comment

"Resident doctors could be trained better and more efficiently" **SCARLETT McNALLY**
"The NHS cannot tackle societal issues such as obesity at a population level" **PARTHA KAR**
PLUS Healthcare services and tobacco during pregnancy

PRIMARY COLOUR Helen Salisbury

Austerity and efficiency in the NHS

If you eat less you get thinner and have to tighten your belt. Of course, this isn't always good for you—it depends on what your waist measurement was to begin with. A new round of belt tightening for the NHS has just been announced by the government, but as the UK lags behind its European neighbours in terms of per capita health spending, it arguably doesn't have much fat to trim.

The stated aim of the latest austerity measures in the NHS (euphemistically referred to as a "financial reset") is to "cut bureaucracy and invest even further in the frontline." These cuts are unlikely to make the NHS leaner and more efficient, and patients will inevitably be harmed.

Some trusts are being asked to cut their spending by as much as 12%. When estimates of spending on management are in the region of 2-3% of the overall NHS budget it's clear these cuts will come at the expense of patient care. Nor can we afford to reduce the amount of management in the NHS, as the service is already undermanaged. Doctors and nurses alone can't make the changes that would improve efficiency.

Clearly there's room for improvement. Many patients are well aware of—and frustrated by—the poor organisation and communication that results in multiple letters being sent about the same clinic, often arriving after the appointment date has passed. However, what drives such inefficiencies tends to be staff shortages and underinvestment.

Last week GPs in a neighbouring county to ours were spending 40 minutes on the phone just trying to get through to their local hospital to refer patients, and many had to resort to simply sending them to the emergency department. Do switchboard operators count as frontline staff? They're certainly essential to the smooth running of a service.

A more efficient NHS would provide a better service for the same cost. Many people have made suggestions about how we could achieve this, but most of these require initial investment in people and technology. Some of the changes needed to improve the interface between GPs and hospitals, such as hospital electronic prescribing and efficient systems for seeking advice, would be relatively easy to implement but are unlikely to happen if spending is frozen.

These belt tightening measures, along with the dismantling of NHS England and the 50% cut in integrated care board budgets, are being done in the name of efficiency. But we should learn lessons from across the Atlantic, where swingeing, ideologically driven cuts to spending are damaging all parts of the US public sector, with no obvious increase in value for money.

Just cutting a budget without a well thought-out plan doesn't magically improve efficiency, and it's very likely to disrupt the healthcare you were trying to deliver.

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A more efficient NHS would provide a better service for the same cost

DISSECTING HEALTH Scarlett McNally

Postgraduate training needs rebalancing

NHS England is making its last call for evidence for a review on postgraduate medical education. There have been dozens of similar reviews in my 35 years as a doctor, but this one has a chance to make a difference. It must galvanise action to deliver the medical workforce needed by our increasingly ageing and comorbid population.

Postgraduate training is competitive, tough, and principally arranged to fulfil an archaic model, expecting doctors to undertake work of low educational value and cover intense rotas. We don't need to train residents the way we have historically.

The Tooke review in 2008 described doctors as the "diagnosticians and handlers of uncertainty." Well trained doctors reduce waste, unnecessary hospital admissions, and unwarranted tests, reviews, and interventions. But unless we can get doctors through 5-10 years of postgraduate training, we lose decades of their potential as GPs, consultants, and SAS (specialist, associate specialist, and specialty) doctors.

The NHS has reconfigured many services, but most presentations do not need a 24/7 approach, and many hospital admissions are preventable. Experienced staff should make decisions about who may need an investigation or intervention—ideally delegating these decisions to rapid assessment clinics and general practice. Increasing the number of GPs would be the best and most cost effective way to improve health and would reduce the workload of resident and other doctors in secondary care. But we currently have many unemployed trained GPs, and many services are at risk of closing. Budgets for acute services are seven times that of primary care, so rebalancing funding could help.

We need to be honest that resident doctors are often delivering service and work that might be unnecessary. Most of their time is not spent saving lives, instead it is used on administrative work and dealing with inefficient computer systems. This inefficiency is contributing to them working overtime, with 60% regularly exceeding their rostered hours. Some of this administrative work could be delegated to doctors' assistants or scribes. There are support workers for seven other health professions, but none for doctors.

Resident doctors could be trained better and more efficiently

More posts are needed

In the 15 years since I was director of medical education for my trust, there's been a 25% increase in doctors qualifying from UK medical schools and a 78% rise in international medical graduates working in the UK, yet there hasn't been a commensurate increase in training posts. More posts are needed, with more funding to allow each placement to deliver focused education.

Once in training posts, resident doctors could be trained better and more efficiently. Reducing administrative work would free up time for more clinic interactions with patients and supervisors, team meetings, responsibility, interventional sessions, and self-development.

With increasing subspecialisation, doctors could

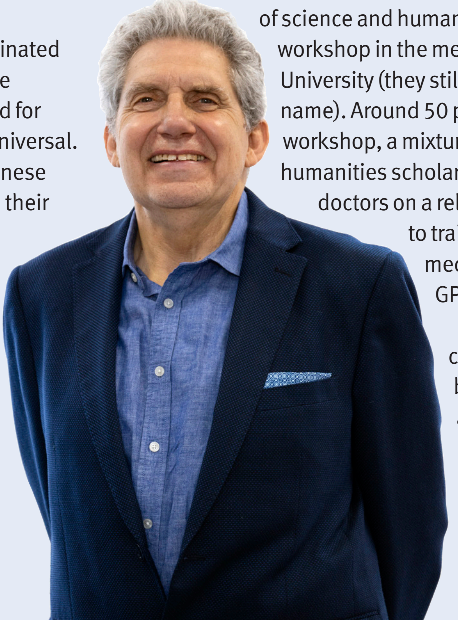
TALKING POINT John Launer

Encountering family medicine in China

A few months ago I visited China for the first time. I was there to teach narrative medicine—what health professionals can learn through listening to people's stories and how much difference this can make to medical care.

The field of study originated in the west, but of course storytelling and the need for attentive listening are universal. Not surprisingly, the Chinese are now reinventing it in their own image, integrating elements of traditional Chinese medicine, as well as western approaches to understanding why stories are so central to medicine.

The younger recruits were trailblazers for a more modern style of general practice



I gave a lecture at the Beijing Forum, an annual event covering the whole range of science and humanities. I also ran a workshop in the medical school at Peking University (they still use the historic name). Around 50 people came to the workshop, a mixture of clinicians and humanities scholars. A few were young doctors on a relatively new programme to train specialists in family medicine, the equivalent of GP registrars or residents.

As in many other countries, there has been reluctance to accept family medicine as equal to hospital specialties. Many primary care physicians may have relatively little training in the specialty, or they come from a background in other fields. The younger recruits at the workshop were trailblazers for a more modern style of general practice. They were, conspicuously, among the most enthusiastic participants.

