in isolation each will have only a marginal effect on obesity prevalence.[22] Less political timidity will be required to meet the government aim, set in 2018, to halve childhood obesity rates by 2030.[23] Government decisions to postpone commitments to restrictions on multibuy deals and further advertising restrictions for high fat, salt, and sugar foods are evidence of this timidity. The ideology of choice is used to justify overly cautious timeframes in proceeding with fiscal and regulatory policies that don't depend on individual agency to reduce obesity prevalence.[21] Wider modelling of the effects of interventions to reduce obesity could provide evidence to counter factors such as vested interests and political impediments that are influencing policy decisions.[24]

Embracing the challenge of holistic, system-wide modelling

Holistic modelling that compares obesity policies individually and in combination is needed to quantify the overall effect of any policy strategy. Modelling can inform both the choice of target and associated policy innovation by estimating the scale and scope of cumulative obesity policies required to achieve specific targets. Government commitment to measurable, time defined, targets for reducing obesity prevalence is therefore essential to drive progress.[2,5]

Modelling would also indicate what level of spending on interventions to tackle obesity would represent good value for money compared with other uses in terms of effects on health and society. Including health inequalities in modelling would allow policy makers to decide whether to use targeted interventions for obesity that address wider determinants of health, even if these may not be highly valued in cost effectiveness terms.

There are significant challenges in implementing a holistic modelling approach. Obesity is a chronic, relapsing health condition with health and wider impacts throughout the life course. Modelling must therefore use a lifetime horizon to estimate the cumulative effect of both sustained treatment and preventive interventions.[10] Moreover, model techniques need to be appropriate to accommodate obesity's multiple causes and consequences.[25] Current limitations in modelling of obesity need attention to make holistic modelling viable and ensure the effects on health are not underestimated or overestimated.

Models must avoid unwarranted assumptions, including heroic assumptions translating short term drops in calorie intake into substantial or sustained reductions in body mass index (BMI), as appetite regulation responses can undermine dietary changes in the longer term.[26] For example, 2019 modelling reported that a successful 5% sugar reduction programme would reduce calorie intake by 19 kcal a day and UK adult obesity by 5.5%, but included a caution that unanticipated changes in eating habits could negate these effects.[11]

Additionally, current models tend to rely on four serious health outcomes associated with obesity: cardiovascular disease, cerebrovascular disease, some cancers, and type 2 diabetes.[27] The effects of BMI on mental health, musculoskeletal health, and productivity are often missing from current models,[27] which may considerably underestimate the cost effectiveness of interventions.[28] An evaluation of Transport for London's ban on fast food advertising[18] suggested that the largest cost savings (29% of the total) resulted from prevention of osteoarthritis, and UK productivity losses related to obesity in 2021 were estimated to be £8.9bn.[29]

Problems also exist with the availability and quality of data on a breadth of long term health and societal outcomes. Potential solutions include creation of frameworks for minimum data requirements in trials that are designed to support modelling of more comparable lifetime appraisals of interventions. Increased use of natural experimental studies— in which real world data are collected from settings that have introduced policies at different times or levels of intensity—can also provide data to inform modelling of combinations of population level measures.[30]

Towards more effective policy

Modelling inevitably represents a simplification of reality. Nevertheless, it is a valuable tool for informing policy development and evaluation,[14] and countering lobbying interests resisting changes to the policy status quo.[16] A key benefit of modelling is that it can identify and explore uncertainty through transparent statistical methods to inform risk management by decision makers. Developments in microsimulation modelling techniques, and adherence to existing expert recommendations on obesity modelling, including requirements for model validation, already provide a functional framework.[10]

A more comprehensive modelling approach would highlight to policy makers, and those responsible for scrutiny, where the cumulative impact of existing policies is not sufficient. Politicians may then be emboldened to champion identified policy strategies to reduce obesity prevalence, including tackling the upstream influences on obesity.[2,5] An analogous case is the UK's net zero strategy for greenhouse gas emissions, which took a systems approach, using modelling to work backwards from a target, rather than leaving governments to pick and choose from a "shopping list of policies which might help." [2] A similar approach for obesity would address the current bias towards individual level policies shaped by political ideology and support the acceleration of fiscal and regulatory measures that modelling is likely to show are essential for sufficient impact.[2]

