“To improve the DNACPR conversation we need to convey key messages” DAVID OLIVER
“A Swiss cheese model of pandemic control gives us a good chance” HELEN SALISBURY
PLUS The dangers of scientific petitions; long covid in children

CRITICAL THINKING Matt Morgan

Walking the green five miles

The currency that brings joy as a doctor has seemingly changed over time. While the thought of long lunches on the golf course is long gone, so too are the necessities to keep you sane when working in a system as stretched as Donald Trump’s truths. Nowadays, the things I aspire to most are a parking space, a password I can remember, and some scrubs that fit. On this last point, most hospitals seem to have forgotten that the average scrub wearer is, well, average. The predictable empty racks of scrubs in the middle portion of a bell shaped sizing curve are not a great start to the day. Apart from today.

To avoid looking like an extra in an MC Hammer video in the only size available (XXL), I opted for a different coloured uniform. Gone was the pale powder blue worn by surgeons, anaesthetists, and my ICU colleagues. Instead I wore the emerald green scrubs used by staff working in the wheelhouse of medicine: healthcare assistants. It radically changed the course of my day. Each step in the five miles I walked on that shift was subtly different from usual. In some ways better, in some ways worse. As I left the changing room, I was stopped mid-stride to help move a patient off a bed and onto a theatre trolley. A visitor asked me the way to the canteen. Another member of staff gestured to me to hold the doors while an x ray machine was guided through.

I was late for handover as a result. But that was fine. I suddenly felt useful in a very practical way. Not through a prescription, or through talking, or through medical procedures. I could use my body, my mind, and my experience to materially affect the lives of others. Not that this doesn’t happen in my usual blue scrubs, but it’s less common and with less expectation.

However, just as the thicker material of the green top was less kind to my skin, so too were some of the subtle changes I noticed in others’ behaviour. A busy, suited professional slipped in front of me at the queue for lunch. Medical teams strode down the corridor, filling its width with their bodies and loud conversations, leaving me to squeeze past, skirting the wall. I was repeatedly asked why I was walking into wards—places that are normally very pleased to see an ICU consultant.

We work not just in a multidisciplinary team but in a multi-dressed team. Other professions distinguish roles by using subtle badges, motifs, or military stripes. The bold uniforms in healthcare are seen from afar. This has its advantages, but it needs further thought. It’s not the visibility of the uniform that’s the problem but the way we treat the person in it.

Perhaps this is not even a problem that needs to be solved, but rather one that we should all experience. Rather than stepping into the shoes of others you work with, try wearing their scrubs for a day. It may change how others treat you—and, in turn, how you treat others.

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It’s not the visibility of the uniform that’s the problem but the way we treat the person in it
PERSONAL VIEW  John P A Ioannidis

Scientific petitions and open letters in the covid-19 era

Vote counting is a faulty method of scientific inference

Petitions and open letters signed by large numbers of scientists are not new, but they have proliferated in the covid-19 era. They have a clear role when it comes to questions of ethics, social problems, and injustices. With monumental consequences from both the pandemic and the response to it, debating ethical and social matters is the right of every citizen, including scientists. Collateral damage occurs, however, when these documents aim to prove or disprove scientific positions.

Scientists may take pride that their advocacy can save lives, mobilise resources for worthy enterprises, or teach leaders and fellow citizens. They may fervently support opposing positions on measures such as lockdowns or school closures. They may press on matters of transmission (is airborne, aerosol transmission common?) or risk (are children at risk? for example). The public’s participation in these debates is welcome, but the bounds of civility are often crossed and scientists are unjustifiably smeared.

Most importantly, however, petitions should not be used to prove that the positions of the signatories are scientifically correct. This is a fallacy implying that the larger the number of scientists who sign, the more valid their scientific positions. Vote counting is a faulty method of scientific inference. Science is replete with situations where vehement majorities have held wrong beliefs.

Signatory credentials carry little weight for further validating the veracity of petitioned materials. Expert opinions are at the bottom of the evidence hierarchy. Angry, scared, opinionated experts have even less trustworthiness. Over-confident petitions can be embarrassing when recruited experts do not even cover key dimensions of necessary expertise. There are other drawbacks in using petitions to prove scientific points:
• Absolute knowledge that can be summarised with a few paragraphs or bullet points is almost non-existent across science. Good science is nuanced. Forced consensus or over-simplification is detrimental.
• Signatories may not fully agree or may even partly disagree with what they co-sign. A survey examining the positions of signatories on a petition denouncing “statistical significance” showed several had not read the petition, many held opposite views to points made by it, and most had adopted research practices that contradicted what it espoused.

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• Petitions create covert coercion, stifling academic freedom. When academic leaders encourage their faculty to sign, coercion exists, even if the language is relaxed. Younger or more junior faculty members depend on seniors for their academic prospects.
• Petitions create a false sense of certainty during a new pandemic where uncertainty unavoidably exists. This hinders scientific inquisitiveness. Scientists may feel threatened by the mass mentality expressed by these letters and the media smearing; they may self-censor their high risk or unpopular ideas. Challenging orthodoxy is never easy, but it becomes almost impossible when proponents of orthodoxy speak vehemently about how incontestable their “truth” is.
• Exaggerated certainty can backfire and damage science if vehemently held positions are refuted by accumulating evidence.

