New measures to curb UK infection rate

The prime minister has set out new national measures designed to halt the current rise in covid-19 cases.

Boris Johnson told MPs that, in England, hospitality venues, including pubs, bars, and restaurants, will have to shut by 10 pm from 24 September and will be legally permitted to provide table service only.

He added that masks will be compulsory for staff in shops, drivers and people using taxis, and staff and customers in indoor hospitality venues, except when seated at a table to eat or drink. Fines for breaking these rules will increase. People are also advised to work from home if possible.

Guidelines for the retail, leisure, tourism, and other sectors will become legal obligations, and the maximum number of people at weddings will be reduced from 30 to 15 from 28 September.

The fresh restrictions came after the four UK chief medical officers announced on 21 September that the UK’s alert level was being raised from level 3 to 4, as the incidence of the infection was “high or rising exponentially.” That day 4368 daily cases were reported in the UK, and cases are doubling every seven to eight days.

Announcing the changes in the House of Commons on 22 September after a meeting of COBRA, the government’s emergency committee, Johnson said the new measures were likely to be in place for six months.

“We always knew that, while we might have driven the virus into retreat, the prospect of a second wave was real. I’m sorry to say that, as in Spain and France and many other countries, we’ve reached a perilous turning point,” he said.

Scotland and Northern Ireland—whose leaders attended the COBRA meeting—have both announced that households will be banned from mixing. Wales is expected to announce further restrictions, after imposing a series of local lockdowns.

Johnson said the threat of covid had not disappeared since the first national lockdown. “If we fail to act together now, we not only put others at risk but jeopardise our own futures with the more drastic action that we will inevitably be forced to take.”

Saffron Cordery, deputy chief executive of NHS Providers, which represents NHS trusts, said, “No one doubts the impact of these restrictions on people’s lives. But the consequences of failing to act and failing to protect the NHS would be even worse.”

Gareth Iacobucci, The BMJ

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SEVEN DAYS IN

New indicators will track doctors’ careers to expose racism

NHS England has launched a set of indicators to expose ethnic disparities in the medical workforce, with data set to be presented to trusts later this year. The Medical Workforce Race Equality Standard (MWRES) will capture “several issues” particular to doctors that are not picked up by the general NHS staff. WRES was introduced in 2015. Around two fifths (41%) of NHS doctors are from ethnic minority groups, and evidence shows they are less likely to be treated favourably than their white colleagues and have poorer experience and progression opportunities.

The new indicators include the percentage of ethnic minority people in each medical and dental subgroup in NHS trusts and clinical commissioning groups; consultant recruitment; and complaints received. Differential attainment in medical schools and differential pass rates in postgraduate examinations will also be looked at, as well as experiences of harassment, bullying, or abuse from patients, relatives, or other staff.

Mala Rao, chair of the working group that created the indicators, said, “The MWRES is a world first in creating an evidence base to expose racism in the medical workforce at a national level. It will enable the NHS to translate that evidence into meaningful action.”

Covid-19
Moonshot project faces legal challenge
The government’s Moonshot project, which could spend as much as £100bn to increase covid-19 testing capacity to 10 million people a day, is facing a legal challenge. The move is the latest in a series of High Court challenges from the Good Law Project, a not-for-profit group, over the government’s handling of the pandemic. The group sent a letter before action to the government’s lawyers, claiming that the project was unlawful because it ignored scientific evidence and committed a vast sum of public money with no transparency about how the decisions were made.

Universal screening is likely to miss cases
One time screening for SARS-CoV-2 in apparently healthy people is likely to miss those who are infected, public health measures such as face coverings, physical distancing, and quarantine for those who may have contact with an infected person continue to be very important.”

Point-of-care test reports 94% sensitivity
The CovidNudge test—which the government plans to roll out nationwide—can provide results in 90 minutes, with 94% sensitivity and 100% specificity when compared with standard polymerase chain reaction testing, found a study by the manufacturers published in Lancet Microbe. But the study’s lead author, Graham Cooke, emphasised the test was not likely to be used at crowded events because the machine can process only one test at a time, with a daily maximum of 15 tests per machine.

MPs and peers say lessons from deaths must be learnt
The government should immediately organise a quick interim review into deaths from covid-19—making deaths in care homes a priority—to ensure that lessons are learnt before a new autumn or winter peak of the pandemic, said MPs and peers on the Joint Committee on Human Rights. They also urged the government to ensure that care homes were not implementing blanket bans on visiting, saying that any restrictions “must take into account the risks to the person’s emotional wellbeing and mental health of not having visits.”

Prescribing “Allow minor substitutions” in drug shortages
Leaders from the BMA, the Royal College of General Practitioners, pharmacy organisations, and the patients’ group National Voices wrote to England’s health and social care secretary, Matt Hancock, calling for pharmacists to be allowed to make minor substitutions for a GP’s prescription in a drug shortage, particularly after Brexit. Currently, pharmacists are legally obliged to refer back to the prescriber before making even a minor adjustment, which “can cause delays in access to medicines and takes up health professionals’ time, which could be used elsewhere to support patient care,” they wrote.

Lithium product “must stay on market”
Pharmacists, GPs, psychiatrists, and patients urged the government to ensure that Priadel, a brand of lithium costing £4.02 for a pack of 400 mg tablets, remains available to patients. Essential Pharma, which owns the rights to Priadel, has announced it will withdraw the brand next April and has raised the price of the other main brand of the drug, Camcolit, to £48.18 per pack of 400 mg tablets. In direct drug costs alone it is estimated that the change will cost the NHS around £15m a year.