The UK also needs greater clarity on the organisational responsibility and accountability for government-wide obesity policy development and implementation. After Public Health England was abolished in 2021, the Office for Health Improvement and Disparities (OHID) became responsible for leading action for healthy weight in England.[31] However, its recent fragmentation and large cuts to staffing raise serious questions about its ability to ensure systematic public health leadership and advocacy and oversee obesity policy making.[32]

NICE has a key role in appraising interventions, and its established expertise in using modelling to inform cost effectiveness assessments makes it a natural home for the development of holistic modelling tools. The increased prominence of public health in the current consultation over NICE's transformation is encouraging,[33] but a fully holistic policy appraisal and advisory remit would be a substantial step away from its current function. An effective partnership with OHID, therefore, will be required to achieve a prioritisation of holistic obesity policy making, drawing on public health leadership to incorporate policy development and implementation expertise.[2] This will also require cross government collaboration and political leadership, for which there is precedent.[34] The Health Select Committee's scrutiny of government decision making should use the results of modelling of policy choices.

Although holistic modelling should have a fundamental role in obesity policy innovation, it is by no means the only tool required. For example, qualitative analysis of stakeholder insight, including the experience of people living with obesity, is essential and can inform modelling parameters, validate model output, and contribute to holistic decision making. Challenging decisions lie ahead once modelling output is available—for example, the judgments to be made between policies that seek to achieve universal impact versus those targeted on health inequalities in certain population groups. Nevertheless, the ability to make such decisions based on data is essential to support government commitment to obesity policies of sufficient breadth and scope, including use of politically sensitive fiscal and regulatory measures, responsive to both cost effectiveness and health inequalities.

Although holistic modelling should have a fundamental role in obesity policy innovation, it is by no means the only tool required

Joanna McLaughlin, public health academic clinician
Joanna.mclaughlin@bristol.ac.uk

Carlos Sillero Rejon, senior research associate in health economics

Karen Coulman, clinical lecturer

Hugh McLeod, senior lecturer in health economics , University of Bristol, Bristol, UK

Mike Bell, public contributor, Public representative, UK

Bjoern Schwander, health economics consultant, Agency for Health Economic Assessment and Dissemination, Bietigheim-Bissingen, Germany

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EDITORIAL

Poor mental health in Nigeria's displaced youth

Targeted interventions are urgently required to deal with this growing crisis

The United Nations Refugee Agency (UNHCR) estimated in June 2024 that Nigerians account for roughly 3% of the world's displaced people.[1] Ongoing conflicts and insecurity in several regions of Nigeria have resulted in the internal displacement of about 3.3 million people—around 1.65% of the total population—with children and young people among the most affected.[2] In 2019, the UN Children's Fund (Unicef) reported that 1.9 million people were displaced in north east Nigeria alone; 60% of these were children, and one in four were under 5 years old.[3]

An analysis of the current response by government and other stakeholders found that although the immediate physical needs of displaced young people have been given some attention, vital mental health support remains inadequate, especially in view of the growing number of violent events.[4,5]

A 2021 poll by Unicef of over 21 000 people across 21 countries, including Nigeria, indicates that young people in Nigeria are facing serious mental health challenges. The poll, which gathered the views across two age groups (15-24 years and ≥40 years), found that one in six young Nigerians between the ages of 15 and 24 report often feeling depressed, having little interest in activities, and experiencing worry, nervousness, or anxiety.[6]

Internal displacement is the leading driver of mental illness in conflict affected regions of Nigeria. Displaced people often present with diverse mental health conditions such as post-traumatic stress disorder (PTSD), anxiety disorder, depression, substance misuse, psychosis, antisocial behaviours, and somatic symptoms such as headaches, non-specific pain or discomfort, dizziness, weakness, and fatigue.[7]

ICRC

One in six young Nigerians reports frequent nervousness, anxiety, or depression

Children and adolescents displaced by conflict experience severe psychological stressors, including loss of family members, disruption of social networks, and exposure to violence and sexual exploitation.[8] These experiences can lead to various mental health conditions, including PTSD, anxiety, depression, and developmental delays. Lack of stable environments such as education, home, and healthcare exacerbates these problems.