The anti-vaccine movement and climate emergency deniers draw ammunition from the reversals of opinion and policy during the pandemic. Clearly the strategy of deniers is inappropriate, since the knowledge we have about covid-19 is still evolving, while we have

BMJ OPINION  Frances Simpson, Amali Lokugamage

Recognising children with long covid

With the recent announcement that the NHS will provide services for patients with long covid, there was a palpable sense of triumph among the community of long haulers. We both have long covid and are active campaigners for the condition. We should have been elated, but, although we’re pleased by this commitment, we have concerns about the lack of paediatric services for children with covid-19.

Research shows that children generally have less severe covid-19, but paediatric long covid has received much less attention. Many parents in online support groups describe their fear at the strange and fluctuating symptoms experienced by their children, their frustration at the lack of medical care, and their struggles to be believed.

Parents have expressed upset at encountering “medical gaslighting”

On social media support groups, parents have reported that their children experienced fatigue, gastrointestinal problems, sore throats, headaches, and muscle pain or weakness. Other symptoms include fevers, nausea, mood changes, rashes, dizziness, breathing difficulties, and cognitive blunting. These informal reports show the need for further epidemiological data collection to quantify and qualify the existence of long covid in children. They also show the need for research into the pathophysiology of these symptoms, as is being investigated in adults.

When children presented with this new multisystem disorder in the first wave of the
Detoxifying DNACPR decisions

Could healthcare practitioners do more to demystify and detoxify the public conversation on “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) decisions? Even before covid-19, such orders featured in many a misunderstanding or formal complaint. The pandemic response has made them more contentious, and the Care Quality Commission recently announced that it would review how DNACPR decisions had been used during the pandemic.

Stories emerged early in the pandemic of NHS commissioners pressuring care homes to complete DNACPR orders for patients en masse or GP surgeries writing to patients with serious illnesses, asking them to complete forms. Doctors and advocacy groups expressed fears about using age or clinical frailty scores for crude rationing of intensive care or CPR.

Among medical and nursing staff who deal daily with end-of-life care, acutely deteriorating patients, or cardiac arrests, the issues seem far less contentious, but if we’re to improve the public conversation we need to convey some key messages.

First, DNACPR is specifically about what happens when your heart stops. It’s not synonymous with “Do Not Treat”—despite understandable concern that some health and care workers without adequate training or protocols may be less likely to escalate treatment in deteriorating patients, doctors and patients asked before the emergency, is not necessarily the right course of action.

Fourth, advance care planning well before emergencies and treatment escalation, or when people arrive in acute hospitals, is a good thing: we should be doing more of it. If there’s any scandal, it should concern the failure to have had documented these conversations and decisions, not the fact that we’ve had them.

As well as being open in the media and using plain language public information, we can also help to detoxify the DNACPR issue by talking about it in our day-to-day interactions.

If there is a scandal, it’s the failure to have had and documented advanced care conversations and decisions.

solid evidence about the efficacy and safety of the measles, mumps, and rubella vaccine or the dangers of climate emergency.

- Petition letters can easily fall prey to political ideology. In a polarised, charged environment they often reflect the political preferences of the leaders who composed them. This becomes most obvious in attacks against government officials and task force figures. Brilliant scientists such as Anthony Fauci have been ferociously smeared and now need bodyguards. Even when letter writers have no intention of taking sides, their petitions may be misused to promote political agendas. Mixing science with politics can be damaging.

- Many signatories may have conflicts of interest, but these are hardly ever disclosed in the petition format. Dealing with covid-19 requires the best science and the best environment to foster freedom, with healthy scepticism and with full transparency. Petitions are a superb advocacy tool but should not masquerade as weapons of scientific argument. Scientific truth is not a matter of zealotry; nor is it decided by the bulk of signatories.

If there is a scandal, it’s the failure to have had and documented advanced care conversations and decisions.
A newspaper columnist recently suggested on social media that responding to the pandemic with a lockdown does not prevent deaths but merely postpones them. Unsurprisingly, there was pushback. Until someone discovers the secret of eternal life on Earth, death can’t be prevented. Postponing it is, however, the main purpose of medicine, alongside reducing suffering.

Perhaps what the columnist meant was that the most vulnerable people will catch the virus anyway and some will die, so efforts to slow the spread are merely prolonging harm. If we can’t prevent excess deaths, we may as well get them over and done with quickly, to allow our economy to flourish once more.

However, there are problems with this generous reading. Many of us (and not only doctors) are still haunted by the images from Italy and Spain during the first wave of the virus: the people lying in hospital corridors, the systems and individuals utterly overwhelmed by an influx of very sick patients. It’s clear that some of the early deaths could have been prevented with more staff, medicines, oxygen, and ventilators. If the flow of patients into a hospital is moderated, patients into a hospital is moderated, the best chance of recovery—and more resources are available to give each patient the best chance of recovery—and possibly to postpone their death by years or decades.

Some commentators complain that the focus on coronavirus is disproportionate, preventing proper care for other illnesses. It’s certainly true that, while hospitals and intensive care units are full of patients with a highly contagious virus, there are inevitable restrictions on treating other conditions. As many as 18 000 excess cancer deaths are estimated this year because of delayed presentation, diagnosis, and treatment. Short of turning away patients with covid-19, however, we have no choice but to divert resources.