China isn't the first country where I've noted the irony of other societies taking up a model of GP education and service provision based on the British example, while so many GPs here feel it's being devalued and replaced by less effective and more expensive alternatives.

I went to the conference with a small group of teachers of narrative medicine from the UK and Europe. From our encounters, we all came away with the impression that most people now report after visiting the country: although still lagging in some areas, China is ahead of the game in many, including technology. For example, everyone we met, including police officers in the street and do short secondments, or attend regular shared specialist clinics, for important topics. This could reduce the time spent on lengthy rotations in training posts learning the detail of complex interventions they will never deliver.

The *Shape of Training* review in 2014 wanted to make all doctors generalists. I argue that we will never teach generalism while the system is arranged with doctors being siloed in single specialty departments. At the Centre for Perioperative Care, we are designing modules to educate doctors at all stages to fill in the gaps across care pathways. Such education could help diversify careers and establish generalist skills for resident doctors.

We should ensure all doctors are valued, with high quality ongoing medical education. This includes SAS and locally employed doctors who currently have large unmet educational needs and unequal training opportunities. Having access to portfolio training is good, but it requires funding and support.

We need to value resident doctors with focused funding to get them through postgraduate training efficiently and ensure they are confident in their skills. We also need more GPs and support workers to help reduce their workload.

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market traders in villages, seemed to know how to use dictation and translation software on their phones to direct us to our destination or discuss a purchase.

China has a tradition going back millenniums of doing projects on a vast scale, including the Terracotta Army and Great Wall. After the conference, we visited two gigantic modern equivalents: Chongqing, a futuristic megalopolis with a population of 33 million, and the nearby Three Gorges Dam on the Yangtse River. The largest dam in the world, it supplies electricity to a population the size of the UK and required the relocation of 1.25 million people. The ecological and social questions raised by the project have given rise to much debate, but the feat seems a typical example of China's capacity to do things big and to do them fast. I wouldn't be surprised if highly developed family medicine now takes off more quickly there than we expect.

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THE BOTTOM LINE Partha Kar

Weight loss drugs have opened the door to a two tier health service

Obesity was once devalued in most areas of health policy but has recently taken centre stage. Unfortunately, this is not due to a recognition of the rising prevalence or a sudden appreciation of the problem. Instead, it follows the emergence of tirzepatide and other dual GIP and GLP-1 receptor agonists for weight loss.

After a data review NICE recently published guidance on tirzepatide, recommending it for certain population groups. This was followed by subsequent interim commissioning guidance from NHS England that provided a plan for implementation. NICE's recommendation has landed NHS England in a tight spot, because limited finances will hamper funding for the implementation plan.

The interim guidance will also leave primary care clinicians in the lurch. Because only a fraction of the population will be eligible for tirzepatide, it will fall on clinicians to explain this "rationing." Or, in some cases, the layered pathway to access the drug. Owing to funding variation, NHS England has asked for the rollout of tirzepatide in eligible groups to happen over 12 years. For the first three years patients will need to meet eligibility criteria that are based on number of comorbidities. A 12 year timeframe implies that NHS England is kicking a burgeoning issue into the long grass. But obesity is here right now.

There is a wider problem that policy makers seem to have ignored: if something is "popular" or strongly desired it is difficult to control centrally. People will still try to get the drug by self-funding and through private clinics. It will be a challenge to restrict access to drugs for a condition as common as obesity, especially with tirzepatide now being "everywhere," discussed widely in the media, and endorsed by many celebrities. It is a fallacy to believe access can be controlled through an implementation plan. It's likely GPs will prescribe it beyond the plan's tight remit—and in many cases this will be a fair choice from a clinical perspective. Money allocated for its implementation has not been ringfenced, so funding for something else will have to be stopped as demand for the drugs intensifies.

There is a bigger question: what is the point in asking NICE to review any evidence if there is no money for implementation or if politicians can't decide what to prioritise? The NHS cannot tackle societal issues such as obesity at a population level. At the government level, there is conflict between being a "nanny state" and taking a neoliberal approach that depends on the food industry and its sales for economic upturns. Without good health and a reduced prevalence of obesity, the economy and NHS will continue to struggle.

We are left with a medical option to treat obesity. Weight loss drugs challenge the idea we can tackle obesity by focusing on societal issues and behaviour alone. The drugs are an intervention that the public broadly wants and is in high demand. Attempts to control the rollout will be futile unless obesity is prioritised over other conditions. All this does is open the door to unregulated use and give access that is based on ability to buy.

It's not all doom and gloom, however. There seems finally to be recognition that obesity needs a coordinated, focused approach. The wide discussions can be considered a sign of progress but the guidance ducks the fundamental issue and is not backed up with the funds to deliver.

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Attempts to control the rollout are futile

The state of England's maternity services

With report after report castigating the care received by mothers and their babies in hospitals, *BMJ* commentators discuss what the NHS is still getting wrong, and one story of success

OPINION Alice Giucca

Postnatal wards should nurture new mothers, not heighten their vulnerability

As I watch my newborn daughter sleep in one of her three hour stretches of peaceful bliss, I do what I have been conditioned to do throughout my medical career: I reflect.

It baffles me that a high income country has let its healthcare slip into a state of such desolation

As is often the case, my daughter's arrival did not go to plan, spiralling terrifyingly quickly from a state of calm to intrapartum sepsis. I can't fault the care I received on the labour ward and intra-operatively, but the state of the postnatal ward and my experience there was scandalous.

Sadly, I am not alone. I have yet to speak to one mother who had a positive experience on the postnatal ward. I know the problems that have beleaguered NHS maternity services and how hard it can be to work in a struggling system, but it's important to voice the appalling conditions if we want to improve care.

Postnatal wards are meant to nurture and support new mothers at a time when they are highly vulnerable, but this is the opposite of what I saw in an environment that was understaffed, space restricted, and disorganised.

Most women arrive in postnatal wards after a long labour and are exhausted. They have not slept in 24-36 hours, are often recovering from surgery, and are in dire need of sleep and food. Even taking the baby out of the equation, recovery for a caesarean section alone is six weeks. Now add in a newborn to care for and the sudden increase in metabolic rate to prepare for breastfeeding and you will understand how fragile new mothers feel at this time.

In my case, there was no formal welcome to the ward. The baby was placed in a bassinet equipped with a key; no one explained to me if I should use this and prevent anyone from stealing her. I was haphazardly instructed to self-administer my own heparin injections, and paracetamol and ibuprofen were left on my table but no other painkillers were offered.

I was promised support at night, but by the time a member of staff came after I pressed the buzzer for someone to help me lift the baby, I had slowly managed to walk around the bed and soothe her. This took a full 10 minutes and was incredibly painful, but it was hard to otherwise ignore her cries.

With my limited mobility and not enough staff around to support me, it would have been incredibly helpful to have had my partner there to assist with nappy changes and feeds, but the little space around the cubicle removed any possibility of a partner staying at night. The lack of room also meant women were not able to move around their cubicle.