Need for targeted support

Recent studies have highlighted the importance of targeted mental health interventions for displaced children and young people. For instance, a systematic review on support interventions for children affected by armed conflict in low and middle income countries shows that timely psychosocial support can substantially mitigate the adverse effects of trauma.[10] Unfortunately, Nigeria's mental health services are underfunded and understaffed, with little emphasis placed on the needs of displaced populations.

Other studies show that forcibly displaced women and girls experience high rates of sexual and physical violence, which are linked to a greater risk of adverse mental health outcomes.[11] Displaced survivors also face substantial barriers to reporting and accessing timely care, highlighting the urgent need for targeted interventions and support systems for women and girls.[12]

The mental health challenges faced by displaced young people in Nigeria are exacerbated by a scarcity of trained professionals, societal stigma surrounding mental health, and ongoing social and economic crises. Government agencies and their international partners need to take urgent action to address these challenges and provide targeted support. Firstly, more resources must be allocated to mental health programmes specifically tailored for displaced children and adolescents. This includes funding for counselling services, support groups, and mental health education initiatives.

Secondly, local health workers and educators should be trained to identify and manage mental health conditions more effectively to ensure early intervention and support for those in need. Integrating mental healthcare into humanitarian aid packages and emergency responses is another critical step.

Thirdly, culturally sensitive, community based mental health programmes must be developed and implemented. These programmes should be accessible and designed to meet the unique needs of displaced populations. Continuous research and monitoring of mental health among displaced young people is also important to inform the evaluation of interventions.

Recognising that population mental health affects social stability and a country's future development, policy makers, international organisations, and mental health professionals must act decisively. By prioritising comprehensive mental health support, we can empower displaced young people to rebuild their lives, contribute positively to society, and break the cycle of trauma and marginalisation they face.

Oche Joseph Otorkpa, executive director, Department of Public Health, National Open University of Nigeria, Lokoja, Nigeria
drochejoseph@gmail.com

Adefunmilola Adebola Onifade, head of department, Department of Family Medicine, Federal Teaching Hospital, Lokoja, Nigeria

Chinenye Oche Otorkpa, director, Directorate of University Health Services, Federal University, Lokoja, Nigeria

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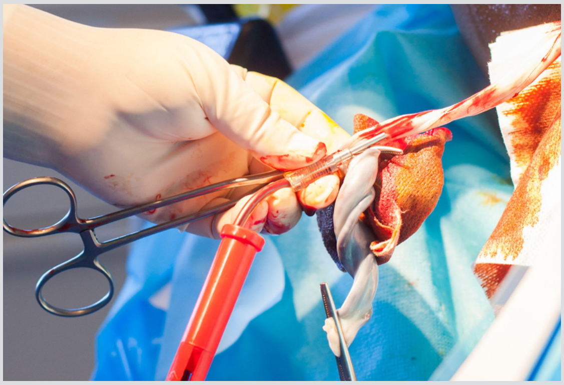

LETTER OF THE WEEK

The unsung generosity of cord blood donation

The investigative feature by Kwan on private cord blood banking (Cover, 27 July-3 August) illuminates a troubling and misleading practice, frequently promoted in NHS spaces.

Umbilical cord blood banking has gained prominence as an option for expectant parents worried about their child's future health. Parents pay private companies up to £3000 to freeze their baby's cord blood, which contains stem cells, in case the infant develops a condition that could be treated with stem cell therapy.

This profit driven approach of storing stem cells for vague "future use" detracts from the benefits of cord blood donation, which facilitates lifesaving acts of generosity across borders and generations.

For patients with acute leukaemia, an allogeneic stem cell transplant is often crucial for a cure. Some patients find a suitable match among siblings or unrelated adult volunteers, but others might have difficulty finding a compatible donor. A cure might still be possible, however, through cord blood transplants, which use stem cells from the umbilical cords of one or two babies.

This quiet act of generosity is remarkable in several ways. Firstly, it necessitates exceptional international cooperation, with some patients receiving cord blood donations from two different continents—even during the covid-19 pandemic. Secondly, it transforms umbilical cord cells, which are almost useless to their original owner and typically discarded, into a lifesaving therapy for a stranger. Thirdly, the intergenerational nature of this gift is profound: in their first moments of life, a newborn can provide the gift of life to an unrelated child or adult.

Private cord blood banking undermines this remarkable practice. The desire to protect our children from future threats is natural and good, and private cord blood banks exploit this concern. A better path to future wellbeing for newborns and all people lies in acts of generosity and mutual care.