Public health
Paying GP clinics to provide LARCs cuts abortions
A 2009 scheme paying GPs to offer patients long acting reversible contraceptives resulted in an extra 4.53 prescriptions per 1000 women above what would be expected without the scheme by 2013-14, a study in PLOS Medicine found. Abortions fell by 38% beyond what was expected in the same period—equivalent to 95 170 fewer abortions in the UK.
Surgery
Perioperative care can cut complications by 80%
An evidence review by the Centre for Perioperative Care—a partnership between the Royal College of Anaesthetists, other medical and nursing royal colleges, and NHS England—found that good perioperative care could reduce the length of stays in hospital by an average of two days across different types of surgery. It also reduced the need for intensive care and improved communication between patients and clinicians. Different interventions, such as “prehabilitation,” exercise, and smoking cessation, could reduce complications after surgery by 30-80%.

Medicinal cannabis
Lack of prescribing harms patients, say experts

“The failure of the medical and pharmacy professions to embrace CBPMs [cannabinoid based products for medicinal use] despite their being made ‘legal’ over 18 months ago is a great worry to patients” and may have led to preventable deaths from conditions such as epilepsy, researchers wrote in BMJ Open. Barriers to doctors prescribing included misplaced concerns about a perceived lack of scientific evidence for CBPMs and government insistence that they be considered a “special” product, said the authors. They called for a change in attitudes to promote the appropriate use of CBPMs for pain relief.

A&E
Pilot scheme tests NHS 111 for booking urgent care
Twenty five trusts will receive a share of £150m to expand their A&E departments to make more physical space for treating patients and managing patient flow while improving infection control, said England’s health and social care secretary, Matt Hancock. He also announced a pilot scheme for NHS 111 to be the “first point of contact” for patients seeking urgent care. Under the plans, intended to be rolled out nationally from December, patients will call the helpline before being booked into A&E or an urgent treatment centre or to see a GP.

COVID-19
Between 18 March and 21 September the NHS in England dealt with 913,542 telephone inquiries for coronavirus and 3,211,167 online assessments [NHS Digital]

SIXTY SECONDS ON...
CIRCUIT BREAK

IS THIS A PHYSICS LESSON?
No, it’s just the government’s latest covid-19 buzz phrase. It refers to a proposal, apparently under consideration by ministers, to tighten restrictions for a short period to try to halt the current surge in England.

HOW WOULD IT WORK?
The BBC reports that the government’s Scientific Advisory Group for Emergencies has suggested rewiring the current set-up so that parts of the hospitality industry could be closed or asked to close early for a couple of weeks, while schools and workplaces would remain open.

ARE WE HEADING FOR ANOTHER NATIONAL LOCKDOWN?
The government is desperate to avoid this, but with covid-19 cases now doubling every seven to eight days, rising to 4,368 new cases reported on 21 September, it says “targeted interventions” are needed to keep infection rates down as much as possible, while protecting education and the economy.

BUT WHAT ABOUT THE RULE OF SIX?
That’s still in place, and the government is closely monitoring its impact to see if it has helped slow the spread of covid-19. Ministers have emphasised that people caught meeting in groups of more than six will face police action—particularly if they live next door to the home secretary, Priti Patel, who has said she would report them.

DOES MATT HANCOCK WANT US ALL TO SNOOP ON OUR NEIGHBOURS?
Yes. The health secretary has also said he would be prepared to twitch the curtains if necessary and has said it’s critical that people follow the guidelines and any local lockdown rules that are in place.

BUT WILL A CIRCUIT BREAK WORK?
The jury is out. Rowland Kao, professor of veterinary epidemiology and data science at the University of Edinburgh, said, “While a two week lockdown will undoubtedly reduce the infection rate, it is uncertain whether something less than the total lockdown of March will have enough of an impact if schools and universities are allowed to continue to operate with in-person contact.”

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2020;370:m3696

Cite this as: BMJ 2020;370:m3686
Independent SAGE’s plan to avoid lockdown

The Independent Scientific Advisory Group for Emergencies has published a 10 point plan to avoid a national lockdown, while criticising the government for abdicating its responsibility to provide such a plan.

Stephen Reicher, professor of social psychology at the University of St Andrews, said, “If we dither and waste a week, as we did in March, then we will slither into a national lockdown.”

The plan calls for urgent measures that will be reviewed when a working test system is in place and infections are under control. It calls for pubs and cafes to be limited to outdoor service, for people to work at home, and for affected workers to get financial help. It also says schools should be funded to allow smaller, socially distanced classes and for universities not to have any face-to-face teaching.

Jacqui Wise, London

Cite this as: BMJ 2020;370:m3695

The absence of data leaves major questions over the app’s effectiveness unanswered

Josh Keth, Health Foundation

Results of tracing app pilots must be published, experts say

Health experts have urged the government to publish the results of pilots of its covid-19 contact tracing app to demonstrate that it is effective and won’t exacerbate health inequalities.

The app was due to be launched in England and Wales on 24 September, but the government has not yet released the results of pilots that took place in August on the Isle of Wight and Newham in east London.

The Health Foundation said that greater transparency was needed to show that the app was effective and ready for mass rollout. This will be crucial to building public confidence and encouraging people to download and use it, it argued.

As well as publishing data to confirm the app’s overall effectiveness, ministers must demonstrate that the technology won’t exacerbate existing health inequalities by leaving some people at greater risk of covid-19 than others, the foundation said. It said that piloting the app in Newham, one of England’s most ethnically diverse and deprived boroughs, provided an opportunity to understand how it worked among different groups but said the findings should be made public to understand the app’s effect.

“Digital divide”

The foundation also pointed to previously unreleased polling by Ipsos MORI on its behalf that reinforced concerns of a potential “digital divide” along the lines of ethnicity, occupation, educational level, and age.

The polling, conducted between 17 and 29 July among British adults, found that respondents from an ethnic minority background, women,

Experts divide into two camps: shielding v blanket policies

Sunetra Gupta and Karol Sikora

The harm caused by uniform policies will outweigh the benefits

To divide a group of vulnerable people from those less vulnerable is practically impossible

Trisha Greenhalgh and Harry Burns

Two open letters sent to the UK’s four chief medical officers signal the polarisation of opinion among medical professionals over how the government should tackle the emerging “second wave” of covid-19.

One group of doctors and academics is calling for segmentation and shielding of the most vulnerable groups of people rather than local or national lockdowns. However, another group says efforts should continue to suppress the virus across the entire population.