The most effective way of postponing deaths is to reduce the transmission rate of the virus. There isn’t a magic bullet, but there have been useful illustrations of a “Swiss cheese” model of pandemic control: no single element is sufficient (they all have “holes”), but by running these alongside each other we have a good chance. These elements include face coverings, social distancing, handwashing, open windows, rapid and accurate testing, contact tracing, and isolation with support. How well each of these is done will determine how big the “holes” are and how effective their combined protection is.

My small contribution is to keep my surgery as free of infection as possible. This means doing as much work as we can remotely. I wouldn’t choose to consult this way, and many of my patients don’t like it much either—but most realise that we don’t have a choice.

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Second wave updates: how it’s affecting practice

As the second spike in cases of covid-19 grows, we’ll be taking stock of what’s happening in the NHS with second wave updates, which feature clinicians from primary care, secondary care, and public health. In the first of these podcasts, Fiona Godlee, editor in chief of The BMJ, talks to our columnists Matt Morgan, a consultant in intensive care, and Helen Salisbury, a GP. Here Matt Morgan discusses the obstacles he foresees: “The thing I’m struggling with now more than ever is the division. In wave 1, if you want to call it that, we were all together as a society, as a profession, as a world really, and that was pretty unique. And now it feels as if because of the uncertainty, which is inherent in science and medicine, we are more divided than before. I think that’s going to be one of the big challenges going into the winter.”

Personality disorder

Personality disorder is often referred to as the Cinderella diagnosis of mental health. In this episode of Deep Breath In, the team hears from a psychologist, a psychiatrist, and a patient about how GPs can help this group of patients. Leisha Davies, a clinical psychologist, begins by explaining what personality disorder is: “When I think about personality disorder, my starting point is, well, what is personality? Fundamentally, it’s generally thought of as a collection of characteristics or traits that are developed as we’ve grown up, and these traits will include the way we think, the way we feel, and the way we behave. Personality disorder is the degree to which these aspects of someone’s personality have developed to make life difficult both for themselves and often for people around them on a pretty consistent basis.”

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Edited by Kelly Brendel, deputy digital content editor, The BMJ
Effect of Athena SWAN funding incentives on women’s research leadership

Analysis shows that coupling awards to schemes such as an institution’s gender equality action plan can work and more funders should trial them, say Pavel V Ovseiko and colleagues

“Is it difficult being a woman scientist?” the biochemist Dorothy Crowfoot Hodgkin was asked at high table dinner in an Oxford college by the man sitting next to her. “Not since I won the Nobel Prize,” she replied. In 1964, the British press had reacted to her award with the headlines: “Oxford housewife wins Nobel” and “British woman wins Nobel Prize—£18 750 prize to mother of three.” While such overtly sexist treatment of female scientists by the media is now rare, progress towards gender equality in universities has been astonishingly slow.

A UK parliamentary inquiry into women in scientific careers found that with only 17% of professors in science, technology, engineering, and mathematics (STEM) in 2011-12 women were still under-represented at senior levels across all STEM disciplines. Concerned with the sustainability of increasing the scientific workforce, the inquiry concluded that efforts to inspire more women into science were wasted if they were subsequently disadvantaged compared with men and recommended that universities should do more to support and retain women in scientific careers.

To accelerate women’s advancement and leadership, the UK’s National Institute for Health Research (NIHR) introduced an innovative policy intervention in 2011 linking its research funding to biomedical research centres and units—partnerships between NHS organisations and universities. The strategic objectives, scope, and magnitude of funding of these centres have parallels with the Clinical and Translational Science Awards Program of the US National Institutes of Health.

Biomedical research centres cover several disease, organ system, technology, and activity based research themes (eg, cancer, cardiovascular disease, genomics, and patient and public involvement) with multiple investigators in each theme. Centres are led by a director (senior leader) responsible for the strategy and coordination of research across themes and by theme leads (mid-level leaders), who have similar responsibilities across research topics within their theme.

Funding awards are based on peer review by an international selection panel of senior researchers and informed by bibliometrics. The panel considers applicants’ research strategy, research facilities, budget, narrative track record of success in translational research, publications, grants, and the career history of the proposed director and theme leads, including a narrative description of why they are at the forefront of their field internationally and a list of publications over the past five years.

National translational research infrastructure

With the aim of creating a national infrastructure for translating scientific breakthroughs into new treatments for patients, NIHR has awarded £2.2bn of taxpayers’ funding for translational research to biomedical research centres and units—partnerships between NHS organisations and universities. The strategic objectives, scope, and magnitude of funding of these centres have parallels with the Clinical and Translational Science Awards Program of the US National Institutes of Health.