In the toilet facilities there were pots of sanguineous urine samples waiting to be measured post-catheter removal; this felt very unsanitary. The thin curtains around each cubicle also provided no acoustic privacy and limited my sleep. All these factors were detrimental to recovery.

Little training or experience

The medical staff I was able to speak to was limited to the most junior members of the team who had very little training or experience with babies, and consequently were not able to provide suitable advice—for example, when it came to explaining what the surgical recovery would entail (expected bleeding patterns, when to drive again, appropriate lifting weight).

They were unable to confidently explain why the baby's suboptimal positioning, which had led to my emergency caesarean section, was not picked up earlier, and had no senior member of the team to escalate these queries to. After they continually failed to return with a decision regarding discharge, I grew

frustrated about being stuck in the limbo of the postnatal ward and self-discharged, going home with inadequate analgesia.

I don't blame these doctors, who are often not obstetric trainees and don't get adequate support. I know all too well how they feel; a lack of senior support is endemic in the NHS. But equipping trainee doctors on postnatal wards with a simple proforma to aid them in what to ask women and a leaflet about postnatal care would be an effective start. It should be more of a cultural norm for the surgeon or care provider during the birth to come to ward rounds or simply to check in on their patient.

It baffles me that a high income country with a strong service industry has let its healthcare slip into a state of such desolation. It would take so little to improve the experience of patients in postnatal wards, from letting partners stay to providing simple training to junior team members, but the underfunded and understaffed system we have seems unable to manage even this.

The news that maternity services will be hit with harsh cuts makes it unlikely we'll see these improvements and bodes ill for women's postnatal care, leaving us with a system that continues to fail mothers and babies at a crucial stage of life.

Alice Giucca, resident doctor, patient author

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OPINION Caitlin Notley, Linda Bauld, Hazel Cheeseman, and John Waldron

Reducing smoking in pregnancy in England—a public health success story

In recent years rates of smoking in pregnancy in England have declined, from 11.7% of pregnant women in 2014/15, to 5.9% in the third quarter of 2024/25, according to the latest smoking at the time of delivery (SATOD) figures.

This is remarkable progress and suggests a target set in the 2017 Tobacco Control Plan for England—to reduce rates of smoking to less than 6% of pregnant people by 2022—has finally been met. The past few years have seen an acceleration in declines not mirrored in smoking rates in the general adult population.

What factors have contributed to this progress? We believe it is a combination of sustained multi-agency working and system change, including embedding a comprehensive approach to stopping smoking during pregnancy as part of the "Saving Babies Lives" care bundle and NHS Long Term Plan.

Multi-agency working began at pace in 2012 when the then Conservative public health minister, Anne Milton, posed a "challenge" to the health community to identify new ways to tackle smoking in pregnancy, which is a major cause of preventable morbidity and mortality for mothers and babies. This resulted in the formation of the Smoking in Pregnancy Challenge group (SPCG) convened by Action on Smoking and Health (ASH) and involving members from medical Royal Colleges, public health, primary, secondary, and community care and academia.

Since then, the SPCG has ensured a sustained focus on maternal smoking, developing materials for practitioners and patients, convening networks and meetings, promoting evidence-based training, and lobbying for investment to embed smoking cessation support in the maternity pathway. This sustained approach and the community of committed professionals it has built has undoubtedly helped to influence the rapid observed decline in rates of smoking during pregnancy.

Smoking cessation offers championed by the SPCG, and gradually implemented in the NHS, includes dedicated and targeted support from a trained adviser throughout the maternity care pathway. This is an opt out treatment approach, providing behavioural support and stop smoking medications.

This approach has been embedded through the "Saving Babies Lives" care bundle—a set of clinical recommendations for reducing perinatal mortality. Introduced in 2016, the bundle has driven a shift from largely voluntary, inconsistent uptake of best practice to a more systematic approach. Since 2019, it has been enhanced by dedicated funding for NHS tobacco dependence treatment services, enabling trusts to embed cessation support within maternity services.

This comprehensive offer has recently been further strengthened by a national financial incentives scheme built on clear evidence of effectiveness and cost effectiveness, alongside support during pregnancy to switch to vaping as a reduced harm option for smoking cessation. This follows emerging evidence of the effectiveness of vaping for smoking cessation in this population. Maternity services working in partnership with local authorities have been able to apply to the "swap to stop" scheme—the first worldwide to offer free vapes for switching away from tobacco smoking.

This combination of government investment, a systematic evidence-led approach, and innovative solutions to reach those who may struggle to quit means we now see the possibility of a smokefree future for generations of people entering pregnancy, and for their families.

We now see the possibility of a smokefree future for generations entering pregnancy

Despite this positive news, the battle against smoking as a leading cause of poor birth outcomes is not yet won. Continued investment is needed to sustain the current rate of progress and tackle longstanding inequalities in maternal smoking rates. Those from more deprived backgrounds are still much more likely to smoke during pregnancy than those from more affluent backgrounds.

Targeted action is needed to close this gap and engage with those who may not be well served by existing interventions, such as when they lack adequate access to maternity services, are marginalised, or living in poverty.

This must be a key focus of future policy efforts—alongside tackling high rates of relapse to smoking postnatally—to ensure every child has a smokefree start in life.

Caitlin Notley, professor of addiction sciences, Norwich Medical School, University of East Anglia

Linda Bauld, Bruce and John Usher professor of public health, University of Edinburgh

Hazel Cheeseman, chief executive

John Waldron, policy and public affairs manager, Action on Smoking and Health

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LETTERS Selected from rapid responses on bmj.com

Banners outside the Royal Courts of Justice in 2018 ahead of hearing for an independent public inquiry

CARE IN IMMIGRATION REMOVAL CENTRES

Remember the purpose of immigration detention

Howard's insightful feature on immigration detention highlights concerns about the impact on health of those detained and the demanding nature of this medical practice (Feature, 5-12 April). Importantly, immigration detention, unlike incarceration in prisons, is discretionary and imposed for the administrative interest of the Home Office, rather than part of criminal proceedings.

The Home Office has long agreed that people who are particularly vulnerable to harm in detention should not be detained except in exceptional circumstances. Rule 35 of the Home Office's Detention Centre Rules is an important safeguarding mechanism for identifying such people. It enables people with particular vulnerabilities to be assessed by a detention centre general practitioner, who writes a report to the Home Office, in accordance with the international standards set out in the Mandela Rules, so that release can be considered to prevent further harm.

The rule 35 process, however, has been found to be dysfunctional by expert non-governmental organisations and government inquiries, including the recent Brook House Inquiry. As a result, vulnerable people—including victims of torture and those with serious health needs—continue to be detained, in breach of Home Office policy and Office of the United Nations High Commissioner for Refugees guidelines. The critical purpose of these reports—to protect people in administrative detention from further harm to their health—must not be lost in ineffective processes. For victims of torture and persecution, these reports are also critical to identify their right to protection under international law, including non-refoulement and right to rehabilitation.

