this week

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Manager regulation is "long overdue"

NHS managers who silence whistleblowing doctors or endanger patients through misconduct could be sacked and permanently barred from working in the NHS, under new proposals.

Regulating health service managers will tackle a "culture of cover up" that has been present in numerous patient safety scandals in recent years, the government said. Health minister Karin Smyth said, "We need the best and brightest managing the health service, a culture of transparency that keeps patients safe, and an end to the revolving door that allows failed managers to pick up in a new NHS organisation."

Proposed options include statutory mechanisms to place legal obligations on employers to prevent certain managers working in the health service, full statutory registration, or an accredited voluntary register on which managers could choose to be listed. A consultation also proposes a statutory duty of candour to make managers accountable for responding to safety concerns.

Medical leaders said regulating managers in line with how doctors are governed by the GMC was "long overdue" but cautioned that regulation alone would not eradicate the "fear of blame" culture that has affected whistleblowers who have tried to raise concerns about patient safety, such as consultants in the Lucy Letby case.

Phil Banfield, BMA chair of council, said, "Doctors are regulated by the GMC and can face significant sanctions if they fall seriously short of its standards. However, while NHS managers make decisions that directly impact patients, they are not held to any equivalent standards. We hope this proposal marks a shift away from a culture of organisational protectionism towards true accountability."

In May the Hospital Consultants and Specialists Association warned that whistleblowers were targeted by a systematic employer "playbook" designed to silence or remove them. Its president, Naru Narayanan, said, "We want to see a new criminal law against victimising whistleblowers and a new independent body to guard against repercussions for those who speak out. Without these measures we are only addressing part of the problem."

The Department of Health and Social Care said at a minimum the new regulatory framework would apply to all board level directors in NHS organisations in England, all board level directors in arm's length bodies, and all integrated care board members.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024;387:q2648

Phil Banfield (centre) and Naru Narayanan (right) gave a cautious welcome to the proposal introduced by health minister Karin Smyth

LATEST ONLINE

- COP29: Finance deal to raise $300bn a year by 2035 for poorer countries is hailed—and slated
- Anaesthesiologist in Texas sentenced to 190 years for poisoning IV bags
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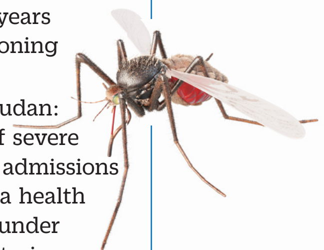


UK claimants plan legal action against Johnson & Johnson over talc cancer claims

Around 2000 people in the UK are proposing to take legal action against Johnson & Johnson (J&J) over claims that its talcum powder products caused cancer.

The law firm KP Law has sent a letter before action to the company, to be followed by an application for a group litigation order at the High Court in London. J&J has been hit by long running US litigation, but KP Law said the case would be the first in the UK.

Tom Longstaff, partner and head of product liability at KP Law, said in a statement on the firm's website, "All of the claimants who have sustained cancer after using Johnson & Johnson's talcum powder products have experienced a life changing illness, leaving their families devastated. All of these innocent individuals deserve justice."

The law firm added, "We believe the US based multinational corporation knew as early as the 1970s that asbestos in its talc products was dangerous but failed to warn consumers and carried on producing and selling the products in the UK up to 2022."

Claims in the US alleged that talc causes ovarian and other gynaecological cancers, and that talc laced with asbestos causes mesothelioma. In September J&J increased its offer to settle claims relating to ovarian cancer to around $8bn to be paid over 25 years.

Clare Dyer, *The BMJ* **Cite this as:** ***BMJ*** **2024;387:q2618**

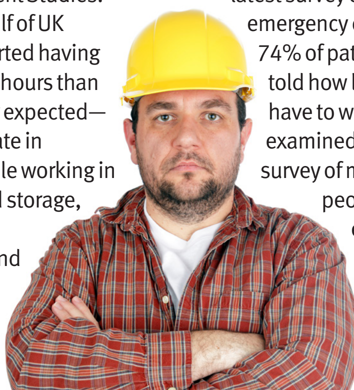
Workforce

UK "over-relies" on international recruitment

The UK had a shortage of around 176 000 doctors, nurses, and midwives in 2022 and has become over-reliant on international recruitment, warned the Organisation for Economic Co-operation and Development. EU countries had an estimated shortage of 1.2 million doctors, nurses, and midwives. The OECD said the number of doctors in the UK was "well below the average across EU countries" at 3.2 per 1000 population in 2022 against an EU average of 4.2.

Poor quality jobs threaten workers' health

Workers' health is being significantly affected by poor work conditions, with 1.7 million people in the UK reporting work related health problems in the past year, said a report from the Institute for Employment Studies. It said that half of UK workers reported having to work more hours than contracted or expected—the highest rate in Europe. People working in transport and storage, construction, commerce, and hospitality reported poorer quality outcomes across a range of indicators.



Resident doctors

Demand for missing back pay is issued to trusts

Resident doctors have appealed to NHS trusts in England to pay money owed to them without further delay. After a July pay deal between the government and the BMA's Resident Doctors Committee it was agreed back pay for 2023-24 and 2024-25 would be in November pay packets. However, the BMA said doctors at several hospitals report that their trusts have failed to process this back pay on time, especially where doctors have moved their place of employment in the past year or have returned from maternity leave.

Emergency care

CQC survey shows A&E crisis, says royal college

The Care Quality Commission's latest survey on urgent and emergency care showed that 74% of patients were not told how long they would have to wait in A&E to be examined or treated. The survey of more than 45 000 people who attended emergency care services found that 64% waited more than four hours to be admitted, transferred, or discharged. Adrian Boyle, president of the Royal College of Emergency Medicine, said, "Patients are suffering the consequences of a system that is in crisis, while staff continue to shoulder the burden of delivering effective and safe care in these conditions."

Trainees

GMC takes action against Norfolk hospital's failures

The General Medical Council has placed conditions on the medicine and surgery departments at Norfolk and Norwich University Hospitals NHS Foundation Trust after repeated concerns about handover, clinical supervision, and inappropriate behaviour. The regulator has placed these departments under enhanced monitoring after doctors in training reported a range of concerns, including racist and misogynistic behaviour. If the concerns are not fully tackled the GMC can place conditions on its approval of a training programme.