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Key messages

- Gender equity in research can contribute to social progress, scientific workforce sustainability, and the quality of science
- Research funders can be critical actors in advancing gender equity through policy interventions and funding incentives
- Linking NIHR funding to Athena SWAN gender equality action plans has been associated with a rise in the number of women in mid-level leadership positions and the proportion of funding going to women
- More research funders should trial policy interventions and funding incentives for women in science and evaluate their effect

Athena SWAN charter

The charter provides a peer review framework for developing action plans and gaining recognition for the advancement of gender equality in higher education and research. The charter, established in 2005, evolved from the work of the Athena Project, set up to promote diversity in UK science—in part a reaction to the experience of women such as Nobel prize winner Dorothy Crowfoot Hodgkin (right)—and the Scientific Women’s Academic Network (SWAN).

Institutions that commit to the charter establish self-assessment teams to collect and analyse evidence, identify priorities, and develop action plans using a framework for supporting and advancing women’s careers’ covering key transition points, career development, flexible working and managing career breaks, and organisation and culture.

Institutions and departments apply to have their applications and action plans peer reviewed by panels of academics, experts, and Athena SWAN professionals from other participating institutions. There are three levels of award: Bronze requires an assessment of gender equality and the issues facing the institution or department plus a four year action plan Silver recognises the successful implementation of the action plan and its demonstrable impact. Gold recognises beacons of achievement in gender equality and champions in promoting good practice in the wider community.
A disproportionately large pool of incumbent male leaders who seek repeated leadership terms more often than female leaders may partially explain the dearth of female directors.

Effect of funding incentives

After the introduction of the Athena SWAN incentives, the proportion of female theme leads increased to 24% (43/177) in 2016 from 8% in both 2006 (8/105) and 2011 (15/200). The proportion of women in senior director positions also increased from 11% (3/28) and 10% (3/31) in 2006 and 2011 to 15% (3/20) in 2016 (fig 1). The incentives seem to have increased the number of female theme leads but not the number of female directors.

Before the introduction of the Athena SWAN funding incentives the proportion of funding obtained by female theme leads was 5% in 2006 and 4% in 2011. This increased to 21% in 2016. The proportion of funding obtained by female directors increased from 2% in both 2006 and 2011 to 4% in 2016 (fig 2) but remained much lower than for male directors.

Leaky pipelines

One possible confounder for gender disparity in leadership positions is the pipeline effect. It is often suggested that once there are sufficient numbers of women entering universities and they are not discriminated against for admission into the pipeline, the under-representation of women at all levels in academic medicine will gradually disappear. To test this theory we estimated admission into the academic medicine pipeline using scientific age—that is, the number of years after the first publication. The scientific age of female and male theme leads (27 and 28, respectively) and directors (27 and 30, respectively) was similar in 2016 (see supplementary data for more detail).

Assuming the leads’ first publication occurred in the first year after graduation, they entered medical school around 1980 when female admissions to UK medical schools were already 40%.

Given that the proportions of female theme leads and directors are much lower than 40%, the pipeline appears to be leaking.

When we examined a leadership pipeline within research centres, we found that in 2016 65% (13/20) of directors and 40% (71/177) of theme leads had held these roles in previous rounds and that more men than women had repeated leadership terms (see supplementary data for more detail). A disproportionately large pool of incumbent male leaders who seek repeated leadership terms more often than female leaders may partially explain the dearth of female directors.

We also examined gender balance on the international selection panel for research centre awards. In 2006 and 2011, the panels were all male but in 2016, 20% (2/10) of panel members were women. However, we could not investigate the possible effects of this change empirically or draw conclusive inferences from previous studies. Whereas some studies reported gender bias in peer review, others found no association between the applicant’s gender and the reviewers’ gender.

One natural experiment suggested that gender equity in funding could be increased by focusing peer review on science rather than scientists.

Although there could still be other unmeasured confounders such as structural changes in the number of centres and their research themes, our analysis suggests that the introduction of the Athena SWAN incentives contributed to the accelerated advancement of women to theme lead positions and gender equity gains in funding. Data from the 2021 funding round will help establish whether there is a causal link.

Funding incentives for women in science

During the 2011 competition for research centre funding, Sally Davies, then chief medical officer for England and and chief medical adviser to the UK government, sought to encourage universities to accelerate women’s advancement and leadership in science. She stated that in the 2016 round of the competition the NIHR did not expect to shortlist any research centre where the academic partners had not achieved at least the Athena SWAN silver award.

NIHR’s policy intervention provided sufficient incentives for universities to develop and implement gender equality action plans. This coincided with a 10-fold increase in the number of medicine related Athena SWAN silver or gold awards in 2016 (one gold and 69 silver awards) compared with 2011 (seven silver awards). Moreover, several major funders and science organisations in Ireland, Australia, the United States, and Canada subsequently adopted modified versions of the Athena SWAN framework contexts.

NIHR removed the requirement for applicants to hold Athena SWAN awards in 2020, partly to reduce administrative burden during the covid-19 pandemic. It stated: “we believe that use of the [Athena SWAN] charter has led to the greater embedding of gender equality practice” and that the future focus for NIHR would be on the broader commitment to all dimensions of equality, diversity and inclusion. Applicants can still choose to evidence the relevant elements of this new broader commitment through the awards.