Targeted approach

Sunetra Gupta, professor of theoretical epidemiology at Oxford University, Carl Heneghan, director of Oxford’s Centre for Evidence Based Medicine, Karol Sikora, a consultant oncologist at the University of Buckingham, and 30 others are calling on the government to take a more targeted approach rather than blanket policy interventions (bit.ly/3mJtq5a).

They argue that because 89% of covid deaths are in the over 65s and are also concentrated in people with pre-existing medical conditions interventions should be targeted at these groups. Given the high proportion of covid deaths in care homes, these should be a priority, they add. “This large variation in risk by age and health status suggests that the harm caused by uniform policies (that apply to all persons) will outweigh the benefits,” the group’s letter says. It adds that blanket policy interventions can have adverse effects on physical and mental health as well as social and economic impacts. The effect on cancer treatment is especially acute, it says, with people delaying or missing screenings, tests, or treatments.

Meanwhile Trisha Greenhalgh, chair of primary care health sciences at Oxford and 21 others argue against pursuing a “herd immunity” approach (p 400). They say that although the incidence and outcomes of covid-19 vary across different groups, deaths have occurred in all age, sex, and ethnic groups and among people with no pre-existing medical conditions. They also point out that “long covid,” in which symptoms extend for
the youngest and oldest age groups, routine and skilled manual workers, and unemployed people had a lower awareness of the government’s plan to use a smartphone contact tracing app. Josh Keith, senior fellow at the foundation, said, “With a virus that is transmitted as quickly as covid-19, the automated contact tracing that the app promises could prove invaluable in reducing its spread.

“However, for any major nationwide public health intervention it is important the government publishes evidence that it is effective and ready for mass rollout in advance of its launch. Any data on the pilots that took place in August have been notably absent, leaving major questions over the app’s effectiveness unanswered.”

A spokesperson for the Department of Health and Social Care for England said that trials had shown the app to be accurate and responsive.

The spokesperson added, “We have spoken with groups with protected characteristics, such as age, ethnicity, and disability, those experiencing health inequalities, and those groups particularly impacted by coronavirus, and the app and supporting material will be available in multiple languages.”

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2020;370:m3708

Testing service wasn’t prepared for surge, chief admits

England’s NHS Test and Trace service wasn’t prepared for the increased demand that has seen thousands of people unable to access tests, the head of the service has admitted.

But Dido Harding insisted that the service had followed modelling from the government’s Scientific Advisory Group for Emergencies when planning for schools to be reopened this month.

The past week has seen a growing number of reports of people across England being unable to access covid-19 tests at local sites. Harding told MPs that current estimates showed that demand was up to four times higher than capacity.

“Absolutely on track”

“We built our [autumn] testing capacity plans based on SAGE modelling. We published our business plan at the end of July, and are absolutely on track to deliver that,” she told the Science and Technology Committee on 17 September.

“I don’t think anybody was expecting the really sizeable increase in demand that we’ve seen over the last few weeks.”

But she added, “I strongly refute that the system is failing. We planned for a sizeable increase in testing capacity. As the prime minister said [last week], plainly we don’t have enough today, and we are doing everything in our power to increase the testing capacity.”

Harding said that surveys carried out at testing sites had found that up to a quarter of people asking for a test didn’t have symptoms. “It is clear that demand is significantly outstripping the capacity. We need to make sure that we protect capacity for the people that most need it.”

“The constraint in the testing system is in the processing and the laboratories. We have to restrict the number of people who are taking tests so that there is no risk of those tests going out of date when they are processed,” she said.

Around half of the testing capacity was being reserved for NHS patients, NHS staff, and care homes, she said. The next priorities were people in hotspot areas, then key workers.

Harding also confirmed the UK was using overseas labs to process tens of thousands of samples.

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2020;370:m3676

I strongly refute that the system is failing

Dido Harding
GPs challenge royal college’s “irrational” interpretation of assisted dying vote

The Royal College of General Practitioners has been threatened with legal action unless it reconsiders its “irrational” decision to continue to oppose any change in law to permit assisted dying.

The college said on 21 February that its 2019 membership survey did not present a mandate to change its stance opposing assisted dying. Critics argue that most respondents voted for the college to change its position from opposition and that a neutral position would best reflect the results.

“The college is failing in its obligations to properly represent the views of its members,” said the solicitor’s letter sent on behalf of RCGP members Aneez Esmail and Sam Everington, the non-profit company the Good Law Project, and the pressure group Dignity in Dying. They accuse the college of a “flawed and unlawful decision making process” that was “irrational, failed to take into account relevant factors, and took into account irrelevant factors.”

The letter says, “With such a polarised result on an important ethical issue there was a fundamental error in treating ‘neutrality’ as a stand-alone third option as opposed to representing the middle ground between two competing, but polar opposite, views with similar levels of support.”

The letter continues, “The results clearly supported change in the college’s position and so neutrality is arguably the only logical way of reflecting that change.”

Legalisation of assisted dying would, in specific circumstances, permit doctors to prescribe lethal drugs to some terminally ill people for them to take themselves. Some people call it assisted suicide.

The survey, run by Savanta ComRes from 29 October to 15 December 2019, had 6674 respondents, a 13% response rate. Of these, 47% (3144) said the RCGP should oppose a change in the law, 40% (2684) said it should support a change in the law, and 11% (701) favoured a neutral position for the college.

We have been stonewalled at every turn by the RCGP Council
Aneez Esmail

The letter accuses the RCGP Council of failing in duties required by the Charities Act 2011 and of lacking transparency, including by not publishing details about members of a steering group it set up to analyse the 2019 survey results.

Esmail said, “The [2019] survey was intended to find out if RCGP members had changed their views since 2013, and there is undeniable evidence that they had.” The college’s 2013 consultation included a survey of 234 members. It found that 77% wanted the college to maintain opposition, 18% wanted it to assume a neutral stance, and 5% wanted it to support a change in the law.