Stephen P Hibbs, clinical research fellow, London

Cite this as: *BMJ* 2024;386:q1927

PAYING CARE WORKERS PROPERLY

We must transition to a preventive care model

The new adult social care workforce strategy commits to improving pay—an example of the farsighted thinking that the NHS needs to adopt (Seven Days in Medicine, 27 July-3 August).

The strategy recognises how poor remuneration affects recruitment. Social care workers and those they look after deserve a well funded service, where financial rewards attract high calibre employees.

The demand for carers will increase as the number of people in England aged over 65 rises by nearly a third by 2043. The number of people with dementia is projected to increase to 1.7 million across England and Wales by 2040.

As demand will likely outstrip increases in NHS funding, we must transition to a preventive care model that focuses on deterring illness and extending a person's healthy and productive years. We must accelerate investment in research into treatment and diagnostic techniques that detect and treat disease earlier and more effectively.

Tomasz J Pierscionek, postgraduate fellow in medical education, London

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FACE MASKS AND RESPIRATORY SYMPTOMS

N95 masks should be prioritised

Solberg and colleagues found that people advised to mask are significantly less likely to develop symptoms of a new respiratory infection over the next 17 days (Research, 27 July-3 August). It also showed a failure rate of up to 70%, which is not surprising given the airborne nature of respiratory viruses and that surgical masks leak.

We found strong evidence favouring respirators over surgical masks but no direct experimental evidence for the superiority of the former in community settings. Andrejko et al showed that any mask is better than none and that N95 respirators are superior to surgical masks, which are superior to cloth.

The evidence base strongly supports a policy that, in a pandemic or serious epidemic, supplies of N95s should be prioritised for health workers; if sufficient N95s are available, they should be recommended for community use; and in the absence of N95s, any mask will offer some protection.

Trisha Greenhalgh, professor of primary care health sciences, Oxford; Raina MacIntyre, professor of biosecurity, Sydney; Amanda Kvalsvig, associate professor of epidemiology, Wellington; Michael Baker, professor of public health, Wellington; Matt Oliver, professional standards advocate, Edmonton; David Fisman, professor of epidemiology, Toronto; Joe Vipond, physician, Calgary

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COVID INQUIRY

Defining triage before future pandemics

The covid-19 inquiry has considered many areas of the pandemic response (Opinion, 27 July-3 August). But triage and rationing are neglected. This is where doctors' clinical decisions can conflict with their consciences. It can be the root of the moral injury associated with burnout and other mental health problems. Clear support and guidance are important.

In March 2020 there was little good quality commentary. The NICE covid-19 rapid guideline on critical care in adults has since been updated but gives links to 2020 medical guidance for support when deciding whether to escalate treatment, which does not discuss rationing.

To prepare adequately for future pandemics we must discuss triage and rationing openly. This must involve different parts of the health system and the public. This will only happen if central government or a national body takes it forward. Otherwise, doctors will continue to be criticised when the system has failed.

Bridget K MacDonald, neurologist, Croydon

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OBITUARIES

Sylvia Gyde

Medical researcher in a major study of perinatal mortality rates in the West Midlands

Sylvia Nancy Gyde (b 27 March 1936; q Oxford 1960; BM BCh MA MFCM FFPHM), died from cancer of the colon and dementia on 23 April 2024

When Sylvia Gyde was appointed district medical officer for North Birmingham Health Authority in 1989 she was described by the *Birmingham Post* as "a tornado," thanks to her emphasis on preventive medicine. "What the health service does is nothing to do with health. It is picking up the tabs on the sick," she declared. "Very little money goes into trying to persuade people into living lifestyles that might promote health."

Such comments didn't always endear her to her colleagues, and she told of being "subjected to frequent male intimidation, harassment, and pay inequality." Her husband recalled that on one occasion the BMA even sent an officer to provide support in tackling the sexism she experienced.

In 1981 she took issue with the author Anthony Burgess over an article he wrote for the *Observer* saying that he assessed female doctors and solicitors sexually while talking to them, which he said distracted him and degraded the women in question. She wrote in a letter to the paper, "Throughout my life I have been distracted while listening to male lecturers, solicitors, writers, etc by assessing them sexually whilst they are talking. This certainly distracts me. Does it degrade the men?"