Social care

Providers are "at risk from national insurance hike"

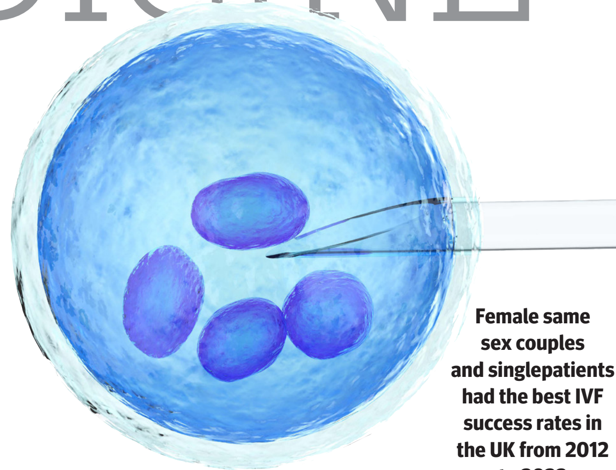
Changes to employers' national insurance contributions announced last month will cost the adult social care sector over £900m next year, more than wiping out the extra funds allocated in the budget, said a Nuffield Trust analysis. Increased costs to the social care sector will rise to an estimated £2.8bn in the next financial year when the planned increases to national minimum wage rates are added in. The report said this would mean that many businesses, especially small ones, risked going bust.

Patient data

Software rolled out across most of NHS England

The NHS Federated Data Platform, designed to tackle waiting lists and reduce discharge delays, has been rolled out across more than two thirds of the NHS in England. The platform brings together real time data, such as the number of hospital beds, elective waiting list lengths, staff rosters, and social care places so staff can better plan resources. NHS England says 87 NHS acute care hospital trusts and 28 integrated care boards in England have signed up in the year since the platform's introduction.

MEDICINE



Female same sex couples and singlepatients had the best IVF success rates in the UK from 2012 to 2022

Fertility treatment

Inequalities in access remain, says regulator

More than half (52%) of heterosexual couples undergoing fertility treatment received NHS funding, said a report from the Human Fertilisation and Embryology Authority. Around 18% of single patients and 16% of female same sex couples received NHS funding. From 2012 to 2022 the number of patients having IVF or donor insemination treatment rose from around 45 300 to 47 000 among heterosexual couples, from 1300 to 3300 in female couples, and from 1400 to 4800 in single patients. Female couples and single patients had the highest success rates, with a birth rate per embryo transferred of at least 40%, compared with 35% in heterosexual couples.

Air pollution

Delhi and Lahore enter partial lockdown

Schools and many businesses in Delhi, India, and Lahore, Pakistan, were ordered to close as levels of pollutants on some days far exceeded the most severe category of the US Air Quality Index (AQI). The commonly used international scale has six categories, with "hazardous" air quality scoring from 301 to 500. Delhi reached 1758 on the scale at noon on 18 November, its worst day this year. Some monitoring stations in Lahore recorded AQI scores above 1900 on 7 November.

Productivity

Empower staff to transform services, says IPPR

Giving a greater say to healthcare workers, including new NHS staff boards, is key to boosting productivity and increasing retention, said the Institute for Public Policy Research. It argued that two major crises facing the NHS—low productivity and poor staff retention—reinforced each other, with high staff turnover raising costs and affecting care delivery, while inefficiencies such as outdated equipment deepened staff dissatisfaction and lowered productivity levels. The IPPR said that restoring NHS productivity to pre-pandemic levels would have freed up £19bn more in 2023-24.

Haiti

MSF staff are threatened

The international humanitarian organisation Médecins Sans Frontières has been forced to suspend activities in Haiti's capital, Port-au-Prince, after an incident on 11 November where two patients were killed and MSF staff were threatened and attacked. Since then police officers have stopped MSF vehicles multiple times and threatened staff members, including death and rape threats. From 20 November MSF stopped admitting patients at its five facilities in Port-au-Prince, which collectively treated hundreds of people weekly, including trauma and burn patients and victims of sexual violence.

Cite this as: *BMJ* 2024;387:q2639

TOBACCO

Smoking will cause almost

300000

cancer cases in the UK over the next five years if trends continue, with around 2800 caused by exposure to secondhand smoke

[Cancer Research UK]

SIXTY SECONDS ON . . . MEDICINAL CANNABIS

WHAT'S THE 420 . . . I MEAN, 411?

Doctors in Denmark can expect to have a new addition to their armamentarium after the country's health minister announced ambitions to legalise medicinal cannabis.

A BUDDING SUCCESS?

The move follows a pilot programme, running since 1 January 2018, to allow all doctors to offer patients medicinal cannabis if authorised drugs haven't helped. The programme was extended in 2021 and is set to run until 31 December 2025. The scheme has focused on helping people with sclerosis, spinal cord injury, chronic pain, or nausea and vomiting after chemotherapy.

HITTING NEW HIGHS

An estimated 20 000 prescriptions have been made through the pilot to 1800 patients. There were 5000 prescriptions in the first half of 2023, almost double the 2600 prescriptions written in the second half of 2020.

IS THE UK BLAZING A SIMILAR TRAIL?

Medicinal cannabis was legalised in the UK in 2018 for some rare and severe forms of epilepsy, vomiting or nausea from chemotherapy, and muscle stiffness and spasms from multiple sclerosis. There have been few NHS prescriptions, although private providers have reported a large rise in demand, with one London clinic reporting a jump in the number of patients during 2023 from 250 to 2750.

ANY DOWNERS?

The Danish Drugs Agency has been monitoring side effects but says no new safety concerns have emerged. Reported side effects can include diarrhoea, nausea, weakness, behavioural or mood changes, dizziness, fatigue, hallucinations, and suicidal thoughts.

IS THE EVIDENCE GROWING?

A study published in *The BMJ* last year reported that cannabis based medicines were "effective in people with multiple sclerosis, chronic pain, inflammatory bowel disease, and in palliative medicine, but not without adverse events."

IS JOINT DECISION MAKING REQUIRED?

The Danish government has invited political parties to discuss the introduction of permanent legalisation.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;387:q2610

Locally employed and international doctors "need better training opportunities"

More must be done to support the rapidly growing number of locally employed doctors to ensure their talents are not "overlooked and undervalued," the GMC has said.

The regulator's annual report on the state of medical education and practice in the UK shows that 28 956 doctors joined the GMC register in 2023, a 21% increase from the 23 838 who joined in 2022—the fastest rate in decades. Overall there were 313 829 doctors registered in the UK in 2023, a 6% increase from 296 182 in 2022.

Areas of growth

The GMC noted that a large proportion of this growth in England and Wales (where figures could be verified) was due to an increase in the number of locally employed doctors, which rose by 75% from 2019 to 2023 (from 21 000 to 36 831). In contrast, doctors on the specialist register grew by 9% over the same period and the GP register by just 9%, said the GMC (which was unable to provide the absolute numbers by the time of publication).

Although becoming a locally employed doctor can be a career choice, with some doctors who have completed foundation training deciding to take a break from training, many come from outside the UK. The GMC has said that these roles were often "poorly defined, with limited opportunities for progression," and many were short term or non-permanent posts. It said that this group needed "opportunities to progress their careers" and that the "unfairness and barriers to the progression of doctors joining from abroad must be tackled head on."