Esmail added that he and Everington had been “stonewalled at every turn” when trying to raise their concerns with the RCGP Council.

The RCGP chair, Martin Marshall, said, “We are very disappointed to hear of this action, especially as we were transparent about our methodology and decision making processes from the outset of the consultation.”

Ig Nobel wins for Donald Trump and Boris Johnson

Politicians are better than doctors or scientists at medical education. Leaders such as Donald Trump and Boris Johnson and their counterparts in Russia, Belarus, Brazil, India, Mexico, Turkey, and Turkmenistan have used covid-19 to teach their citizens about life and death.

For their efforts they jointly won the 2020 Ig Nobel prize for medical education, although none of them showed up to make an acceptance speech.

The Ig Nobels are awarded for achievements that make people laugh and then make them think. The 30th awards were virtually handed out on 17 September.

Research on how income inequality predicts frequency of French kissing won the economics prize for Christopher Watkins, a psychologist at Abertay University in Dundee, and colleagues from 13 countries. “Kissing plays a role in keeping human pair bonds together,” he said. In countries with greater income inequality, his research showed that people kiss more, as commitment to a partner is more important in a harsh environment.

Eyebrows as indicators of narcissism won the psychology prize for Nicholas Rule and Miranda Giacomin of the University of Toronto. “We started with whether people could detect narcissism from the face,” Rule told The BMJ. They found distinctive looking eyebrows were typical in people “who express higher levels of grandiose narcissism,” he said.

A woman who became aggressive when she heard a sneeze led to the discovery of a disorder, misophonia, by psychiatrists at the University of Amsterdam Medical Centre. Damiaan Denys said some people became so irritated by sounds made by others while eating or breathing they could become violent. “The consequences are huge. They socially isolate,” he said. He has found about 5000 people with the problem that can be treated with coping strategies.

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The BMA annual representative meeting

Gareth Iacobucci, Abi Rimmer, and Elisabeth Mahase report the virtual conference’s highlights

Call to fund extra NHS capacity to tackle backlog

The government must fund extra NHS capacity to deal with the backlog of planned care caused by the covid-19 pandemic, doctors said.

Given the likely effect on NHS waiting lists, a motion passed by representatives called on the BMA to work with governments to develop a public information campaign on the likely timescale for the NHS to return to normal services.

Sakkaf Ahmed Aftab of the BMA’s Yorkshire Regional Council, who proposed the motion, outlined the seriousness of the backlog, highlighting estimates from the NHS Confederation that waiting lists may increase to 10 million people by the end of this year.

He said, “Gradually, because of this backlog, anger is growing among the waiting patients. It is important that the BMA works with the government to have a public information campaign to explain the constraint under which doctors are working, in order to maintain public trust in the NHS.

“We must ask the government for adequate funding to increase NHS capacity to address the backlog and the growing waiting lists.”

Representatives also backed a motion calling for the return of NHS funds that were paid to the private sector to retain capacity but have been underused during the pandemic. Aftab said, “This block booking is costing the NHS an estimated £400m a month. Is this the best use of public money?”

Handling of pandemic must be subject to public inquiry

Representatives voted overwhelmingly to pass a motion that said a public inquiry into the government’s handling of the pandemic should cover, as a minimum, the mismanagement of care homes; the purchase, delivery, quality control, and guidelines for personal protective equipment; the UK testing strategy; the wellbeing of health and care staff; the timing of interventions; and the timing of the easing of restrictions.

Proposing the motion, GP Steven Miller said, “We owe it to the nation to ensure that lessons are learnt. Not to do so would be a betrayal.”

New public health agency must be independent

Public Health England’s replacement must be fully independent of the government and must be able to hold it to account on matters of public health, doctors agreed.

They passed a motion calling for the new agency to include a national public health infection service that is “professionally led and in charge of strategy, operations, education and training, with an appropriate budget and regional offices.”

The motion also said that all consultants in public health should be employed on contracts equivalent to those of NHS consultants to ensure that they have “adequate guarantees of freedom to make professional advice public.”

Reward healthcare staff for pandemic work

An overwhelming majority of representatives voted in favour of a motion commending the work of healthcare staff during the covid-19 pandemic, who they said should be adequately remunerated for extra work done.

The motion said staff have worked outside their specialties, worked additional hours, and worked at increased risk to their health, and it asked the BMA to pursue policies to “ensure that an additional reward is made to all healthcare staff to reflect the personal sacrifices and increase in risk to health made during this pandemic.”

The motion also called for reassurances that temporary changes to working patterns would not become permanent and that no long term changes to job plans or contracts would be imposed without negotiation with doctors.

UK trade deal with US must not lead to drug price rises

The BMA must work to ensure that any future trade deal between the UK and the US does not lead to a rise in the price of drugs or weaken the UK’s ability to negotiate prices with US companies, representatives said.

Gio Sheiybani, a gastroenterology registrar who proposed the motion, said, “Although the UK government has said the NHS is not on the table, we are greatly concerned that any negotiations carried out without any proper scrutiny and appropriate protections could lead to concessions which prioritise economic gains over health.”

Government must act on racism and diversity

The government has a “moral imperative” to take firm action against racism and health inequalities, the BMA said. They passed a motion that said a “moral imperative” to take firm action against racism and health inequalities, the BMA said. They passed a motion calling for the new agency to include a national public health infection service that is “professionally led and in charge of strategy, operations, education and training, with an appropriate budget and regional offices.”

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Reward healthcare staff for pandemic work

An overwhelming majority of representatives voted in favour of a motion commending the work of healthcare staff during the covid-19 pandemic, who they said should be adequately remunerated for extra work done.

The motion said staff have worked outside their specialties, worked additional hours, and worked at increased risk to their health, and it asked the BMA to pursue policies to “ensure that an additional reward is made to all healthcare staff to reflect the personal sacrifices and increase in risk to health made during this pandemic.”