Alongside the cost to health is the financial cost, owing to compensation for wrongful detention, which in the financial year 2023-24 totalled around £12m, and the enormous expense of detention itself. With the government planning to expand the use of immigration detention, these costs are only likely to increase.

Lauren Z Waterman, consultant psychiatrist, London; Mishka Pillay, expert by experience, London; Juliet Cohen, independent forensic physician, Oxford

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TACKLING GAMBLING HARMS

Public health approach to gambling related harms

Francis and colleagues summarise NICE clinical guideline on gambling related harms—a complex piece of guidance in a difficult and emerging space (Guidelines, 22-29 March). In a linked editorial, Cowlishaw and colleagues make the obvious point that the NICE guideline is not a public health guideline, and both online and land based gambling products and the nature and practices of the gambling industry escape scrutiny from a population health perspective.

The Faculty of Public Health, the Association of Directors of Public Health, and the Royal Society of Public Health have published recommendations to the government for change. The association has argued that the previous government's white paper didn't go far enough and that we need a new gambling act. Public health experts have said that the statutory levy is not a substitute for reform and regulation of policy and products.

We encourage the government to introduce policy interventions to reduce the harm from gambling.

Greg Fell, president, Association of Directors of Public Health; Kevin Fenton, president, Faculty of Public Health; William Roberts, chief executive, Royal Society for Public Health, London

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SHORTCOMINGS OF COVID-19 VACCINATION

Better communication about vaccines

Vanderslott discusses shortcomings of covid-19 vaccination that need to be tackled in preparation for future pandemics (Opinion, online 28 March). My colleagues and I analysed a large dataset of tweets and found that some people perceive covid-19 vaccines to have lower effectiveness against infection than other vaccines and that this sometimes leads people to question their status as "vaccines."

Some people highlight that you can still catch and spread covid-19 when you are vaccinated—in contrast to the situation with polio or MMR. The term "shot" is sometimes used to imply an inferior and less worthwhile intervention than a vaccine.

In preparation for future pandemics, we must communicate that some diseases, like covid-19 and flu, are vaccine modifiable, whereas others, like measles and polio, are vaccine preventable. Care needs to be taken with informal terms like shot and jab, in case they are perceived as referring to something different from vaccine.

Elena Semino, distinguished professor, Lancaster

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CLINICAL PREDICTION MODELS

Confusion between risk and disease

Riley and colleagues discuss the importance of presenting the uncertainty around risk estimates provided by clinical prediction models (Research Methods and Reporting, online 13 February).

A deeper reason for overlooking uncertainty in prediction models stems from the confusion between risk and disease—the result of increased biological, clinical, and epidemiological knowledge on the risk of chronic diseases and of the application of a population perspective to individual clinical care.

Risk predictions are intended to guide preventive services and treatments at a group level; it is tempting but deceptive to apply them bluntly to individual patient decisions to simplify the inherently complex nature of clinical judgment.

We agree that improving the communication of uncertainty in risk prediction is essential. But this should be accompanied by acknowledgment of the complexity of clinical decision making, emphasising that, regardless of the level of certainty of risk prediction, randomness always plays a part at the individual level.

Arnaud Chiolero, epidemiologist, Fribourg

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HEALTHCARE AFTER A NUCLEAR STRIKE

Are we making ourselves safer or sicker?

Jeng and colleagues argue that health professionals should prepare to respond to a nuclear emergency (Editorial, online 24 February). The UK government recently announced plans to increase defence spending to 2.5% of gross domestic product from April 2027, with an ambition to reach 3% in the next parliament.

The shift in spending priorities leads to underfunded hospitals, worsening staff shortages, and declining public health infrastructure. Rather than strengthening emergency preparedness for real and immediate threats—such as antimicrobial resistance, chronic disease, and the next pandemic—governments are debating how to manage mass casualties from an event that may never happen. The health consequences of a nuclear strike should not distract from the fact that underfunding the NHS is causing avoidable deaths on a daily basis.

If the logic of nuclear preparedness leads to further NHS underfunding, are we making ourselves safer, or just sicker?

Peter R McGhee, locum SHO, Maidstone and Tunbridge Wells NHS Trust

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Regional collaboration will be needed

Jeng and colleagues examine the current landscape of nuclear threats, exploring the shortcomings of healthcare systems in preparing for nuclear strikes and the immense challenges of mass casualty events.

Beyond stockpiling emergency supplies and training medical personnel, I think that collaboration between neighbouring cities is vital, potentially the linchpin of effective nuclear crisis management. A tactical nuclear strike could devastate local medical facilities and transport networks, leading to medical staff themselves needing to be rescued. Neighbouring cities must swiftly mobilise resources and personnel, using helicopters or planes to deliver aid to affected areas and establishing temporary emergency hospitals with nuclear contamination filtration within 24 to 48 hours in safer, low radiation zones. Such regional collaboration maximises lifesaving potential and secures critical time for recovery.

Conscientious nations should unequivocally pledge never to use nuclear weapons first and commit without exception to sparing non-nuclear states and nuclear-free zones from such threats.

Yong Wu, associate professor, Shenzhen

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Educating the public in emergency healthcare

Jeng and colleagues' article on healthcare after nuclear strikes reminds the government and the medical community to make relevant preparations for potential tactical nuclear weapon attacks.

In the event of a nuclear explosion in or near an urban centre, the role of the medical community is severely constrained. Over the initial 72 hour period, the systemic destruction of infrastructure would cause catastrophic failure of the healthcare system, and even with effective triage strategies, the proportion of people who can be promptly transported to medical facilities and survive through timely medical intervention is minimal. The tasks of bandaging, haemostasis, fixation, and transportation of injured people cannot be undertaken by experienced medical staff. Consequently, the medical community should prioritise allocating more resources and efforts towards educating the public in emergency sheltering and evacuation techniques, equipping them with fundamental trauma first aid skills, and conducting appropriate emergency preparedness drills.

Zhiwei Xie, attending doctor; Jizhou Shi, attending doctor, Dongying

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REINVENTING ROLE PLAY

Harnessing our inner thoughts

Launer's reflection on role playing exposes prevailing clinical practice, where adherence to protocol may restrict our ability to engage with patients (John Launer, 22 February –1 March). As trainers, he writes, "we are probably not clear enough about how to make use of the ideas that pass through our heads from moment to moment."

Real life clinical predicaments provide us with data-free associations competing with anxious obligations to follow the script. Launer's inner commentary is relatively cheerful. But we can also harbour suspicions, such as wondering whether the patient is concealing something out of fear or shame. If we ignore such passing thoughts, valuable clues might be lost. Respecting patient experience includes respecting your own, which is a skill that must be learnt rather than taught.

Reflective practice in professional groups encourages participants to speak to their imaginings, however inarticulate or absurd, each bringing a different perspective to construct a richer whole.