The report warned, "Without action, we will sleepwalk into a situation where these talented doctors are overlooked and undervalued, to the detriment of their own development and the provision of good patient care."

It's critical all doctors have the infrastructure, support, and resources they need to achieve their ambitions Charlie Massey

The GMC found that more than two thirds of joiners in 2023 did not graduate in the UK, up from less than half in 2017. These doctors were largely from India, Pakistan, Nigeria, Egypt, and Bangladesh.

The regulator has said it was crucial that "concerted, sustained efforts" were made to ensure these doctors get the inductions they need and that they were supported to integrate into and thrive in the UK healthcare system.

The report also found the number of registered doctors from an ethnic minority background increased by 78% from 2016 to 2023, with the UK now having more doctors from ethnic minority backgrounds (149 385) than white doctors (147 458) for the first time. "There is robust evidence of ethnic minority doctors facing many more hurdles in their careers than

Alcohol, tobacco, and food scientists receive threats

Our hope is that shining a spotlight on these highly unethical tactics may reduce their chilling effect on improving health Karen Evans-Reeves

Researchers investigating the effects of tobacco, alcohol, and ultraprocessed food are often the targets of intimidation designed to deter them from continuing their work or to discredit them, a study published in *Health Promotion International* has found.

The tactic most often takes the form of companies in these sectors seeking to discredit researchers but has also included surveillance, threats of violence, burglary, bribery, and cyberattacks.

Bath University researchers working with others at the George Washington University Milken Institute School of Public Health, Washington, DC, and Inserm, France's national institute of health and medical research, compiled and reviewed public data and reports of intimidation tactics used by the tobacco, ultraprocessed food, and alcohol sectors between 2000 and 2022.

Intimidation

The review found wide ranging tactics used by what the authors described as "health harming industries" (HHIs). They identified 10 main forms of intimidation, including discreditation, legal threats, complaints, and freedom of information requests often attributed to HHIs or third parties.

The most common form of intimidation, found in half of the sources included, was public discreditation, whereby academics, advocates, and their work were criticised in traditional media such as newspapers and advertisements, as well as websites, social media, and in other public forums. The attacks often focused on undermining individuals and organisations, with researchers being labelled as "extremists," "fascists," "Nazis," "zealots," and "prohibitionists."

In addition, there were far less common instances of surveillance, threats of and actual violence, burglary, bribery, and cyberattacks.

One of the study authors, Karen Evans-Reeves, from Bath's Department of Health and Tobacco Control Research Group, said, "Our hope is that shining a spotlight on these highly unethical tactics may reduce their chilling effect on improving health and help researchers and advocates understand how to pre-empt and respond."

She added that spreading misleading descriptions could hinder researchers' ability to shape policy by delaying or stopping their work. Despite the public discreditation, most researchers had continued their work, she added.

Adrian O'Dowd, London

Cite this as: *BMJ* 2024;387:q2644

PRIYA SUNDRAM

white doctors, with differences in attainment through postgraduate training and disproportionalities in the referrals we receive from doctors' employers being two key examples," the GMC said. "It is incumbent on all parties to root out discrimination and unfairness—and continued steps must be taken to combat them if we are to retain this essential, growing part of the workforce."

GMC chief executive Charlie Massey said, "For doctors to thrive and provide high quality patient care, training and development must be tailored to each group's needs.

"It's critical that all doctors have the infrastructure, support, and resources they need to achieve their ambitions. That's in their interests but also the interests of a growing and ageing population."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;387:q2652

THE REPORT found that the number of doctors on the medical register from an ethnic minority background increased by 78% from 2016 to 2023

"Inpatients harmed by out-of-area care"

Mental health inpatients in England are being harmed by being sent for treatment outside the area where they live, a patient safety agency has warned.

The Health Services Safety Investigations Body (HSSIB) found that inappropriate mental health placements can lead to anxiety, physiological stress, post-traumatic stress disorder, and patients dying by suicide.

Neil Alexander, HSSIB senior safety investigator, said "urgent improvements" were needed. "The harm caused to patients when moved far from home or moved back and forth between settings can be distressing, for them and for their families," he said.

HSSIB noted that the previous government had failed to meet its target to eliminate inappropriate out-of-area placements by 2021. Latest data show that such placements in England steadily increased from 793 in March 2023 to 900 in March 2024, of which 805 were classed as inappropriate.

The main driver for the continued use of out-of-area placements is that governance, legal frameworks, and financial commitments differ between the health service and local authorities, the report said. This, it argued, prevented integration between inpatient and community mental health services, social care, and social housing and slowed down discharge and flow of patients.

The report made two key recommendations: a requirement for providers to document preferences of patients and families; and a review of the statutory instruments, business processes, and regulations governing mental health, social care, and housing services to improve integration.

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2024;387:q2609

GPs call for special conference on national insurance rise

GPs in England have called on the BMA to hold a special conference to discuss how practices will survive the increase in employers' national insurance contributions, announced in the budget.

The NHS and the rest of the public sector are exempt from the rise, but social care and GP surgeries are not. It takes effect in April on salaries above £9100.

At the annual conference of England's local medical committees (LMCs) in London on 22 November, Mark Green, representing Berkshire LMC, proposed a motion warning that the change meant general practice in England was no longer sustainable as a business model.

His motion called for a special conference "to discuss and determine what escalatory steps will be needed to ensure the survival of what still remains of English general practice."

The rest of the motion, unanimously supported, demanded that the change to NI contributions be "immediately rectified by the health secretary through commensurate funding into the core GP contract."

"Galvanise the profession"

It said the rise "has the potential to collapse general practice, with widespread redundancies and practice closures highly likely" and called on officers of the BMA's General Practitioners Committee for England "to use any means possible to galvanise the profession around this move by government in order to pull general practice back from the brink."

Proposing the motion, Green said, "General practice was already teetering. Now it's being set up to collapse." He added his LMC had surveyed all its surgeries and received 108 responses, about 45% of the total. He said, "The average cost per surgery [of the increase] in our area was £47 000—67.6% [of respondents] said they would have to make redundancies to remain viable, 72.2% will reduce services and appointments, and one in six were going to hand back their contracts and close their doors.

GENERAL PRACTICE WAS ALREADY TEETERING. NOW IT'S BEING SET UP TO COLLAPSE
Mark Green

"The knock-on effects of those closures would soon impact on the rest of general practice. Looking at the cost extrapolated across the country, this will take £260m out of the national GP budget, and that equates to 2000 full time GPs."

Katie Bramall-Stainer, chair of the BMA's GP Committee for England, said "GPC England will use the outcome of this motion to guide our next steps in our wider dispute with the government."

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2024;387:q2642

MARK THOMAS

NEWS ANALYSIS

Does NICE's "severity modifier" for assessing diseases need to change?