The motion also called for reassurances that temporary changes to working patterns would not become permanent and that no long term changes to job plans or contracts would be imposed without negotiation with doctors.
In May the National Portrait Gallery launched Hold Still to create a unique collective portrait of the UK during lockdown. The public was invited to submit photographs taken in a six week period that focused on three core themes: Helpers and Heroes, Your New Normal, and Acts of Kindness.

The gallery received more than 31 000 submissions, 100 of which now form an exhibition in the London gallery and online (bit.ly/2Hcf24W).

Alison Shepherd, The BMJ
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Long-awaited Cuddle (main image) by Lesley Garven, Auchinleck, East Ayrshire
The photographer made her mother a “cuddle blanket” so she could hug her grandchildren

Akuac (right) by Anastasia Orlando, London
Taken at a Black Lives Matter protest

We Always Wear a Smile (below) by Jill Bowler and Trevor Edwards, Preston
Care workers Beth and Sade reassure their residents that they are still smiling beneath their masks
The NHS people plan
A missed opportunity to tackle the workforce crisis

The NHS England and NHS Improvement published the long overdue people plan for 2020-21 on 30 July 2020. The NHS is the UK’s largest employer and one of the biggest employers globally. It has been described as “the most complex, risky, and expensive single industry in Europe with the most educated (and intrinsically motivated) staff.” Staffing has overtaken funding to become the top risk facing the health and care sector, yet the NHS has a poor track record of workforce planning. Responsibility for workforce issues at a national level has been fragmented since reforms introduced by the Health and Social Care Act 2012, and worryingly high numbers of doctors and nurses are leaving their jobs early. This inevitably affects the ability to deliver good local services and the best outcomes for patients.

Why has a workforce plan taken so long to publish? To be fair to its authors, the exit from the European Union, general election, and global pandemic meant that the national workforce plan was not as high as it might have been on the political to-do list. Covid-19 has proved a deep shock to the health and care sector. But whatever the next few years hold, the NHS relies on its staff to deliver good care for patients. Yet staffing has overtaken funding to become the top risk facing the health and care sector.

Essential changes
Nevertheless, the plan contains some important and valuable commitments. These include essential changes such as a commitment to greater job flexibility, helping to make the NHS a better employer and support the health and wellbeing of the 1.3 million people who work in the service. But it is difficult to see how the other core elements of the published plan—“New ways of working and delivering care” and “Growing for the future”—can be anything other than ambitions without meaningful new funding.

There is strong evidence that a motivated and engaged workforce delivers better care for patients. Yet staff stress is at a five year high, and the reported levels of bullying and harassment are unacceptable. Even before covid-19, the NHS experienced burnout and difficulty in retaining staff, and excessive workloads and stress have been normalised. These problems are endemic in the NHS, and therefore the actions outlined in the people plan will need to be consistently driven at every level of the healthcare system. How likely is this change in culture? The interim people plan openly stated that a previous policy attempt “has not led to the widespread culture change . . . In part, this is because the national bodies have not visibly demonstrated the importance of the framework.” So, can we feel assured that the national bodies will act differently this time around?

The people plan provides a welcome vision to better support the healthcare workforce, and although many of the outlined actions can be delivered by local leaders and will help to make positive and necessary changes, the huge scale of the staffing crisis means they will not be enough. In November 2018, the King’s Fund set out five key tests that the NHS long term plan and a supporting workforce strategy would need to pass, including addressing workforce shortages now and in the medium term and reducing race and gender inequalities in both pay and progression.

A seven month people plan could never pass these tests. It is disheartening that what could have been the most important workforce strategy in the history of the NHS doesn’t directly tackle how to reduce the huge workforce gap.
Operation Moonshot is scientifically unsound

Proposals could do more harm than good to people, populations, and the economy

The polymerase chain reaction (PCR) swab test is useful (but not perfect) for detecting SARS-CoV-2 virus RNA in symptomatic patients. However, problems arise using the test for purposes that disregard symptoms or time of infection—namely, case finding, mass screening, and disease surveillance.

This is because PCR is not a test of infectiousness. Rather, the test detects trace amounts of viral genome sequence, which may be either live transmissible virus or irrelevant RNA fragments from previous infection.

The PCR “cycle threshold” (Ct) provides an estimate of the quantity of target RNA in the swab sample. It correlates with symptoms, and people with low Ct values (indicating more viral material) are those most likely to be infectious. Using a low maximum Ct value has been suggested to reduce problematic detection of dead virus, but it will also miss early infection and rising infectiousness in both presymptomatic and symptomatic people. It is impossible to define a universally optimal Ct value for reliable identification of those who are infectious.

If PCR is used to identify cases through mass testing of healthy people, it will deliver positive results in individuals with previous resolved infections, new infections, and potential re-infections, as well as false positives in people genuinely not harbouring the virus (around 0.8% of all tests performed).

Real concern exists that many people who are not infectious (and not likely to become infectious) will receive positive test results and, together with their contacts, will be forced to isolate unnecessarily. In the context of mass surveillance, this could be a majority of those who test positive. Using PCR for population screening—even with a lower maximum Ct value cut off—is not epidemiologically sound.

Unworkable

Now, Operation Moonshot has proposed that mass screening with “less accurate” point-of-care tests will help “reduce the R rate, keep the economy open and enable a return to normal life.”

Could this work?

The Moonshot proposals are based exclusively on computer modelling not empirical evidence. Critically, the model considers repeated use of tests that are positive only in infected people with high viral loads of SARS-CoV-2. The crux of the assumptions in the Moonshot modelling is that the test must have a high chance of being positive when a person is infectious and a low chance when they are not. Thus, although the proposed test has lower sensitivity than PCR for detecting any infection with SARS-CoV-2, it must have equal sensitivity for detecting infections that could be passed on to others.

It is inappropriate to describe a test with these properties as “less accurate”—a description that has allowed some companies to launch suboptimal products, possibly encouraged by the magnitude of government contracts, low levels of government scrutiny, and the lack of an effective regulatory process for diagnostic tests.