Sebastian Kraemer, honorary consultant child and adolescent psychiatrist, London

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Patient passports could improve patient care

Launer's role playing exercise raises issues relevant to people with rare conditions, who become experts through experience and learning. They have an expectation that healthcare providers will appreciate their knowledge. The GP's inner dialogue described by Launer might indicate anxiety at lack of knowledge, training that encourages the channelling of diagnostic thinking along familiar paths, and time pressures.

"Patient passports" contain the key information that a person wants others to know about their health. They offer scope for the person's priorities to be recorded. Patient passports being created by specialist services and support groups have the potential to improve clinical care. This potential can only be fulfilled if they are used effectively and to help shared decision making and if patients feel heard and respected. Role play can be a powerful tool for learning about unconscious internal dialogue, and it can also introduce new ways to benefit from patient power.

Una MacFadyen, retired paediatrician, Stirling

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ANALYSIS

UK decision not to suppress covid raises questions about scientific advice

Five years on from the first UK-wide lockdown for covid-19, **Anthony Costello** asks why long term strategies of suppression continue to be under-recognised

Early in the covid pandemic, evidence emerged from several East Asian countries that suppression could lead to successful control. Yet the UK did not adopt the approach. Suppression aims to avoid national lockdowns and maintain economic activity for most of the population by introducing surveillance systems to bring new outbreaks under control quickly, thus reducing the reproductive rate of infection (R_0) to below 1 and causing the epidemic to wither. In May 2020, Jeremy Hunt, then chair of the health and social care select committee, criticised UK government advisers for failing to recommend a response focused on suppression of the SARS-CoV-2 virus from early in the pandemic, calling it "One of the biggest failures of scientific advice to ministers in our lifetimes."[1] Why was suppression not recommended, and what can be done to improve advice in future?

The UK and Sweden were largely alone in choosing a plan based on influenza

Early signals

By 24 January 2020 the global threat from covid-19 was clear, with residents in China dying in the streets and three *Lancet* papers reporting high case fatality rates, human-to-human transmission, and more than 500 cases in China, Japan, South Korea, Thailand, Singapore, and the United States.[2-4] East Asian countries had rapidly scaled up case finding, testing, and contact tracing in hotspot areas where cases were rapidly increasing, and introduced financial support for cases and contacts to isolate.

KEY MESSAGES

- The UK did not adopt strategies to suppress covid-19
- Government advisers based their response on influenza plans rather than looking at early evidence
- At the start of the pandemic the advisory committee lacked independent public health expertise
- Immediate mobilisation of resources for case finding, testing, and self-isolation would have saved many lives
- Guidelines are needed to ensure the committee has scientific, ethnic, and gender balance, together with detailed pandemic plans

On 28 January, the UK government's Scientific Advisory Group for Emergencies (SAGE) unanimously recommended a pandemic response based on influenza. The UK's 2011 pandemic preparedness plan, for influenza not coronaviruses, may have influenced SAGE's decision. This states, "It will not be possible to halt the spread of a new pandemic influenza virus, and it would be a waste of public health resources and capacity to attempt to do so."[5]

However, around this time the World Health Organization (WHO) was advising countries to focus on rapid suppression to avoid immediate threat from the spread of the new coronavirus SARS-CoV-2, even though a second wave was possible. Mike Ryan, head of emergencies, on 29 January, said that countries with cases "have to stop transmission … our previous experience is that with adequate public health intervention and measures both at community and hospital level [coronaviruses] can be stopped."[6]

Greece, Germany, Norway, and Ireland took steps to follow these recommendations but, along with the UK, the US, and many other European countries failed to mount a response focused on suppression. The UK and Sweden were largely alone in choosing a plan based on influenza.

On 22 February the report of the WHO-China Joint Mission on Coronavirus Disease 2019 was presented to UK chief medical officers. It showed that suppression measures were reducing cases, hospital admissions, and deaths throughout China's 22 provinces.[7] SAGE minutes do not mention this report.

On 3 March, SAGE minutes report rapidly falling cases and R_0 values in several East Asian countries that had focused on suppression, yet SAGE recommended no change in plan for the UK.[8] On 9 March, Steven Riley, SAGE participant and modeller, reported exponential expansion of the UK epidemic to SAGE.[9] His results showed that "critical care facilities … would be saturated quickly [and] support current advice from WHO, and are consistent with policy decisions by China, Hong Kong, Singapore, Japan, South Korea and most recently Italy [of suppression strategies]." On the same day, a preprint reported that R_0 for the Guangdong province and mainland China had fallen below 1 during February.[10] On 6 March commentators reported a similar fall in R_0 for South Korea.[11]

But SAGE did not change its advice. On 3 March the government published its "contain, delay, research, mitigate" plan based on influenza that would allow the virus to spread to achieve "herd immunity."[8] On 12 March it moved from the "contain" phase, which relied on limited Public Health England resources (under 300 contact tracers) for test and trace to eliminate the disease "for as long as is reasonably possible," to the "delay" phase of its plan and stopped community testing.

OWEN HUMPHREYS/PA/ ALAMY

Inquiry continues to sideline suppression

The ongoing UK Covid-19 Inquiry has focused in public hearings on lockdowns, modelling, "managing" spread of the virus, "herd immunity," shielding of vulnerable groups, and social distancing. However, it has spent less time discussing the suppression strategies to reduce R_0 below 1 that might have proved effective in low prevalence periods, most importantly in February and March 2020 before the first lockdown, and afterwards in July 2020. The next inquiry report will hopefully cover this critical issue.

SAGE's unwavering decision to recommend a response based on influenza has continued to be defended by its co-chairs, Chris Whitty, England's chief medical officer, and Patrick Vallance, chief scientific adviser until 2023. Their defence, including at the inquiry, is based on three arguably mistaken assumptions: that covid could not have been suppressed, that a huge second wave could follow even if it was, and that suppression required prolonged national lockdowns.

Vallance, in evidence to the inquiry wrote, "a 'zero Covid' strategy could have been pursued (but) required a national lockdown and border closures by the end of February, to be continued indefinitely."[12] Whitty, England's chief medical officer, told the inquiry, "If it's spread out of China it cannot be stopped . . . No-one with an ounce of common sense would suppress."[13] But the term "zero covid" may be understood to mean eradication (zero global incidence) or elimination (zero local incidence), and suppression does not aim to eradicate the virus but to bring R_0 below 1.

Different advice

All pandemics are different, but SARS CoV-2 had an R_0 value more similar to the coronavirus SARS-CoV-1 than to influenza. Influenza spreads too fast to be controlled by testing and contact tracing, but coronaviruses have longer incubation periods and potentially can be suppressed, as evidence from early in the pandemic showed.[14,15] Several East Asian states avoided prolonged national lockdowns with responses focused on suppression initiated early in the pandemic. Here is the advice SAGE should have given the government.