Her contributions to public health included a study of perinatal mortality rates in the West Midlands that examined 250 baby deaths and involved interviews with doctors, midwives, and mothers. "It was clear that the biggest potential for reducing perinatal deaths lies in improvements in antenatal care," was the inquiry's key finding when it reported in 1987.

This emphasis on preventive medicine stretched back to her days as a doctor in the 1960s when she and a fellow Oxford graduate offered family planning advice to women on a deprived estate in Woolwich, southeast London. "The only premises were in the community hall, which every day housed the children's playgroup," she recalled.

They acquired a portable couch and a suitcase of contraceptives. "At the end of the hall was a stage, so we drew the curtains and set up shop," she said. "Once word got around we were inundated with trade, with the children peeping under the curtain to see what was going on." Undaunted, the pair set up a similar facility in a nearby centre for homeless families.

Sylvia Gyde lamented that "very little money" goes into persuading people to live healthily

Education

Gyde was born Sylvia Nancy Clayton in Llanidloes, mid-Wales, the daughter of Robert Clayton, who worked as a tannery manager, and his wife, Violet (née Marshall), a chartered secretary, and she is survived by her younger brothers, Robert and Michael. She was a year old when the family moved to the village of Combs in Suffolk.

She was awarded a scholarship to St Felix School in Southwold, although her years there were "the most miserable of my life," she said, with unwarranted punishments and being told, "You're only a scholarship girl."

A Nuffield scholarship in medicine took her to Somerville College, Oxford, where she spent some of her happiest years, enjoying social freedom and intellectual development. Her medical vocation grew under the tutorship of the physiologist Jean Banister and the Nobel prize winning chemist Dorothy Hodgkin, with encouragement from the principal, Janet Vaughan.

"I made so many good friends at Oxford," Gyde recalled. One of them was the writer Alan Bennett.

Remaining at Somerville for her pathology exam, she "had a wonderful year singing in choirs, going to college productions, etc" but neglected her work until the final few weeks.

Public health

She met Humphrey Gyde during their clinical years at the London Hospital Medical College. They were married in 1961, and four children followed in six years. In 1972 Humphrey was appointed consultant in haematology in Birmingham, and the family moved to the West Midlands, where Sylvia worked as a GP. "Being on call at night and at weekends was difficult," she said. Salvation came with a research post in gastroenterology that involved writing papers about inflammatory bowel disease.

In 1983 Gyde joined the public health medicine training scheme, where she was known as "Gran" on account of being the oldest student; however, for a time she resumed smoking, which she had given up when she got married. Subsequent appointments included medical director of clinical audit for the West Midlands, medical director of the Evidence Supported Medicine Union, and director of public health for North Birmingham Health Authority.

She revisited the subject of perinatal mortality in 1992 in her annual report, highlighting how the rate of stillbirths and deaths of newborn babies remained above the national and regional averages. "For a relatively affluent district our rates of losing babies are too high," she said, calling for greater liaison at all levels of care for pregnant women.

In retirement Gyde did locum work in London, sang in choirs, grew roses, collected lacemaking bobbins, and completed a City & Guilds qualification in ceramics. Cheerful and outgoing, she enjoyed the company of a series of basset hounds and entertained visitors at the family's bolthole in Franche-Comté, eastern France.

She is survived by Humphrey; their four children, Emily, Humphrey, Helen, and Edward; and four grandchildren.

Tim Bullamore, Edinburgh

Cite this as: *BMJ* 2024;386:q1848

Stuart Murray

GP whose drive to raise standards saw him design the first mandatory qualification for general practice

Thomas Stuart Murray (b 1943; q Glasgow 1967; FRCGP, PhD), died from frailty of old age on 17 May 2024

Until 1996 the bar to entry into general practice was low. The MRCGP exam wasn't mandatory, and as long as you were signed off by your trainer you could practise.

Stuart Murray had long harboured concerns about GP standards, and in 1990, when the Royal College of General Practitioners (RCGP) and training bodies decided to launch a national standardised assessment, Murray, who was then director of postgraduate general practice education at Glasgow University, seized his chance.