Breast cancer charities and patients are "devastated" Enhertu will not be available after price talks collapsed. **Jacqui Wise** examines calls to change how new treatments are evaluated

What is Enhertu?

Trastuzumab deruxtecan (Enhertu), made by Daiichi Sankyo and AstraZeneca, is a treatment for adult patients with unresectable or metastatic HER2 low breast cancer who have received previous chemotherapy in the metastatic setting or developed disease recurrence during or within six months of completing adjuvant chemotherapy. In December 2023 the drug was approved for use on the NHS in Scotland after the Scottish Medicines Consortium used its own method to reach its decision. It is also available in 18 other European countries. Around 1000 women in England and Wales would have been eligible if it had been approved by the National Institute for Health and Care Excellence (NICE).

What has happened?

Negotiations between NICE, NHS England, and the manufacturers have been under way since July, when NICE issued final guidance rejecting Enhertu over concerns about its cost effectiveness. Clinical trial evidence shows Enhertu gives an extra 6.4 months of overall survival (23.9 months for Enhertu versus 17.5 months for chemotherapy). Clinical experts considered the treatment to be a "step change" in managing the condition.

However, despite the personal intervention of the health and social care secretary, Wes Streeting, NICE said the makers of Enhertu did not put forward a cost effective price that would enable it to recommend the treatment as value for money for the taxpayer. NICE chief executive Samantha Roberts said, "As we've always made clear, the fastest and only guaranteed way to get medicines like Enhertu to the patients who need them is for companies to offer a fair price. We have done all we can to try to achieve that."

How is cost effectiveness decided?

In February 2022 NICE introduced a new way of deciding how much value to assign to some treatments, called the severity modifier. This replaced the "end-of-life modifier" that allowed extra weight to be given only for drugs to treat end-of-life conditions. Now, NICE uses an algorithm to classify the severity of a patient's condition as "high," "medium," or "none." Patients who are expected to lose between 85% and 95% of their discounted expected lifetime quality adjusted life years (QALYs) come under the medium category and receive a 1.2 times weighting. Patients who are expected to lose more than 95% of their (discounted) QALYs are classed as high severity and receive a 1.7 times weighting. Enhertu was assigned a medium severity qualifier.

> **We are deeply disappointed NICE has opted not to make changes to the severity modifier**
> Claire Rowney

How much does Enhertu cost?

The list price of Enhertu is £1455 per vial before discounts. AstraZeneca and Daiichi Sankyo said that they had offered NHS England a fair price in line with those already approved in other European countries, including Scotland. Their statement adds, "For the government to argue that metastatic cancer is a moderately severe disease is a travesty for patients. Recognising this highly severe disease for what it is would enable rapid access to this treatment. We are deeply concerned that too many future late stage cancer treatments may be out of reach for English patients."

Is the severity modifier likely to change?

In September NICE voted not to change the severity modifier after an internal review paper found that it was working as intended and expected. A NICE spokesperson told *The BMJ*, "The severity modifier is working and will not be changed or adjusted at any point in the near future. It has allowed a higher approval rate for cancer and advanced cancers as well as enabling positive recommendations for medicines for cystic fibrosis and hepatitis D."

NICE added that Enhertu was the only breast cancer treatment it had not approved in six years and after 21 recommendations. In February the same process was used to approve talazoparib for treating HER2 negative locally advanced or metastatic breast cancer.

What is the argument for changing the thresholds?

The Association of the British Pharmaceutical Industry (ABPI) has argued that NICE should adjust downwards the cut-off levels used to determine the degree of severity, as the design unnecessarily blocks treatments that the public would expect to see benefiting NHS patients.

The ABPI cited a recent Office of Health Economics report it commissioned that suggested the public was prepared to pay more for drugs when they were used to treat patients with severe disease. A representative sample of 990 people found they gave priority at a substantially lower severity threshold and assign greater relative value to health gains at almost every level of severity, compared with NICE's severity modifier.

Paul Catchpole, ABPI's director of value and access policy, said, "Something has got to change if the NHS is to meet the public's expectation on how the UK treats those with severe illness. The government should step in to allow NICE the flexibility to apply the severity modifier more ambitiously."

Cancer charities and patients' groups believe that HER2 low secondary breast cancer should not be classed as "medium severity." Claire Rowney, chief executive at Breast Cancer Now, said, "We are deeply disappointed that NICE has opted not to make changes to the severity modifier following its recent review and believe its introduction was pivotal to the recent devastating rejection of life extending HER2 low secondary breast cancer treatment, Enhertu."

The patient advocacy group METUPUK said, "We believe that the change in NICE methodology, downgrading metastatic breast cancer to moderately severe, has hindered the price negotiations." The group is calling for the threshold for the highest 1.7 severity to be changed from 95% to 90% discounted QALYs lost, which would capture more severe diseases, including HER2 low metastatic breast cancer. It is also calling for the severity modifier to be tapered, as having two discrete categories fails to fully capture the full spectrum of severity.

NICE's approach is already weighted towards new medicines and cannot be further diluted
Mark Sculpher

? Is there a downside to changing the severity modifier?

Any change would have cost implications and affect other areas of spending. Mark Sculpher, professor and director of the Centre for Health Economics at the University of York, told *The BMJ*, "NICE approves most new cancer drugs. Despite criticism, the benchmarks it uses to assess value for money are generous, considering the greater benefits that could be generated for other patients elsewhere in the NHS with the same money. These benchmarks are even more generous for diseases judged to be particularly severe.

"Despite the 'flexibilities' NICE has introduced, some manufacturers have expectations regarding the prices warranted for their drugs which NICE cannot justify. Patients are understandably resentful, but NICE's approach is already weighted towards new medicines and, given the challenges facing the NHS, cannot be further diluted."

Sculpher added that any adjustment to the severity weighting should clearly reflect the public's preferences—which would require research—and the implications of less funding being available for "non-severe" disease.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;387:q2620

METUPUK is calling for the threshold for the highest 1.7 severity to be changed from **95%** to **90%** of discounted QALYs lost, which would capture more severe diseases, including HER2 low metastatic breast cancer

COVID INQUIRY: NHS was not overwhelmed, Hancock says

Former health secretary Matt Hancock has defended his decision to allow the NHS to postpone routine treatment and care from April 2020, near the start of the pandemic, and insisted the health service was always available to all people according to need. However, in a session on the effects of the pandemic on UK healthcare systems, inquiry chair Heather Hallet pointed out, "It wasn't always available to those who needed cancer screening or who needed a major elective surgery like a hip operation."

Giving evidence on 21 November Hancock replied, "It was better to delay some non-urgent operations in order to protect both the space in the NHS and the patients themselves, as you are more likely to catch covid in a hospital than in almost any other setting."

Hancock insisted that the NHS was not overwhelmed during the pandemic. "Of course, every part of the NHS was under pressure, and some individual parts found that pressure overwhelming, but the system as a whole withstood the pressures, thanks to enormous efforts from literally millions of people."