Coronavirus science

Experts had dealt with two previous coronavirus epidemics: severe acute respiratory syndrome (SARS) in 2002-04 and Middle East respiratory syndrome (MERS), first reported in 2012. Two papers after the SARS outbreak showed that coronavirus infections, with slower transmission rates and longer incubation periods than influenza, could be suppressed.

One paper, coauthored by SAGE participant Neil Ferguson, showed that isolation and contact tracing could bring about control even if asymptomatic transmission was as high as 40% of all transmission.[14] At the start of the epidemic in Wuhan R_0 for SARS-CoV-2 was estimated to be close to 3, similar to that seen in the SARS outbreak, indicating that similar suppression measures might have worked. The other paper, on which SAGE participants Peter Horby and Jonathan van Tam were coauthors, concluded that coronavirus epidemics require a different approach (using isolation and quarantine measures) to control than pandemic influenza.[15]

East Asian success in suppression

China, Japan, South Korea, and several other East Asian states suppressed coronavirus epidemics within two months by quickly implementing conventional infection control measures when prevalence was still low. Certainly, policies differed among East Asian states, and mistakes were made. Japan was slow to roll out testing. Hong Kong initially banned mask wearing. And China suppressed pandemic reporting until 20 January, when cases and deaths in Wuhan exploded.

The WHO-China report describes provincial governments implementing "aggressive case and contact identification, isolation and management and extreme social distancing, to interrupt the chains of transmission." It reported 2478 new cases in early February, and 409 two weeks later, arguing, "This decline . . . is real . . . . Several sources of data support this conclusion, including the steep decline in fever clinic visits, the opening up of treatment beds as cured patients are discharged, and the challenges to recruiting new patients for clinical trials."[7]

Test infrastructure

Whitty and Vallance both said repeatedly that the UK didn't have sufficient test infrastructure compared with countries pursuing suppression strategies. That opinion was not shared by many public health experts or WHO.[16] UK advisers didn't recommend developing public-private testing links until the health secretary launched his 100 000 tests a day target on 2 April. They could have recommended immediate mobilisation of 44 NHS molecular virology laboratories, the Crick Institute, and the British biopharmaceutical sector to produce tests at scale.

At low prevalence the number of tests required to help suppress an epidemic may be relatively low: South Korea (population 52 million) needed a peak of 18 000 tests a day to control its two hotspots (fig 1). Similar measures could have been taken in England's two hotspots, London and the West Midlands.

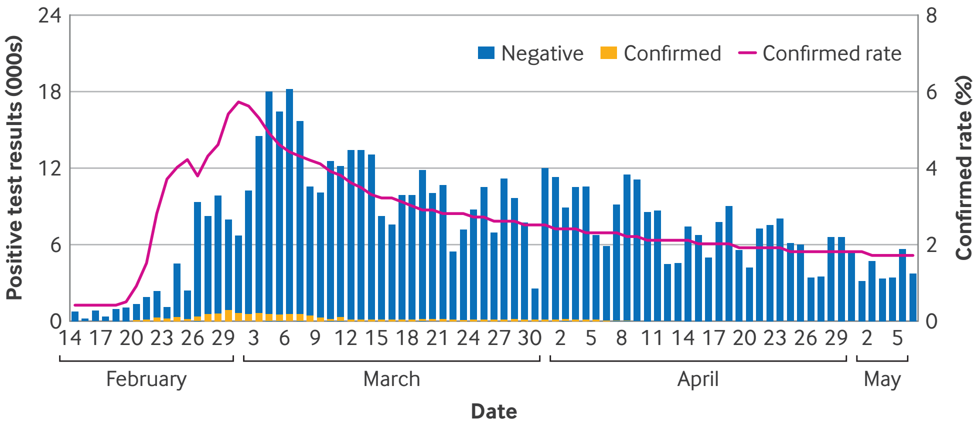

Fig 1 | South Korea test status February to May 2020 (https://dc-covid.site.ined.fr/en/data/korea). Total tested=643 095; tests completed (negative+confirmed accurate)=635 086; confirmed rate (total confirmed/total tests completed)=1.7%

China, Japan, and South Korea had no pre-existing test infrastructure, but all three had established public-private partnerships after the experience of SARS and MERS. Without a reliable test, they focused on finding and isolating anyone with symptoms. Within 14 days of creating a test (on the same day as the UK in mid-January) South Korea had mobilised experts and biotech companies to scale up test production. A test, trace, and isolate system, with smartphone apps to provide case support and monitor case movements, was scaled up within weeks.

Community health workers

China, Japan, and South Korea quickly mobilised thousands of junior doctors and community health workers to hotspots.[7] In the UK, 750 000 people, many with health skills, responded to a call for volunteers.[17] Most were never used in any capacity and none to support case finding. The government could have redeployed environmental health officers, sexual health contact tracers, or medical students to case finding and contact tracing but did not do so.

Support for self-isolation

China, Japan, and South Korea provided generous financial support to encourage infected people to isolate for 14 days and reduce fear about difficulties in paying for rent, food, or drug bills.[18] In the UK sick pay was under £96 a week unless you earned less than £120 a week, in which case you received nothing[19]: this was the third lowest rate among Organisation for Economic Co-operation and Development countries, at 34% of average earnings, compared with 57% in South Korea and 55% in Japan.[20] Compliance with self-isolation in England was poor: in initial waves, just one in five people with symptoms sought a covid test and only 43% stayed at home for 14 days.[21] Government advisers should have drawn attention to this critical policy failure publicly.

With a poorly controlled pandemic, 1.9 million UK people had long covid symptoms in 2023

Poor control leads to poor outcomes

Over the next three years, death rates in China, Japan, and South Korea were five times lower than in the UK (fig 2). Demographics seem insufficient to explain these huge differences: Japan and South Korea had similar gross domestic products (GDP), life expectancy, and age profiles to the UK. Had the UK followed the same strategy and achieved the same excess cumulative death rate by March 2024 as South Korea, 69 instead of 344 deaths per 100 000, it might have prevented up to 180 000 UK deaths.

With a poorly controlled pandemic, 1.9 million UK people had long covid symptoms in 2023.[22] Over 800 000 people had left the workforce because of long term sickness since the start of the pandemic.[23] Evidence on suppression's impact on long covid and long term sickness in China, Japan, and South Korea is mixed.[24 25]

Avoiding prolonged lockdowns, East Asian economies overall grew during 2020. By contrast, in 2020, the UK saw the largest fall in its GDP (9.8%) since 1709. UK spending on covid-19 measures is estimated at £310bn-£410bn,[26] with a further £450bn for quantitative easing to support the economy. International Monetary Fund estimates suggest covid control measures in 2020 cost China $440 per head, South Korea $787, and the UK $5700-$6029.[27]

Flawed advice and systems failure

SAGE faced a difficult and fast changing situation in January and February 2020. However, its advice to government was flawed: its early and enduring recommendation of a response based on pandemic flu ignored the different characteristics of coronavirus transmission; accepted the inevitability of a huge epidemic of a new dangerous virus in the UK, with threats to overwhelm the NHS; and led to modelling of national strategies that excluded WHO's recommendation of suppression. SAGE did not recommend rapid expansion of testing, form plans to mobilise community health workers as contact tracers at scale to hotspot areas and across district health protection teams, or advise on key financial and support measures for effective self-isolation.