31 October 2020 | the bmj

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**Fig 1:** Percentages of female research leaders

**Fig 2:** Percentages of funding obtained by female research leaders
Critical actors

Our analysis shows the salience of “critical actor” leaders over “critical mass” for initiating change towards more gender equitable research leadership. Critical mass theory predicted that once the proportion of female academics reached 30–35%, changes in the sociocultural environment would trigger an increase in women’s leadership. However, recent research suggests that the promise of critical mass should be abandoned in favour of critical actors—“women and men, who individually and collectively have the commitment and power to create gender equitable cultures.”

Davies and NIHR were collective critical actors in introducing the Athena SWAN funding incentives, which were associated with important changes in NIHR funded research. Likewise, many committed leaders and the major national funders and science organisations acted collectively to lead the adoption of Athena SWAN principles globally.

Sally Davies, then chief scientific adviser at the Department of Health, and NIHR were collective critical actors in introducing the Athena SWAN funding incentives

Athena SWAN requires time to affect the numbers of female scientists because it seeks structural and cultural changes for all faculty and staff. Although Athena SWAN has been shown to be effective in challenging discrimination and bias, improving women’s visibility and leadership skills, and initiating structural and cultural changes, it has limitations in tackling longstanding tenure, power, and pay imbalances in the short term. Unintended consequences have also been reported with the project, such as perceptions of administrative burden, women undertaking a disproportionate amount of work, and gender taking priority over race and class.

Effective implementation of Athena SWAN seems to require sufficient commitment, time, resources, and professional expertise. The rise in women’s research leadership in NIHR funded centres contrasts with previous research in 35 medical schools that showed no changes in gender balance among faculty two years after the introduction of the funding incentives. NIHR funded centres had more favourable conditions and sufficient time to implement four year action plans. The linkage of Athena SWAN to the £816m funding scheme incentivised universities to commit time to leaders, faculty, and staff, invest internal resources, and employ equality and diversity professionals to implement action plans in friendly competition with their peers.

Realising the benefits of gender equity

The case for advancing gender equity in research is compelling. Equitable participation of all genders in research is imperative to social progress and legitimisation of public support for science. Drawing on the talents of all genders is also necessary for increasing the sustainability of the scientific workforce. Evidence suggests that gender diversity in groups is associated with greater problem solving and higher quality research.

A gender equitable scientific workforce can therefore enhance the quality of science. As women pursue collaboration and interdisciplinary research more often than men, gender equity can also improve team science. Moreover, health research led by women more often investigates sex and gender related variables than does research led by men. Gender equity in research leadership can therefore increase the scientific rigour and relevance of health research to women’s health.

Funders can advance gender equity in research through policy interventions and funding incentives. For example, the US National Institutes of Health championed inclusion of women and minority groups in clinical trials as research beneficiaries. The Canadian Institutes of Health Research led the world in integrating sex and gender in research as variables to reduce sex and gender bias among research beneficiaries. From 2021, the European Commission will require all public bodies applying to Horizon Europe—the European flagship €81bn research and innovation funding programme—to have gender equality action plans. More funders should assume the role of critical actor in trialling policy interventions and funding incentives for gender equity.

Evaluating interventions and incentives

Given the compelling case for gender equity and a lack of conclusive evidence on what works, for whom, and in what circumstances, we recommend evaluating the effect of Athena SWAN longitudinally using quasi-experimental designs, investigating any rare or unintended consequences, and testing its efficacy for other dimensions of diversity and inclusion. NIHR should consider the pros and cons of term limits for research leaders: refreshing leadership, encouraging innovation, and increasing diversity versus introducing disruption and inhibiting the development of expertise. Finally, NIHR can experiment with the gender composition of interview panels for research centre funding and facilitate evaluation by including in non-blind applications leaders’ gender and previous leadership terms.
LETTERS
Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Transferring adults to paediatric services
Oliver discusses some ethical issues that arise from changing pathways of care to manage demand (David Oliver, 3 October). In the first wave of covid-19, Alder Hey Children’s NHS Foundation Trust accommodated adults in its paediatric intensive care unit, which required novel ethical decision making.

Anticipating major pressures on services, our institution formed a clinical decision making committee and a clinical ethics committee. This multidisciplinary team met daily to provide guidance and support and to tackle any ethical matters that arose. A substantial concern remains, however, regarding the lack of consent for transfer of critically ill patients to units that do not usually treat adults.

The GMC’s new decision making and consent guidance intends to foster shared decision making so that patients can make healthcare decisions that are right for them. This almost directly contradicts the pandemic mindset that resource allocation is a key part of distributive justice from a utilitarian perspective. Many patients accept that usual services might not be available in the event of unprecedented demand. With the rise in patients with covid-19 requiring hospital admission in the north west of England, could transfer of adult patients into paediatric intensive care units be justified again?

Staff in the paediatric intensive care unit were extensively supported by adult colleagues from other sites in Liverpool, but the definite quality of care provision is not quantifiable, and mortality cannot be compared between sites, so the care received cannot be proved to be equal or superior to that provided by our adult counterparts. The moral injury suffered by repurposed healthcare workers has been documented.

Can we expect staff to seek informed consent from patients for their transfer between hospitals when the objective details of outputs and outcomes are not yet appreciated by the staff themselves?