Frequent repeat testing is necessary as the proposed test will only identify people with new infections when their viral load becomes high. Since Moonshot proposes the use of point-of-care tests, delays in receiving results would be eliminated and isolation can be immediate. But no point-of-care tests approved for home use are currently available.

One fundamental challenge is that proper evaluation of any point-of-care test destined for mass screening requires a robust and reliable way to identify true infectiousness: we need a reference standard against which the new test’s performance can be compared. Viral culture is one option, but culture based tests are hard to run and have high failure rates.

The Moonshot proposals have been condemned for not considering the potential harms from repeated frequent testing of whole populations. All tests generate some false positives and false negatives. The consequences of high false negative rates are most serious in symptomatic people who can transmit disease.

False positives become a problem when individuals and their contacts have to self-isolate unnecessarily. Even with a specificity of 99%, proposals to do 10 million tests a day will generate many thousands of false positive results, causing unnecessary but legally enforced isolation of both cases and contacts with potentially damaging consequences for the UK economy and for civil liberties.

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**BRIEFING**

**What has gone wrong with covid testing?**

Increase in demand, “ineligible” applicants, and laboratory capacity have all been blamed. **Jacqui Wise** examines the key questions around the lack of access to tests in the community.

**How big is the problem?**

The UK’s community testing system for covid-19 seems to be under immense strain. This is the “pillar 2” testing: the commercial, centralised system set up by Deloitte consisting of local drive-in and walk-in test sites, with swabs being sent to five Lighthouse laboratories for analysis. In recent weeks the media have been full of stories of people finding that no tests are available or that they must travel hundreds of kilometres to get one. This has led to people turning up at emergency departments demanding tests and to long queues at testing sites.

Speaking at the Commons Science and Technology Committee on 17 September, Dido Harding, the head of NHS Test and Trace in England, admitted the demand for tests was three or four times higher than capacity.

**Has demand increased?**

Demand for tests across the UK has soared in recent weeks with children going back to school, people returning from summer holiday, and more people going back to workplaces. In addition, there are rhinoviruses circulating producing symptoms that could be mistaken for those of covid-19, something that is only likely to worsen through the flu season.

Harding said there had been a marked rise in the number of parents getting children tested and that this hadn’t been predicted by the Scientific Advisory Group for Emergencies (SAGE).

**Are people having needless tests?**

Speaking in the House of Commons on 8 September, the health secretary for England, Matt Hancock, said that “about 25%” of tests were being used by asymptomatic and uninfected people. When questioned by The BMJ the Department for Health and Social Care said that “the figure came from internal track and trace research.” They added, “There has been a spike in demand in recent weeks and the message is clear: only people with symptoms should be requesting a test.”

**Is laboratory capacity the bottleneck?**

There seems to be no shortage of staff or swabs at the testing sites. Sarah Jane Marsh, director of testing for NHS Test and Trace, said it was the laboratories that were “the critical pinch point.” On 8 September she tweeted “heartfelt apologies to anyone who cannot get a covid test at present.” She added, “All of our testing sites have capacity, which is why they don’t look overcrowded, it’s our laboratory processing that is the critical pinch point. We are doing all we can to expand quickly.”

Allan Wilson, president of the Institute of Biomedical Sciences, agreed it was a laboratory capacity issue, although he believes this may have been overstated in the first place. “I would dearly love to know how capacity was defined. The trouble is it is shrouded in secrecy,” he told The BMJ.

**What is the laboratory capacity?**

The government says that testing capacity is higher than ever. Its dashboard shows that the UK laboratory daily testing capacity was more than 370 000 last week. However, this is the total capacity and includes pillar 1 (tests done in healthcare settings), pillar 3 (antibody titre testing), and pillar 2 (commercial system set up by Deloitte).
tests), and pillar 4 (surveillance testing run by the Office for National Statistics). On 17 September 236,219 pillar 1 and 2 tests were processed, and the combined capacity listed for pillar 1 and 2 was 2,429,111. Of this, around 160,000 is pillar 2. However, on 12 September capacity for pillar 1 and 2 was breached, according to government data.

Duncan Robertson, a policy and strategy analytics expert at Loughborough University who has been analysing the government’s data, told The BMJ that pillar 2 capacity was also breached on 23 August, when 121,555 pillar 2 tests were carried out, against a capacity of 120,000. He says, “Once there is a backlog then this can build up, and it can take a long time to get rid of it. It may be they are cutting down on capacity to help clear this backlog.”

He says that pillar 4 surveillance tests also vastly exceeded stated capacity throughout August and September and that these may have been processed under pillar 2. He is also concerned that capacity in pillar 1 laboratories (those run by the NHS and Public Health England) is more than 80% utilised, which may affect how easily NHS workers and inpatients get tests in the near future.

Hancock told parliament on 15 September that the backlog was reducing and is less than one day’s processing capacity. Health department documents leaked to the Sunday Times state that there was a backlog of 185,000 tests on 11 September, which led to some tests being sent to Italy and Germany for processing. The Guardian also revealed an email sent on 24 August asking NHS laboratories to help analyse community swabs because the privately run Lighthouse labs were overwhelmed.

Why is capacity limited at Lighthouse labs?
It seems to be staffing problems rather than a shortage of equipment or reagents that is the issue. “We do know the Lighthouse labs have lost a lot of staff with many postgrads and senior scientists returning to academia,” says Wilson. “But all that was highly predictable.” He adds, “I think they will struggle to recruit staff, as there is a limited pool of experienced scientists, and every hospital trust and health board is fishing from the same pool.”

The Mail on Sunday reported that Boris Johnson has written to the 50 top universities and medical schools asking for urgent support to staff the Lighthouse laboratories.

How is lab capacity affecting availability of tests?
Limited capacity in the laboratories has led booking for tests and home testing kits being periodically taken off line to throttle demand.

Harding admitted this to the Science and Technology Committee, saying, “We have to restrict the number of people who are taking tests in the testing sites so there’s no risk of those tests going out of date when they are processed in the labs.”