SAGE's flawed scientific advice arose from systems failure. The *Guardian* newspaper in April 2020 identified 23 initially confidential SAGE participants, 13 (57%) of whom were paid government employees and so lacked independence.[28] Although the government stated that SAGE drew on "expertise from across the scientific spectrum including … public health and virology,"[29] at the start of the pandemic it lacked participants with coronavirus, independent public health, infection control, and community mobilisation expertise. Such participants might have advocated following contemporaneous advice calling for suppression responses from WHO and the experts who had dealt with previous coronavirus outbreaks.

SAGE's remit is limited to advice on scientific matters. The independent participants were asked not to discuss or recommend policy options. But scientific discussions around a pandemic clearly have policy implications that SAGE should have discussed so that medical and science advisers were able to articulate them to government. In addition, only seven (30%) SAGE participants were women, there was no ethnic minority representation, and the senior medics and modellers were all based in the south of England.

China, Japan, and South Korea had long established standing pandemic committees, detailed pandemic plans, and standard manuals of operations.[30-32] The UK needs similar preparedness. Given the continuing severe national threat of a pandemic, SAGE should have a standing membership to monitor plans and to evaluate rehearsals and guidelines for pandemic action.

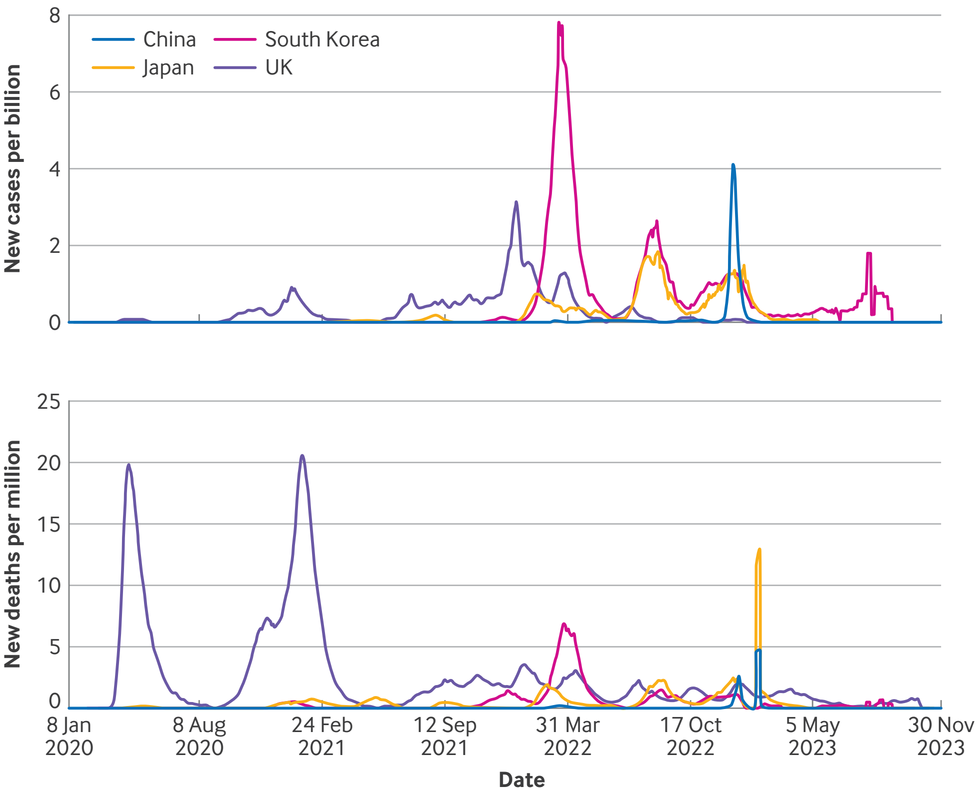

Fig 2 | Covid-19 cases and deaths per million people (7 day rolling average), Jan 2020-Nov 2023 (https://ourworldindata.org)

SAGE needs formal guidelines about which disciplines are represented, with selection of independent scientists based on merit and with ethnic, gender, and four nation balance. SAGE experts independent of government should predominate and declare detailed conflicts of interest. A public inquiry is not needed to make these changes.

SAGE's flawed scientific advice arose from systems failure

The UK was once rated the second best country (after the US) in the world for pandemic preparedness.[33] Covid-19 caused over 230 000 civilian deaths, three times the number during the Blitz.[34] The root failure of the UK response to covid was a strategy devised in January and February 2020. Yet the four chief medical officers in their 2023 technical report for future advisers maintain that their recommendation to "contain, delay, research, and mitigate" was broadly correct, and the report does not recognise suppression successes that led to much better survival rates and lower economic damage in other states.[35]

Chief medical and science advisers are appointed as independent advisers, not as career civil servants, and are free to speak publicly. They could have spoken out about health harming policies—for example, on the inadequate support for people to isolate—as previous chief advisers have when they believed policies would be harmful. *The BMJ* asked Chris Whitty and Patrick Vallance why they had not recommended a suppression response, given WHO advice and emerging evidence early in the pandemic; about SAGE's lack of independent experts; why they were not more outspoken about health harming policies; and whether they stand by the recommendations they made not to focus on suppression, but had not received a response by the time of publication.

Five years on, many of the people who developed the UK's flawed response are still in post; they have not changed their views on suppression, and little has been done to improve government pandemic advice committees or to introduce detailed governance rules for the UK's future pandemic response and resilience. The covid inquiry and the UK medical establishment should properly critique this public health failure.

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OPINION Anna Hood

Racism in pain management causes needless suffering

We need to challenge racialised bias and myths to eliminate inequities in pain management

In healthcare systems such as the NHS, founded on the principles of equity and universality, we would expect all patients to receive equal care. The reality can be starkly different. The experiences of patients from minoritised ethnic groups show that systemic racism remains deeply embedded in medical practice.

This racism goes beyond individual prejudice; it is often built into the foundations of medical education and practice. This is especially apparent in pain management, where discrimination, false beliefs, and inequities combine to perpetuate patient suffering.

For decades, studies have shown that Black and Asian patients are less likely to receive adequate pain relief than white patients with the same condition. The reasons for these inequities are manifold: entrenched racial biases, misconceptions about biological differences between ethnicities, and systems that often silence the voices of patients from minoritised ethnic groups. This inequity is not just a moral failing; it leads to unnecessary suffering, worsens health outcomes, and erodes trust in our medical institutions.

Pseudoscientific myths

One of the most damaging aspects of inequities in pain treatment is the persistence of pseudoscientific myths about biological differences between racialised groups. Research from the US and UK has found that medical professionals still commonly think that Black patients have thicker skin or less sensitive nerve endings than white patients—an absurd yet enduring notion.