Thomas Hampton, otolaryngology specialist registrar; Victoria Sadlers, paediatrics specialist registrar, Liverpool

Cite this as: BMJ 2020;371:m4089

COVID-19 IN SWEDEN AND UK

Medical leadership should energise wider debate
Scally’s opinion that we have nothing to learn from Sweden is disappointing (This Week, 3 October). When cases rose we locked down the UK, prioritised care of those with covid-19 over society, and generated fear by telling people they were at extreme risk. Despite this, outcomes were poor for those who were hospitalised. Overall, however, the vast majority recovered.

Lockdown stops transmission. In a country that depends on external trade it will return. A vaccine is at least a year away. The lives “saved” in the first lockdown will be lost in a subsequent wave. The long term effects of lack of education, social development, or a job are not counted in the same way as acute deaths.

UK policy fails because it delays acute deaths at great national cost. We need honest public debate to co-produce a new solution. Politicians seem focused on acute care: medical leadership must energise wider debate, not close it down.

Andrew Spooner, GP locum, Crewe

Cite this as: BMJ 2020;371:m4066

Life is a casino: risk is the game
Excess death is the only hard number we have for covid-19. In the UK, there is a surge in cases but not deaths.

We must establish a true case fatality rate. Government estimates suggested a rate of 0.4%, but if the known number of cases is only half because of asymptomatic carriage then it is more likely to be 0.2%. If the rate is 0.2%, then 42 000 deaths means roughly 21 million cases in the UK—a number in keeping with the virus being in the country earlier than thought and a higher R number. This would indicate we are developing herd immunity and won’t see a second spike like the first.

Experts are risk averse; but life is a casino, best we know the odds. First principal fact—the epidemiological numbers are unknown.

Des Spence, GP, Glasgow

Cite this as: BMJ 2020;371:m4068

COVID-19: SHIELDING VERSUS BLANKET POLICIES

We can avoid lockdown without herd immunity
All scientists who argue for caution share Sikora and colleagues’ desire for normality (This Week, 26 September). But even if we optimistically assume that immunity persists after infection and that vulnerable people can really be shielded, infecting, say, half the 35 million 20-59 year olds in the UK would have serious consequences. Conservatively, there would be 10 000 deaths, 50 000 hospital admissions, and hundreds of thousands of people with long covid.

No countries have shown that they can shield vulnerable people when community transmission becomes widespread because people at high risk are cared for by young health and social care workers or family members. But our choice is not binary between lockdown and herd immunity. We could avoid national lockdown with an improved find-test-trace-isolate-support system, sensible social distancing, high usage of masks, good border control, and clear communications that engender public trust. These are all feasible in well governed, high income countries.

K K Cheng, director, Institute of Applied Health Research, Birmingham

Cite this as: BMJ 2020;371:m4051
A recent meta-analysis indicates that clinical decision support is effective in low resource settings.

Cite this as: J F Cosgrove, consultant in anaesthesia and intensive care, Newcastle upon Tyne

Burman and colleagues question the extent of decision support developing guidance at short notice. Bassford, consultant in acute and intensive care medicine, University Hospitals. Coventry and Warwickshire NHS Trust; on behalf of 7 others. Simon Conroy, clinical lead for frailty networks, NHS Elect; Christopher Penda Health, Nairobi. Santhanam Sundar, consultant oncologist, Nottingham. Don’t torment me with hope. Filby’s painful experience around her father’s death emphasises the need for more open and upfront conversations about prognosis and death (What Your Patient Is Thinking, 12 September). Society doesn’t embrace death rationally, and oncologists are no exception. Honest conversations about death don’t mean extinguishing hope when discussing treatments for incurable disease. Hope helps to dissipate anger and frustration. Hope keeps the cloud of despair at bay as the painful journey progresses towards acceptance of death. Many patients prefer the “cup half full” type of hopeful honesty over “cup half empty” pessimism. Many patients with cancer undergo palliative chemotherapy for small survival benefits even after an open honest conversation about benefits and risks. Furthermore, not all cancers behave in the same way, and prognosis of advanced cancers is dependent on response to treatment. Hoping for an optimistic outcome is the default coping mechanism of many patients and their oncologists.

Cite this as: BMJ 2020;371:m3904

CLINICAL DECISION SUPPORT SYSTEMS

Effective in low resource settings

A recent meta-analysis indicates that clinical decision support is associated with only modest improvements in healthcare quality (Research, 19 September).

We are successfully implementing clinical decision support systems in a low resource ambulatory care setting in Kenya. Clinical decision support is likely to be far more effective in low resource settings than the existing literature suggests.

Cite this as: BMJ 2020;371:m3952

DON’T TORMENT ME WITH HOPE

In defence of hope

Filby’s painful experience around her father’s death emphasises the need for more open and upfront conversations about prognosis and death (What Your Patient Is Thinking, 12 September). Society doesn’t embrace death rationally, and oncologists are no exception. Honest conversations about death don’t mean extinguishing hope when discussing treatments for incurable disease. Hope helps to dissipate anger and frustration. Hope keeps the cloud of despair at bay as the painful journey progresses towards acceptance of death. Many patients prefer the “cup half full” type of hopeful honesty over “cup half empty” pessimism. Many patients with cancer undergo palliative chemotherapy for small survival benefits even after an open honest conversation about benefits and risks. Furthermore, not all cancers behave in the same way, and prognosis of advanced cancers is dependent on response to treatment. Hoping for an optimistic outcome is the default coping mechanism of many patients and their oncologists.