The health department spokesperson also told The BMJ that it was targeting testing capacity at the areas that needed it most, including those with an outbreak.

How does the UK compare with other countries?
The Our World in Data website shows that seven day averages up to 14 September the UK had carried out 2.8 tests per 1000 people, higher than most other European countries, including France (2.1 per 1000) and Spain and Germany (both 1.8). However, this was below Denmark, at 5.7, and how tests are counted is not necessarily the same in each country.

Maggie Rae, president of the Faculty of Public Health, told The BMJ, “Other countries are managing a more effective system on less tests than we are doing, so we need to build a much more intelligent and agile testing strategy.” She said that the £10bn being spent on NHS Test and Trace would be better spent on a more localised system, like that in Germany. She fears that the current situation will become even worse in the coming weeks, particularly once the new NHS covid-19 app is launched, which will encourage more people to get tested. “We need to act now and redesign the system, as we cannot afford to wait,” she warns.

What is the government’s plan?
Johnson, appearing before the Commons Liaison Committee on 16 September, admitted the testing system had “huge problems.” The government has said it plans to increase capacity to 500,000 tests a day by the end of October. It hopes this can be achieved when new Lighthouse laboratories in Newport, Gwent, and Charnwood, Leicestershire, are added to the network in the coming weeks. Until these come on stream, the plan is to ration tests by giving priority to NHS acute care patients, NHS and social care staff, and teaching staff with symptoms, as well as for outbreak surveillance. This priority list was announced by Hancock in the Commons on September 21. However, Robertson warns, “We cannot wait for extra capacity to come along in October. There is now a very real risk that the test, trace, and isolate system will break down and we will see the virus becoming out of control.”

The Lighthouse laboratories were built extremely quickly because the UK had very few diagnostic testing facilities of this type. The government chose to centralise the system, working with private companies and universities, rather than existing NHS laboratories. Wilson believes this was a mistake. “The Lighthouse lab model isn’t sustainable in the long term, and we need an exit strategy,” he says.

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DOCTORS’ TRAINING

Medical schools fear for quality of education as funding axe falls

As nearly a million students start term this month, universities face a perfect storm of financial problems that could dramatically affect medical degree teaching, reports Stephen Armstrong

“The sense of a funding crisis in higher education is very significant,” warns Malcolm Reed, dean of Brighton and Sussex Medical School and co-chair of the Medical Schools Council. “Most universities have started to feel a squeeze, and many will have run voluntary severance schemes—there’s an unpredictable uptake, and they can’t control who goes. They’re not yet going to be compulsory, but it would not be a surprise if that happens.”

Reed is one of many people in higher education battling the realities of a severe funding squeeze due to reduced research grants, a drastic drop in numbers of international students, and lockdown related losses of revenue from student accommodation and conference operations.

The situation is so dire that letters seen by The BMJ show medical schools asking staff to consider voluntary pay reductions, early retirement, redundancy, or changes to clinical academic contracts to cope with budget constraints. These moves are causing significant concern about the effects on student education.

In July, the Institute for Fiscal Studies warned that the covid-19 crisis posed a considerable financial threat to universities. Although the size of the sector’s losses is uncertain, the institute expects the figure to be around £11bn, which is more than 25% of the sector’s annual income. This means that less prestigious and financially weaker institutions face insolvency, the institute says, with some 13 unnamed universities needing a government bailout to survive.

Medical schools should be in a strong position to weather this storm because their funding comes from three pillars: student fees, the government/NHS, and research grants. Recent figures from the Medical Schools Council show that clinical academic posts throughout the UK are paid for by a combination of university funding (46%), NHS (42%, including the National Institute for Health Research), and research councils, charities, and endowments (12%).

And yet, fees and grants are severely threatened after covid-19, while recent pay rises for NHS staff mean that clinical academic consultants and senior academic GPs are paid at least 2.8% less than equivalent NHS posts, attracting senior academic clinicians away from teaching.

Too many and too few
Before this summer’s A level fiasco, 9500 training places were on offer this autumn around the UK. After the recent confusion over grades, which saw many students initially refused but then awarded their first choice place at universities and medical schools, the government lifted the cap on the number of medical school places on offer and agreed to cover the cost of additional places.

The Medical School Council estimates that an extra 950-1000 domestic students will start training this autumn, and visa applications from prospective international students are running at 10-15% of previous years’ totals. For the first two pre-clinical years of medical school training international students pay
about £35 000 a year, depending on the university, and fees for the final clinical years rise to over £45 000. By comparison, domestic students pay a maximum of £9250 a year.

“There has been some help, some funding for research brought forward, but no bailout,” says Reed. “Universities have been set up as independent bodies and encouraged to compete around the world for international students. This year it looks like international recruitment may drop off a cliff.”

Charity shortfall

Alongside this is the hit to medical research funds. In 2019, members of the Association of Medical Research Charities (AMRC) invested £1.9bn in UK research and development—roughly the same as the total funding provided by the Medical Research Council and the National Institute for Health Research added together.

For the financial year 2020-21 AMRC members expect a 41% fall in funding, resulting in a projected reduction in medical research investment of £252m-£368m. As 87% of AMRC funds went through universities to pay for 17 000 researchers’ salaries, including 1750 PhD students, that funding stream drying up will threaten jobs.

Cat Ball, AMRC head of policy, explains, “A huge chunk of charity funded research at universities has been paused thanks to lab closures, social distancing, and working from home—meaning that research becomes more expensive. Lots of clinical academics were seconded to the front line and returned to full time clinical care. But the biggest impact is felt in future research.”

Staff cuts leave shortages

The BMJ has seen letters to staff in medical schools at a number of universities, including University College London, offering a voluntary retirement scheme, voluntary temporary unpaid leave, a career break, and part time working options. Aberdeen has asked staff for a change to existing contracts to effectively forgo one year of an agreed three year pay rise.