Jacqueline Carey, lead counsel for the inquiry, said the fact that nurse ratios were stretched to one nurse to six patients in intensive care showed that the NHS was in fact overwhelmed. But Hancock said, "No, because people could get treatment. The treatment was not as good as normal. But that was not the measure."

"Within hours" of running out of PPE

Hospitals in England came within six or seven hours of running out of gowns and other personal protective equipment, in the early months of covid, Hancock told the inquiry. Asked whether England ever ran out of PPE, he replied, "As a whole, no, but individual locations did.

"We came extremely close. We came within small numbers of items on a regular basis during April and May 2020. By the second wave we were in better shape." He added, "Gowns I think at one point we got to within six or seven hours of running out."

Asked about reports that some nurses had to wear binbags early in the pandemic, Hancock said that the NHS needed to learn lessons and put in place better stockpiles in the future. On the question of whether face masks should be worn by hospital staff and visitors in a future pandemic, he said, "It should be brought in immediately and supplies need to be ready, preferably in each hospital, to make that possible."

Northern Ireland minister pressed on use of blanket DNACPRs

Giving evidence on 18 November, the former Northern Ireland health minister Robin Swann said he was not aware that blanket or inappropriate "Do not attempt cardiopulmonary resuscitation" orders were being imposed on patients during the pandemic. He said he knew patients' families were concerned about an increased number of DNACPRs being applied to patients being admitted to hospital. But he had made it clear in his witness statement that orders based on age or disability were "discriminatory" and "unethical" and said media reports that there was a blanket policy to apply DNACPRs were "ill founded."

Swann said such orders were medical assessments that should have been negotiated and discussed with regards to the individual and their family members as well.

Swann said no in-depth assessment was done of DNACPRs that had been imposed in Northern Ireland, and the inquiry heard that DNACPR forms weren't available on the Northern Ireland electronic care record.

Jacqui Wise, Matthew Limb, Gareth Iacobucci Cite this as: *BMJ* 2024;387:q2624

THE BIG PICTURE

Mexico urged to give migrants more healthcare

The charity Médecins Sans Frontières has called on the Mexican government to guarantee the safe passage of migrants making their way to the US and to provide more healthcare en route.

Migrants have been moving northward across the Americas in growing numbers this year in the hope of reaching the US before potential immigration restrictions resulting from a Donald Trump presidency.

Up to 1800 migrants now make up each caravan, instead of the usual 150 to 250, exceeding the capacity of medical aid groups to treat them. More than 925 000 “irregular” migrants were reported in Mexico between January and August this year, up 131% on the same period in 2023.

Most migrants travel with minimal funds and belongings and are undernourished, leaving them vulnerable to illness. Long walks in high temperatures and a lack of basic conditions for maintaining personal hygiene also increase health risks.

Organised crime networks have tightened their grip over their trails across Mexico, and doctors are seeing increasing numbers of cases of kidnapping, extortion, trafficking, and sexual violence, particularly along the southern border. “We witness every day the suffering and invisibility of people on the move and the impact on their physical and mental health,” said Daniel Bruce, head of MSF’s base in the southern city of Tapachula.

Luke Taylor, Bogotá

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A caravan leaves the southern Mexican city of Tapachula last week behind a banner declaring, "We want legal passage"

EDGAR CLEMENTE/AP/ALAMY; ISAAC GUZMAN/GETTY

EDITORIAL

Health policies under Trump

Distrust in science underpins the new administration

ALEX BRANDON/AP/ALAMY

Donald Trump with his nomianted health secretary Robert F Kennedy Jr

The second term of office of US president elect Donald Trump looks set to be characterised by loss of influence of scientific and medical expertise. Scepticism and hostility to expertise portend poorly for policies on vaccines, health insurance coverage, Medicaid, and female reproductive rights.

Trump's choices of staff for the new administration is a case in point. Robert F Kennedy Jr, nominated as health secretary,[1] has displayed ignorance of how science and medicine work, hostility to vaccination, a penchant for spreading misinformation, ignorance of how Medicare and Medicaid—the government's main health programmes— operate, and has no management experience or knowledge to lead a department with a $1.8tn (£1.4tn; €1.7tn) budget and 80 000 employees.[2,3] These deficiencies are clearest in his scheme to dismantle the nutrition and food sections of the already understaffed Food and Drug Administration.

Vaccine policy

Policy changes to undercut mandates for vaccines and reimbursement are likely to result in declines in vaccination rates.[4,5] Less noticed is the effect on vaccine research and development. The administration's aversion to vaccines will increase the risks surrounding FDA vaccine approvals and Centers for Disease Control and Prevention (CDC) recommendations for vaccination and payment. It could also result in less National Institutes of Health funding for research into infectious disease and vaccines[6] and appointing vaccine sceptics to the CDC's advisory committee on immunisation practices (ACIP). With threats posed by H5N1 influenza[7,8] and the potential health benefits of developing new vaccines outlined by the World Health Organization,[9] this could be damaging, not just for the US, but for the world.

The administration's aversion to vaccines will increase the risks surrounding FDA approvals

Access to care

Trump is unlikely to repeal the Affordable Care Act (ACA),[10] which extended health insurance access to 45 million Americans,[11] as the act has widespread support,[12,13] but changes are likely. First, substantial increases in ACA marketplace subsidies enacted during the covid pandemic will expire at the end of 2025 and are unlikely to be renewed,[14,15] potentially leaving four million people without coverage from 2026. Second, policies from the first Trump administration that decreased enrolment—such as shorter open enrolment periods[16] and fewer navigators to help people buy insurance[17,18]—might be reinstated.

The new administration is likely to make changes to Medicaid. These could include lower payments to states, work requirements to get coverage, and block grants—lump sums for health with state discretion about how it is spent. Block grants have previously been open to misuse and misallocation.[19]

Trump and his vice president elect, JD Vance, have offered mixed messages on whether they support a national abortion ban.[20] In the November election, 7 of 10 states where abortion was on the ballot passed laws supporting it.[21] Even without a ban, however, further restrictions on abortion are possible.[22] For example, the administration could place restrictions on sending abortion pills such as mifepristone through the post.

Global health

The "America First" attitude of this administration is likely to mean a reduction in global health assistance. In recent years Republicans have tried to reduce or end the President's Emergency Plan for AIDS Relief.[23] Trump is hostile to WHO, and this could endanger funding and support for the organisation.

The administration faces many other health and healthcare issues, from Medicare drug price negotiations to lax oversight over mergers and consolidation of insurers and hospital systems leading to healthcare inflation. Progress in health equity will slow. Difficult times lie ahead for the US, as it faces an administration that shows little regard for the expertise of physicians, nurses, public health experts, and researchers to address health and healthcare problems.