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The tax on wax

Salisbury describes the way GPs have contributed to cutting the essential service of ear wax removal (Helen Salisbury, 19 September).

An important cause of temporary deafness, ear wax also affects orientation, balance, and safety. It disproportionately affects older people, particularly those wearing aids, but also bus drivers, pilots, and construction workers. Relief is usually immediate.

How did the idea that it’s “not part of our contract” develop? Around four million ears are irrigated annually—this service could not be provided by ENT departments.

Some GPs recommend non-NHS services, costing up to £70 a session. This is unacceptable and unaffordable for many. Without public consultation, primary care is making people pay for services directly rather than through their taxes. This breaks a key understanding of the meaning of the NHS.

Cite this as: BMJ 2020;371:m3917

Be wary of which patients are affected

Patients are likely to be aware that many GP services have a low priority. It is ironic that an older patient who has become socially isolated and depressed from difficulty with hearing might be a candidate for antidepressants and counselling but not a less time consuming, simple, and curative procedure. If we want to keep the public on our side we need to be wary about which services are withdrawn, which new tasks are added to the workload, and whether the patients most likely to be affected are the most vulnerable and least able to influence the system.

Cite this as: BMJ 2020;371:m3952
OBITUARIES

John Derek Rickinson
General practitioner
(b 1927; q King’s College Medical School, Newcastle, 1950; MRCGP), died from Alzheimer’s disease and a fractured acetabulum on 30 June 2020

John Derek Rickinson was in singlehanded practice at first and then joined Prospect House Medical Group as a trainer. He did medical boards and was secretary of the Newcastle local medical committee and chairman of the area health authority for some years. He also gave anaesthetics for a local dentist and at St Nicholas Hospital in Gosforth. He was factory doctor for Unilever at Domestos and at Commercial Plastics at Cramlington. In retirement in Scarborough he continued to do medical boards in Scarborough and York and did domiciliary visits in a large area and continued to work till he was 79. He was diagnosed with Alzheimer’s in 2017 and died after a fall. He leaves Brenda, his wife of 68 years; four children; and two grandchildren.

Brenda Rickinson
Cite this as: BMJ 2020;370:m3361

Ian B Pearson
Consultant psychiatrist
(b 1931; q Sheffield 1955; MD, DPM RCP, MRCPsych), died from multifactorial issues associated with type 2 diabetes mellitus and old age on 30 June 2020

Ian B Pearson worked in academic research, teaching, and clinical posts at Sheffield University and Saxondale Hospital, Nottinghamshire. During the 1970s Ian was consultant psychiatrist at Nottingham University’s department of psychiatry at Mapperley Hospital. From 1977 he worked in clinical research for Roche Products in Hertfordshire. Ian resumed clinical practice in the 1980s and until retiring in 1993 was consultant psychiatrist at the Crichton Royal Hospital, Dumfries. Ian was living in Lockerbie, Dumfriesshire, in December 1988, when the bombed PanAm plane crashed (BMJ 1989;298:127-8). He helped colleagues, emergency service workers, and residents with post-traumatic stress disorder. He leaves two children and two grandchildren.

Tamsin Pearson
Cite this as: BMJ 2020;370:m3360

Timothy George Frankau
GP Dursley, Gloucestershire
(b 1950; q St George’s Hospital, London, 1973; DObst RCOG, DA, FP(cert)), died from squamous cell carcinoma on 9 July 2020

Timothy George Frankau (“Tim”) was a GP principal in Dursley from 1978 until he retired in 2010. He was also an active member of the Gloucestershire local medical committee and a valued and respected town councillor for nearly 30 years. He acted as president of the Dursley Chamber of Commerce in 1991, was town mayor from 2003 to 2005, and also served on Stroud District Council. Tim enjoyed sporting events, real ale, and classic cars. Always keen to enjoy a pint with locals at the Old Spot pub, Dursley residents remember Tim fondly as their very own “Doc Martin.” Predeceased by his first wife, Patricia, in 1995, he leaves his wife, Sonya; a brother; two children from his first marriage; and two grandchildren.

Jude Frankau, Caroline Frankau
Cite this as: BMJ 2020;370:m3355

Martin Thornton Tanner Bryant
Consultant anaesthetist
(b 1934; q Cambridge 1960; FFA RCS), died after a myocardial infarct on 22 July 2020

After working as a GP in Exeter for nine years, Martin Thornton Tanner Bryant returned to the London Hospital to train as an anaesthetist. Once appointed as consultant anaesthetist to the Queen Elizabeth Hospital, King’s Lynn, he started a pain clinic. Martin moved to St Albans and Hemel Hempstead hospitals in 1981, where he set up another pain clinic. As clinical tutor, he was instrumental in establishing the postgraduate centre. He retired in 2000. His professional qualities of empathy, selflessness, and meticulous attention to detail proved invaluable assets in his work for charities and in his hobbies of furniture upholstery, book binding, and gardening. He leaves his wife, Maureen, whom he married in 1972; their two sons; and two grandchildren. He also leaves two sons from his first marriage.