Two senior academics at two city based medical schools, who wished not to be named, have told The BMJ of their “significant concerns” about the effects of financial pressure on the quality of student education. One of the schools has followed some London medical schools in cancelling fixed term contracts. One of the academics tells The BMJ, “All of the fixed term and short term contracts have been picked off, reducing in particular the number of GP tutors at a time when high quality GP training has never been more important.”

Although there was NHS funding for one post, the college would not start the hiring process because of a blanket recruitment ban, he adds. “The NHS money is not the university’s money,” he says, “but the university said it’s their policy not to advertise posts. Universities have trustees—what are they doing to protect health professional training, at this time of limited resources and so much uncertainty?”

In the resulting cuts, says one professor, “there has been no protection for the medical school whatsoever. There is no sense that the school has to meet a national need to keep the medic pipeline going—that has no sway at all. They’re just battling faculties off against each other.”

Senior academics needed

To date, the BMA believes that staff redundancies have been administrative rather than academic, although the process is still under way. “There will be some universities using this as an excuse to get rid of the people they don’t want,” says David Strain, senior clinical lecturer at the University of Exeter Medical School and co-chair of the BMA’s Medical Academic Staff Committee. He adds that, after the A level issue and the subsequent huge increase in medical school places, making
Soldiering on despite covid-19

Covid is changing the kind of teaching medical students can expect. Many medical schools have suspended clinical placements and moved teaching online. Most schools have cohorts of volunteer patients or patient experts, simulation suites, and actors to replace the experience of students being on ward or at a general practice.

Despite the increased hours and additional tasks, the pressure on jobs and salaries, and the confusion over student numbers, “clinical staff and NHS staff have soldiered on,” says Malcolm Reed, dean of Brighton and Sussex Medical School.

“Staff were sent off campus, and it’s been a struggle to persuade them things have changed and that they can come back to work safely—but they’ve returned,” says Reed. “Every medical school has contingency plans for producing a safe foundation year 1. There’s innovation, adaptation, and steps forward in the way we’re delivering education and learning... This year’s cohort of students will have a very different experience, but I am sure they will be good and safe doctors.”

Chris Smith, a final year medical student at Southampton University and co-chair of the BMA’s student committee, says that students depend on the “goodwill” of academics to do extra teaching sessions. “Social distancing means that teaching groups have had to get smaller,” Smith explains. “For simulations, for instance, the academics have had to run extra sessions, from two groups of six to four groups of three, which means everyone working into the evening. Certain facilities have strict limits on the number of people in a room: medical students might not be allowed in, so we’re missing out on seeing patients. There’s also uncertainty about the format of exams—you can’t move from station to station, for instance.”

Bethan Clayton, a final year medical student at Manchester University, is trying to make the best of a difficult situation. “Since we’ve gone back in mid-August I’ve been catching up on psychiatry,” she says. “It’s not been the same—we’re allowed one medical student on the ward at a time. I’m at Bolton, which is obviously a hotspot, so everything is very carefully handled. Today I did a 24 mile journey to hear a doctor speak to a patient on the phone—I understand why, but it’s not the best learning experience.”

She adds, “I don’t blame anyone. Medical schools have never faced this issue, and I have a lot of patience. If I was a third year going into patient contact, on the other hand, I’d be worried. That’s a formative time when you’re getting to grips with medicine.”

academics redundant now would seriously damage teaching.

“As it is, administrative redundancies mean an academic like me would have to spend more time doing those duties which we are not as good at, and we are an expensive resource to put on that type of job,” he says.

The University and College Union warns that cuts could not have come at a worse time, with clinical academics treating patients during lockdown and medical researchers leading the fight against the virus. The union’s general secretary, Jo Grady, says, “NHS key workers have rightly been celebrated throughout the pandemic, but we need the clinical academics in place to teach medical students, or we risk leaving the NHS under-resourced.

“It’s very worrying to see cuts to the medical schools that teach our doctors. We urge universities to work with us to make sure their medical schools have the capacity to research and develop new medicines, and the staff in place to train the doctors our NHS needs.”

Clinical academics have received support from the University and Colleges Employers Association, the trade body for UK higher education institutions, which wrote to universities at the end of August recommending that they increase pay for clinical academic consultants and senior academic GPs by 2.8%, in line with that recently offered to senior hospital doctors.

The BMA is concerned about the decline in senior clinical academics: although the overall clinical academic staffing numbers have remained roughly level from 2004 to 2019, the number of readers and senior lecturers has fallen by 26.8%, while the number of junior lecturers has risen by 59%. Strain says that the temptation to join the NHS is strong—“where we would be paid for our hours, not for the job”—and that a pay differential will only increase the departure of senior academics.

He adds, “We’ve lost too many senior clinical academics over recent years, and we cannot afford to lose any more: to do so would be disastrous for the extent of medical research in the UK and the quality of learning in our medical schools, to the detriment of the NHS workforce of tomorrow. It’s vital, then, that universities are able to offer this award in full.”

Both academics who spoke to The BMJ describe their universities as having borrowed heavily to expand campuses, now facing the additional strain of debt repayments. The sector’s debts have risen over the past year to £10.8bn, three times higher than before the financial crash, show figures compiled by the Times.

Strain says, “Universities across the country have over-expanded, which has made them particularly vulnerable to these financial problems. At Exeter we were fortunate to be preparing for an expansion which we’ve put on hold, helping us weather the storm. Other universities are not as lucky.”

Bethan Clayton, a final year medical student at Manchester University, says that staff have worked hard to minimise the pressure on students. “The academics are under a lot of pressure, but they don’t pass it on to us,” she says. “You can tell they’ve been working hard and are stressed, but we’ve been very sheltered and protected by them.”

Chris Smith, a final year medical student at Southampton University and co-chair of the BMA’s Medical Students Committee, describes a sense of solidarity with staff. “We’ve heard stories up and down the country of medical school staff leaving and not being replaced,” says Smith. “We stand shoulder to shoulder with the academics: we don’t want to see anyone forced into taking a pay cut, and, if we lose academics, medical students will be the ones that lose out.”

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