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EDITORIAL

League tables for the NHS

Measures of performance need to be meaningful

The secretary of state for health and social care, Wes Streeting, has announced NHS league tables to guarantee "no more rewards for failure" in UK healthcare.[1] Under the plan, the worst performing hospitals would have turnaround teams installed and managers sacked, while the best would have more freedom to invest capital.[2]

This package of measures mirrors the policy approach of the early 2000s. A wealth of evidence from that period suggests this is no easy fix.[3] Designing a ranking that is fair and accurate for organisations as huge and complicated as NHS trusts is difficult. Star ratings in the 2000s saw repeated cycles of a crisis of confidence before major revisions and improvements were made.[4]

Goodhart's law states that once a measure becomes a target, it stops being a good measure, as managers find ways to hit the target without making anything better.[5] Ambulance trusts under star ratings would delay starting the clock for waits and recategorise calls so that standards were lower.[6]

Position in a league table may seem important but can be meaningless. Confidence intervals for clinical indicators may be so large that the best ranked performers could actually be among the worst.[7] This difficulty in measuring actual patient outcomes often puts the focus on process measures and waiting times. This risks incentivising trusts to stop putting safety or improving health as their top priority.[6]

Controlling for the local population, staff availability, and other public services is also difficult. There is the question of what matters most: performance or direction of travel. Should a well performing trust on a downward trajectory get more praise than a poorly performing one that is improving?[8]

League tables and targets can also make managerial behaviour worse

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Limited effectiveness

League tables are designed to motivate trust leaders to prioritise what matters. But there are limits to what this can achieve. Leadership focus can make a difference. The system of star ratings was associated with rapid improvement in ambulance waiting times in England.[6]

However, management effort can bring only slow change to problems such as the quality of buildings, poor culture, or poorer quality staff. External factors such as the availability of social care, rurality, the quality of primary care, and the health status of the population have an impact.[9] This may be why, overall, research has found that changing the chief executives of NHS trusts is not associated with appreciable performance changes.[10]

League tables and targets can also make managerial behaviour worse.[11] This is particularly likely if they rely on inflicting reputational damage rather than offering support for improvement. Punitive approaches can also create toxicity and bullying and can lead to poor staff engagement, low morale, and recruitment problems. The 2022 Messenger review of NHS leadership and culture found that the volume of targets and demands was associated with "higher absence rates, deteriorating staff engagement and performance downturns" and "an organisational instinct to prioritise the needs of the system over a focus on better patient and public health outcomes."[12]

Streeting's carrots and sticks—sackings, turnaround teams, and greater freedoms for successful trusts—also have a mixed record. They rely on an accurate diagnosis of the reasons for failure, and league tables may not provide this.

Evaluation of "special measures" interventions for quality of care have shown some prolonged improvements. But this could come at the cost of staff morale. An approach focused on improvement is associated with better results.[13] Greater autonomy may be a welcome response to the hierarchical mindset Messenger warned about. But giving successful hospitals freedom to spend capital may deprive others of it, and the lack of capital may be a reason for their problems in the first place.

The "targets and terror" approach of the early 2000s was accompanied by a big improvement in waiting times, but times have changed, and the mixed evidence on league tables needs to be looked at closely. In the 2000s a huge influx of funding made it more reasonable to expect leaders to deliver impressive results. Not only does the NHS now have a budget that is growing less than half as fast, it already has multiple rating and assessment systems poring over its relative performance—oversight frameworks, Care Quality Commission ratings, and performance management from the health department and NHS England.

The secretary of state warned that "one person behind a desk in Whitehall cannot deliver the mammoth task ahead of us" and criticised the lack of autonomy in the NHS. This is correct, but a heavy handed approach to ranking trusts could undermine this and mean NHS executives spend even more time working out how to dodge blame.

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BMJ INVESTIGATION

How much does the fossil fuel industry fund medical research?

An analysis of links to the fossil fuel industry in medical research publications reveals a case for stronger action against the influence of these health harming companies, find **Hristio Boytchev** and colleagues

An investigation by *The BMJ* shows the extent of the fossil fuel industry's involvement in medical research, leading to fresh calls for academics and publishing companies to cut ties with such companies.

Over the past six years more than 180 medical articles have acknowledged funding by fossil fuel companies, and a further 1000 articles have authors who worked for a fossil fuel company or related organisation, found *The BMJ's* analysis.

Many studies don't have an obvious link with fossil fuel industry interests, but experts speaking to *The BMJ* say that publishing research benefits the companies by enhancing their reputation and buying influence among researchers and health practitioners. Some of the papers cover topics related to environmental health effects or that might relate to workforce health issues.

David McCoy, a research lead at the United Nations University International Institute for Global Health in Malaysia, says the issue is particularly charged for doctors and public health professionals because of the health effects of the climate emergency. Collaborations with academia give industry a "social licence to continue and behave in the way that they behave," he says.

"Fossil fuel industries are very politically active," he adds. "They lobby governments. They have a huge amount of power in shaping energy policy and industrial policy."

A previous investigation by *The BMJ* found that the fossil fuel industry has funnelled billions of dollars to academia in a decades long effort to weaken messages on climate. A recent review found that "universities are an established yet under-researched vehicle of climate obstruction by the fossil fuel industry."

Drilling deep

The BMJ asked fossil fuel companies and their associates to respond to criticism of the industry's involvement in medical research.

Its analysis found that Saudi Aramco, Saudi Arabia's national oil company, was involved in around 600 medical articles, mostly through Johns Hopkins Aramco Healthcare (JHAH), a joint project between the oil giant and Johns Hopkins Medicine. Many papers with JHAH involvement concerned infectious diseases such as covid-19 and mpox. Johns Hopkins University and Johns Hopkins Medicine did not respond to *The BMJ*'s request for a comment. Saudi Aramco declined to comment.

ExxonMobil was linked to the second largest group of articles. The ExxonMobil Foundation has funded the WorldWide Antimalarial Resistance Network, which supports malaria research. Until recently the company spent almost three decades drilling for oil in Equatorial Guinea, a country with a high risk of malaria.

ExxonMobil did not answer *The BMJ*'s invitation for a comment and instead deferred to the American Petroleum Institute, which didn't reply.

One researcher was responsible for a high number of papers linked to ExxonMobil: Edward Calabrese, professor emeritus of environmental health sciences at the University of Massachusetts Amherst, who acknowledged support from the ExxonMobil Foundation in more than 60 publications. Calabrese did not reply to *The BMJ*'s request for a comment.

Collaborations with academia give industry a social licence to continue and behave in the way that they behave
David McCoy

More than 1000 articles were coauthored by employees of fossil fuel companies. Often this was due to the involvement of hospitals or research institutes that are directly related to the companies, such as Kuwait Petroleum Corporation's Ahmadi Hospital.