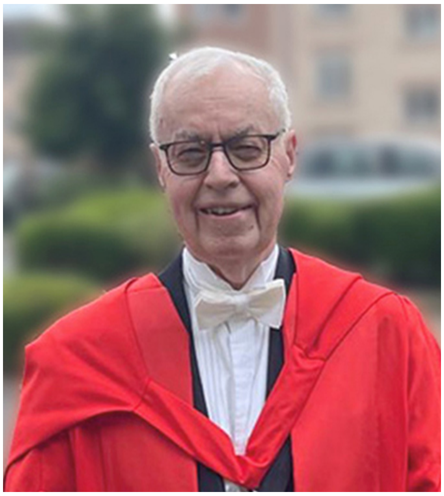
He and his team at Glasgow University developed an assessment tool that would ask one simple question: is this doctor competent to be a GP? Their tool had four components: multiple choice questions, an assessment of videotaped consultations, a written report, and the trainer's judgment of the student. The project was piloted in the West of Scotland deanery in 1992 before being rolled out across Scotland the following year. In September 1996 summative assessment was launched throughout the UK.

To say that the new project had its critics is an understatement, and doctors who first tested it in Scotland were particularly angry about the video element. In the 1998 William Pickles lecture at the RCGP, Murray reflected on the "enormous backlash" from GPs and trainers in Scotland. "They certainly orchestrated a very effective campaign," he said. "It was very difficult to forecast where the next thunderbolt was going to appear from."

He took the concerns on board, particularly over patient consent and confidentiality. "Evidently, the turbulence was an enormous smokescreen designed to derail the train," he said.

Academic rigour

Murray and his team weren't working in a vacuum: the RCGP and other bodies had recognised that standards needed to be raised. Teams in other parts of the country were also working on GP assessment, but it was mainly the West of Scotland model with its academic rigour—each module was underpinned by research—that the college selected.


Stuart Murray faced an "enormous backlash" from GPs over plans to video patient consultations

He had taped some consultations to show trainers how the system would work. One trainer was horrified at the lack of competence on display, believing that he was watching a training video rather than a consultation with a real patient.

Moya Kelly, former director of general practice at NHS Scotland who worked with Murray on the development of the training programme, said that they saw some real "howlers" in the assessment videos: doctors missing differential diagnoses or listening to patients' chests through jumpers and shirts. Before summative assessment these doctors would have got through, she said.

"Stuart was all about standards and academic rigour," said Kelly. "Patient care and patient safety were paramount, and if somebody wasn't ready to be an independent practitioner they should be held back and get further training until they were."

Summative assessment and the MRCGP exam ran in parallel until, in 2007, the MRCGP finally became the single postgraduate qualification for entry into general practice.

Education

Thomas Stuart Murray was born to Annie and Tom Murray in the Ayrshire town of Muirkirk in 1943, the youngest of three boys. Tom was a grocery manager in the local Co-Op, and Annie was a housewife.

The family lived in just two rooms and shared an outside toilet with four other families until, in 1952, they moved to a newly built council house with a large garden, which became his mother's pride and joy.

Murray was a hard worker and one of only three pupils in his class to stay on after the age of 15. Local children used to throw stones at his bedroom window when he was studying—this hardened him to the brickbats hurled his way by GPs, he said.

Murray attended Glasgow University, where he confessed to feeling like an outsider at first but made lifelong friends, including Stewart Hillis, who became the doctor for the Scottish football team and with whom he shared a passion for the sport. Murray was a lifelong Rangers fan and bought season tickets for his grandsons.

On qualifying he worked at Glasgow Royal Infirmary, where he met Anne, a nurse. He then moved into general practice, working in the Vale of Leven, a working class area, before he started to think about broadening his professional interests.

In 1975 he moved to Glasgow University, where he combined research and clinical practice at the Woodside Health Centre, a large group practice serving about 45 000 people. GP training was starting at that time, and Murray completed a PhD on the new teaching programme. This led to a senior lecturer post before he became the director of postgraduate general practice education in the West of Scotland in 1985 and professor of general practice in 1992. He showed signs of his reforming zeal—and determination—when he first moved into academia and began visiting GP training practices, removing accreditation from those that weren't up to scratch.

Murray retired in 2011, taking his whole family—16 people in total—to New York to celebrate. He was made emeritus professor of general practice, but spent much of his retirement enjoying being a proud grandfather.

He leaves his wife, Anne, three children, and nine grandchildren.

Anne Gulland, *The BMJ*

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