These beliefs contribute to the under-treatment of pain in Black patients, particularly in emergency settings. In the US, for example, Black children in emergency departments are less likely to receive opioid pain relief than white children with comparable injuries. A recent study in the UK found that Black and Asian women were significantly less likely to receive neuraxial anaesthesia (such as epidural pain relief) during childbirth than white women.

Patients from minoritised ethnic groups often report their pain is dismissed or downplayed by medical professionals. The implicit assumption seems to be that Black and Asian patients can "endure more," a harmful and unfounded notion.

Women of colour face the double burden of race and gender biases, leading to poorer pain management. Many recount experiences of being invalidated or told their pain is exaggerated or psychosomatic. Thus, when a South East Asian woman downplays her pain owing to cultural stoicism or when a Black girl is perceived as "aggressive" rather than in distress, the result is under-treatment and patient harm.

For those with chronic pain conditions such as sickle cell disease—disproportionately affecting Black populations—the consequences of bias can be dire. Patients with sickle cell disease frequently report being treated with suspicion when requesting pain relief. Given the disease's hallmark episodes of severe pain, prompt opioid administration is essential. Yet, many patients are subjected to accusations of drug seeking behaviour, leading to delays in care or prolonged pain.

These experiences are not isolated incidents and reflect a wider culture of disbelief towards patients from minoritised ethnic groups, exacerbated by institutional failures that include inadequate staff training about sickle cell disease and bias.

The absence of ethnic diversity in medical research compounds this problem. Clinical trials on pain medications have historically under-represented minoritised ethnic groups, meaning that treatment guidelines are often based on data that do not factor in their specific needs. Without diverse data, we will fail to develop equitable treatments.

The absence of ethnic diversity in medical research compounds the problem

Despite the overwhelming evidence of ethnic inequities in healthcare, efforts to tackle them through diversity, equity, and inclusion (DEI) initiatives have been met with increasing resistance. The Trump administration in the US, for example, has scrapped DEI initiatives and programmes, arguing they promote division, lower standards, or amount to "reverse racism." This reframing is dangerous and untrue. Portraying equity as preferential treatment rather than a means to correct longstanding injustices stalls progress.

Structural discrimination

Such narratives distract from real life problems: the ongoing structural discrimination that negatively affects patients' pain outcomes. The medical field, which prides itself on evidence based practice, must resist these regressive narratives. Tackling ethnic inequities in pain management is not about political correctness—it is about clinical accuracy and ethical responsibility. Equity is not a threat to excellence; it is a prerequisite for it.

Pain is universal, but suffering should not be. We must confront the uncomfortable truth that racism—both overt and insidious—continues to shape who suffers needlessly. The evidence is not just anecdotal—it is a systemic problem embedded in medicine, fuelled by historical biases, myths about race, and inequitable healthcare structures.

It is time to listen and, more importantly, act to eliminate inequities in pain treatment and care. Equity in pain management is not just a matter of fairness—it is a fundamental human right.

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EDITORIAL

Height as an indicator of child health

Narrowing inequalities in child height may reflect widening inequalities in obesity

Data from England's national child measurement programme (NCMP) show an unprecedented jump in mean height during school year 2020-21 compared with 2019-20.[1] In 5 year olds mean height increased by 0.5 cm in boys and 0.4 cm in girls, compared with the 0.2 cm rise seen over the previous 10 years from 2009 to 2019. The increase among 11 year olds was even greater, with rises of 1.4 cm in boys and 0.8 cm in girls from 2019-20 to 2020-21 compared with 0.7 cm over the previous 10 years for both boys and girls.

The long term trends in mean height show the greatest increases among children living in the most deprived circumstances, narrowing height inequalities. This looks like good news. Socioeconomic inequalities in child height have long been recognised, with poorer children tending to be shorter than their more affluent peers, reflecting the many social determinants of child growth, including diet, illness, psychosocial stress, and environment.[2-5] Child height has been considered an important influence on adult health and wellbeing.[6,7] Historically, child height has increased as social conditions improved in the UK[8] and worldwide.[9]

Influence of obesity

But our perceptions might be reshaped by the sharp increase in child height in England that occurred during the covid pandemic, alongside a spike in child obesity. From 2019-20 to 2020-21 obesity prevalence rose by 30-53% among 5 year olds and by 23-30% among 11 year olds during a time of school closures, reduced physical activity,[10] and less healthy eating habits.[11,12] Studies suggest similar trends in child obesity and height in the context of covid lockdowns in other countries.[13,14]

Obesity is associated with accelerated linear growth during childhood

Lifestyle changes during the pandemic explain the spike in obesity, but they could also explain the increase in child height. Obesity is associated with accelerated linear growth during childhood, and, compared with their healthier weight peers, children with obesity tend to be more developmentally advanced and hence taller. However, they stop growing earlier, end up no taller as adults,[15] and have an increased risk of morbidity and mortality in later life.[15-18] The covid induced rise in adiposity may have accelerated the rate of growth through hormonal pathways, leading to the observed jump in height.

The association of increased child obesity and accelerated growth seen during covid has relevance for interpreting longer term trends in child height. When childhood obesity was at its peak in 2020-21, the prevalence among 5 year olds in the most deprived areas of England was more than twice that in the least deprived areas (20.3% *v* 7.8%).[19] Among 11 year olds the obesity gap was even greater (33.8% *v* 14.3%). And the difference has been widening over time. Meanwhile, child height has increased in England since 2009, with overall height rises being driven by rises among more deprived children. This raises the question of whether the height rises reflect increasing obesity rather than better overall health.

A longitudinal study of the NCMP obesity data suggests the pandemic changes were real rather than the result of sampling bias.[20] The NCMP's large dataset of 1 million children provides high precision, enabling detection of average height changes with a standard error as small as 1 mm. The pandemic caused challenges with data collection, including measurement delays and reduced participation. Delays were accounted for using age standardisation to adjust each child's height to their 5th or 11th birthday. Reduced participation introduced the possibility of sampling bias, but this seems unlikely to explain the results since the same trends in obesity and height were seen across all deprivation deciles, most ethnic groups, and many local authorities (including, notably, those that achieved participation rates similar to previous years).

Further research is required into the interactions of obesity, height, and health during childhood and beyond, but it seems that height alone may not be a reliable indicator of child health when obesity is prevalent and increasing. This has relevance for interpreting global trends, especially among populations experiencing the double burden of child undernutrition and obesity. Recognising how and why child growth patterns are changing is necessary for understanding changes in child health and inequalities. Child height data for England also suggest the continuing importance of population level policies tackling child obesity, particularly in ways that will most benefit those who are most deprived. This may include making healthy dietary and exercise options more accessible and affordable—through greater regulation of the food industry[21] and safer active travel strategies,[22] for example—but also policies to make the most deprived children less deprived.

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