Alongside the papers that included academic or medical institutions, *The BMJ* also found around 75 articles written by coauthors affiliated with fossil fuel companies that didn't have academic partners. These included Shell, ExxonMobil, and the Kuwait Petroleum Corporation (involved through Ahmadi Hospital). Employees of Shell and ExxonMobil coauthored a paper on the health effects of benzene with various industry employees.

"Shell has a strong record of supporting important academic research and our involvement is always made clear," a company spokesperson said. "When we publish our own research in journals, this is for transparency and also to allow the peer review process to ensure quality and robustness."

Overall, articles tied to the fossil fuel industry were cited by more than 18 000 other articles, and 29 had more than 100 citations.

Time to ban?

The BMJ's findings come as some experts demand that the fossil fuel industry be treated in a similar way to tobacco companies. Some academic journals and institutions have issued bans on collaboration with tobacco companies, because of their negative effect on public health and also their history of manipulating research. Although the situation is complicated by society's greater dependence on fossil fuels, the industry has a similar history of influencing science and sowing doubt about its effects on health.

In 2020 *The BMJ* made a commitment to ban advertising and research funded by companies that produce fossil fuels, a ban now being extended to other BMJ Group journals. "We are extending this policy to *BMJ Open* and *BMJ Medicine* and will begin a process of rolling out this policy to other BMJ Group journals," says *The BMJ*'s editor in chief, Kamran Abbasi.

The BMJ has also strengthened its advertising policy by banning advertising by banks that fund fossil fuel companies. "Medical journals have an important role in not only advocating for climate action but also taking action," adds Abbasi.

The investigation found six articles with fossil fuel industry association in BMJ journals published since 2019, of which four were published after the beginning of 2021. The papers were in the journals *BMJ Open*, *BMJ Open Quality*, and *BMJ Open Respiratory Research*.

Among the five leading medical journals as ranked by the Clarivate impact factor, only *The BMJ* has a policy banning publication of research with fossil fuel ties.

"The fossil fuel industry has a damaging role in climate change and the intersection with health," said a spokesperson for the Lancet Group. Its editors would "strongly scrutinise any fossil fuel industry funded research," the spokesperson said, and the "Lancet journals are very unlikely to publish such research unless it provided a clear benefit to public and human health." A spokesperson for *Nature Reviews Disease Primers* said that competing interests were made available to referees and that "there is a high degree of editorial oversight for reviews published in the journal." The *New England Journal of Medicine* and *JAMA* did not comment.

There exists a "systemic capture of academic institutions by the fossil fuel industry," said Paul Lachapelle, professor in the department of political science at Montana State University-Bozeman, who has studied such interaction.

"Fossil fuel companies and the tobacco industry are similar in both the vast scale of harm they cause to health and their tactics of deliberately distorting science," said Anna Gilmore, director of the Tobacco Control Research Group at the University of Bath. "Research journals and academic institutions must rethink their collaborations with the fossil fuel industry."

Similar calls have been made for medical organisations to divest from the fossil fuel industry. John Middleton, past president of the Faculty of Public Health, said that, in addition to divestment, organisations should consider restricting researching and publishing together with the industry. "I think that's got to happen," he said. "It does compromise the research as well as keeping us in the pay of an industry that we don't want to be in the pay of. We are profiting from climate disaster."

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There's a systemic capture of academic institutions by the fossil fuel industry
Paul Lachapelle

BMJ ANNUAL APPEAL

David Miliband on hospital attacks, Trump, and the International Rescue Committee in a "flammable world"

Former UK foreign secretary, now president of the International Rescue Committee, talks to **Kamran Abbasi** about hospital attacks in war, the US president elect, and how his parents were refugees

What is the International Rescue Committee?

It was founded at the behest of Albert Einstein, who was a refugee in New York in the 1930s. He wrote these pained letters to Eleanor Roosevelt, then first lady, saying that there was an unspeakable trauma that was going to hit Europe and that persecuted minorities—Jews, intellectuals—needed haven in the United States. But the US did not open its doors in the 1930s, so Einstein, along with 50 of his friends, created the Emergency Rescue Committee—which became the International Rescue Committee—to help get people out of Nazi occupied Europe.

Our first employee worked in Marseille in Nazi occupied France. He issued fake passports to over 2000 people. People like Marc Chagall, the painter, escaped from Nazi death camps thanks to the Emergency Rescue Committee. Our mission today is to help people whose lives are shattered by conflict, persecution, or disaster to survive, recover, and gain control of their futures. About 40% of our international work is in the health field, because it is a basic human need. And in emergency situations, it's especially compromised.

We help people who are trapped in war zones—Gaza, Sudan, Ukraine. People who are displaced owing to conflict—that might be internally displaced in Syria or in Ethiopia or in Latin America. We help people who cross borders, refugees, and asylum seekers.

We have programmes in Bangladesh, Jordan, and Lebanon but also in the US, Germany, and the UK to span what we call the "arc of crisis." We're trying to support people in extreme poverty from vulnerability and danger, with the cause being the conflict and disaster that is sadly growing in our flammable world.

What drew you to working with the IRC?

Both of my parents were refugees from conflict. My mum came to the UK as a 12 year old girl on her own in 1946. She'd lost her father in the Holocaust, and her mother put her on a boat to the UK. My dad was a refugee to the UK in 1940 when the Germans invaded Belgium. Both came from Jewish families. When the Germans invaded Belgium, my dad and his dad took the last boat out of Ostend and came to the UK. I felt that, in a small way, I could close a circle because I would be helping people who shared the same fear for their lives that my parents had.

I'd worked as foreign secretary, of course. But this was foreign policy from the other end of the telescope. It was not starting with the politics and then looking at the people. It was starting with the people and then looking at the politics—whether getting medical aid into war torn Syria or tackling sexual violence in the Democratic Republic of the Congo.

Our mission is to help people whose lives are shattered by conflict, persecution, or disaster to survive, recover, and gain control of their futures

An IRC worker helps an elderly woman into a mobile clinic in Kherson, Ukraine

TAMARA KIPTENKO/IRC

IRC is, unusually, big on research. Why?

People say that research in those conflict settings and with refugees is difficult to do, but to me that's just an excuse. People used to say that, because it's a matter of life and death, we can't do impact evaluation.

Our position is that, because it's a matter of life and death, you must do research. On malnutrition, on violence against women, on immunisation, on maternal health, we've really been proud to say that you can do randomised control trials and impact evaluations. You've got to be ethically careful—we're not going to deny people food as a way of testing what happens if people are hungry—but you can do serious work. My approach has always been to go to donors with proven programmes, because that's a more powerful way of generating action than just empathy.

We've just done a randomised control trial in a conflict ridden part of northern Nigeria. One side of a valley distributed cash to farmers before a flood hit—as determined by predictive analysis—the other side of the valley received it after. We'll see what the evidence base is for either approach and where the evidence

Biography

David Miliband is president and chief executive officer of the International Rescue Committee (IRC), where he oversees the agency's mission to help people affected by humanitarian crises to survive, recover, and rebuild their lives. The IRC now works in more than 40 countries affected by crisis and conflict and has refugee resettlement and assistance programmes in over 29 US cities, as well as in the UK and Europe.

From 2007 to 2010, Miliband was the 74th secretary of state for foreign and Commonwealth affairs of the United Kingdom, driving advancements in human rights and representing the UK throughout the world. In 2006, as secretary of state for the environment, he pioneered the world's first legally binding emissions reduction requirements. He was the member of parliament for South Shields from 2001 to 2013.

MORRISON OWIRO/IRC

base is lacking. Firstly, we want to be able to say to our donors that we're investing in programmes that either we know work or we're testing. And secondly, we've done the cost effectiveness and cost efficiency studies as well to make sure that we're using the money well.

A good example is malnutrition, which is linked to about half of all deaths among children under 5 years old. Efforts to combat it tend to divide between severe acute malnutrition and moderate acute malnutrition, which we think makes no sense because they're the same disease—anyone who's severely acutely malnourished will have previously been moderately acutely malnourished.

We tested out a combined and simplified protocol for the treatment of moderate and severe acute malnutrition together, instead of separately. The results showed that the combined protocol is equally effective in facilitating recovery in malnourished children, more cost effective, and easier to scale than the standard, more complex protocol. There were also important learnings about protocols for the way to work and delivery methods.

We're also working on immunisation in East African states supported by GAVI, the Vaccine Alliance. We're getting striking results about how to deliver healthcare in conflict zones, particularly in maternal health where there's massive problems of maternal mortality; the rate in South Sudan is 135 times that in the US. One of our programmes, focused on unintended pregnancies, reduces the death rate by 30%.

People feel that they are disempowered. Part of our job is to show that there are things you can do

How do you decide where and what to act on?

We're guided by our Emergency Watchlist, an annual study that identifies the 20 countries at greatest risk of humanitarian deterioration for the forthcoming year. It's not a straitjacket for us, but it's a good way of prioritising.

Top of our list for 2024 was Sudan. Why? Because there are 26 million people in humanitarian need in that country—12 million displaced by conflict both inside and outside the country; 3.5 million have fled to countries like South Sudan and Chad, which are incredibly poor countries.

Gaza has warranted a very significant effort. We work with Medical Aid for Palestinians, deploying 13 emergency medical teams that have been working in hospitals in Gaza. We also have water, sanitation, and hygiene services, nutrition teams, and child protection teams. It remains a very difficult, dangerous situation with huge humanitarian need among two million people there.

South Sudan, Burkina Faso, and Mali all have very significant conflicts. Myanmar is probably not on most people's radar these days, but there is a growing conflict there. There is conflict in Somalia, the Chad Basin—so northern Nigeria, Niger, Cameroon, Chad—and Ethiopia. And in the Democratic Republic of the Congo, where the east has been roiled by unspeakable conflict for about 40 years.

A lot of those countries are rarely discussed, if ever, in the media. How can we address that?

It's difficult. For one, there's more conflict and disaster. That has an aversive response in people because it seems overwhelming. So, the first question is how do you make the problems a bit more granular and manageable? That's why our watchlist is important. If you say, "300 million people in humanitarian need," people think it is like climbing Mount Everest. But if you say there are 20 countries in which more than 70% of the people in humanitarian need are located, you can begin to get a fix on that.

Second, there is a globalisation of lack of agency. People feel that they are disempowered. Part of our job is to show that there are things you can do. There is a difference that you can make. Third, it's easier to get information out than ever before in human history, but the algorithms of our now digital world reverberate the negative rather than the solutions. We're a solution focused non-governmental organisation, and we face an uphill struggle because negativity gets three times around the world before any positive response.

I haven't got easy answers to these. But our approach involves a focus on solutions, for a diversity of voices, and the use of trusted intermediaries like *The BMJ* to get our message out.

In all of the wars currently being waged attacks on hospitals and other healthcare sites continue—in the face of humanitarian laws and Geneva conventions. How do we fix that?

This is incredibly distressing and incredibly dangerous. We had two IRC health workers driving an ambulance in north west Syria in 2016, and they were hit by a Russian missile that targeted their ambulance and killed them. It really woke me up to this march of impunity in conflict zones.

Attacks on healthcare are increasingly a feature of the conflict zones that we work in, whether in Gaza or Sudan or Ethiopia or Ukraine. Civilian infrastructure is becoming part of the battle space in an incredibly dangerous way.

Our 2023 Emergency Watchlist was called *Time to Build Back the Guardrails*. The international laws and norms you mentioned—they were set up after the second world war. I think there is a march of impunity, and the obvious fear is that it coincides with a retreat of democracy. They're related but separate trends. Larry Diamond, the Stanford professor, talks about "democratic recession": wherever a country is or was on the spectrum between democracy and autocracy, it's moved in a less liberal direction—not in a traditional left-right political sense, but in a classical sense of respecting human rights.

This democratic recession is separate from but related to the axis between impunity and accountability. Democratic states set standards for themselves to live up to those guardrails. And democratic states are meant to have their own house in order. In some cases, they're retreating from that.

There is also a change in the global landscape where the power of the UN is being questioned in an instrumental way from all sorts of sides. That is very dangerous for the civilians whom we represent and the aid workers we are. Because it's not just health facilities that are getting targeted, it's aid workers and health workers in particular.

This march of democratic recession is incredibly dangerous. At the moment there is more impunity than there is sanction on impunity.

What are you expecting from Donald Trump's new presidency?

The first Trump administration reissued on its first day sweeping restrictions on funding and action around sexual and reproductive health in developing countries funded by the US government. We know that most of our clients are women and girls, that sexual and reproductive health services are fundamental to life. So, we're bracing ourselves for that change to be repeated. We're really fearful about our programmes supporting unintended teenage pregnancies and reducing maternal death rates.

We also know that President Trump in his first term severely reduced from about 90 000 to 12 000 the number of refugees being allowed into the country under the refugee resettlement programme. The commitments or comments so far suggest that that is also likely to be on the chopping block.

In the wake of those decisions, in 2017, we appealed to a wider donor base to support our programming. And we'll do that again. The success of *The BMJ* Christmas appeal will help to fund things like sexual and reproductive health in emergency settings.

What the money [raised by readers of *The BMJ*] will go into is our most impactful, most cost effective programmes. Those are programmes around malnutrition, immunisation, sexual and reproductive health, and economic empowerment. We're about helping people to survive and to thrive.

Kamran Abbasi, editor in chief, *The BMJ*

Mun-Keat Looi, international features editor, *The BMJ*

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