Maureen Bryant, Michael Ormiston
Cite this as: BMJ 2020;370:m3354

Norman Hugh Moore McKinney
General practitioner
Morecambe (b 1933; q Pembroke College, Oxford, 1958; MRCGP), died from pneumonia on 3 January 2020

Norman Hugh Moore McKinney (“Hugh”) did his national service in Hong Kong and the New Territories. He then joined his father in practice in Morecambe and started what was to become over 30 years of involvement in the local community, not just as a GP but in many other ways. He was also the GP member of the health authority and other committees and helped to get the new Morecambe Health Centre built. Retirement gave him more time for his hobbies. He was a keen gardener, played golf, and was an excellent croquet player. He and his wife, Pat, travelled the world and made good use of the BMA overseas conferences. Sadly, his last few years were impaired by increasing loss of memory. He leaves Pat, three children, and nine grandchildren.

Miles Rucklidge
Cite this as: BMJ 2020;370:m3357

David George Edwin Wood
General practitioner
Conwy (b 1946; q Bristol 1969; MBE, FRCP), died from covid-19 and complications of a stroke on 13 July 2020

David George Edwin Wood (“Woody”) was a GP trainer and course organiser in Bangor, north Wales, before moving to Llys Meddyg in Conwy, where he pursued his interest in medical education. As associate dean for Cardiff University, he championed the All Wales non-principals scheme, ran a course for local GPs, and was the driving force behind a project to bring medical students from Liverpool into north Wales. Rather than specialise, he brought his skills in ophthalmology into the practice. Despite a diagnosis of inoperable carcinoma of the oesophagus in December 2018, he continued to work through palliative chemotherapy until forced to self isolate in March 2020. He leaves his wife, Pat; two sons; two stepchildren; six grandchildren; his sister; and her family.

Bridget Osborne
Cite this as: BMJ 2020;370:m3362

The BMJ 2020;370:m3360

The BMJ 2020;370:m3355

The BMJ 2020;370:m3354

The BMJ 2020;370:m3357

The BMJ 2020;370:m3362

The BMJ 2020;370:m3361

The BMJ 2020;370:m3360
OBITUARIES

Tony Keable-Elliott

GP who turned around the fortunes of the BMA

Tony Keable-Elliott (b 1924; q 1948), died from pneumonia in hospital on 25 July 2020

When Tony Keable-Elliott was BMA treasurer he increased the association’s reserves more than sevenfold, from £1.9m in 1981 to £15.2m in 1987, converting the Great Hall and updating rooms so they could be commercially let.

Honouring the achievement in July 1987, Stephen Lock, then editor of The BMJ, wrote that when Keable-Elliott came to office, “The Great Hall was ridiculed as the most expensive badminton court in Europe; empty day after day because it failed to meet acceptable standards of acoustics, warmth, or fire safety.”

BMA

Keable-Elliott overcame many obstacles to achieve a cleaner, brighter, financially viable building, with humanity and his characteristic “moderate medicopolitical stance,” Lock added.

“Tony literally turned things round when membership had fallen below 50% and the association was on the brink of bankruptcy,” said John Marks, a contemporary of Keable-Elliott’s and chairman of council from 1984 to 1990. “He had finance at his fingertips, was a wonderful negotiator, and won us a brilliant pension scheme. He was also warm, and completely trustworthy.”

This approach left its mark with at least one of the politicians he negotiated with. Barbara Castle, Labour secretary of state for health and social services from 1974 to 1976, and a neighbour in Ibstone, Buckinghamshire, remained a friend until her death in 2002. “There was a certain amount of negotiation over the garden fence, and Tony came to trust her,” said his son, Simon.

Keable-Elliott, who has died at the age of 95, joined the BMA in 1948—the year he went into general practice in Stokenchurch, Buckinghamshire, where he would remain until he retired in 1987. He went on to become a member of council and served for 20 years, and he was chairman of the General Medical Services Committee (GMSC) from 1974 to 1980. He also served as chairman of the journal committee and was awarded an OBE in 1988 and the BMA’s gold medal in 1993. He served on the GMC, was a Freeman of the City of London, and was a member of the Society of Apothecaries.

His competence won him wide respect. When he announced his intention to stand down from the GMSC chairmanship, at the local medical committees’ conference dinner in 1980, “the effect was rather as if Margaret Thatcher had made a similar departure from the head of the Tory party,” a leader in GP magazine noted.

Early life and family

His start in life was as unusual as the rest of it proved stable. His parents, Robert Keable and Jolie Buck, who never married, met in France during the first world war when Keable, a writer and former missionary, was serving as an Anglican army chaplain, and Buck, the 18 year old daughter of a retired colonel, was driving an ambulance.

Their affair would form the basis of Keable senior’s successful novel, Simon Called Peter. Published in 1921, it sold in thousands and in the words of critic, Hugh Cecil, “took a tilt at Victorian sexual hypocrisy and conventional English religion.” Keable himself said: “I laid a parson’s life bare and didn’t give damn.” F Scott Fitzgerald alluded to the book in his novel The Great Gatsby.

After the war Keable left his wife, religion, and ministry to set up home with Buck in Tahiti. When Buck became pregnant in 1924 they returned to England hoping for a safe delivery. But Buck died giving birth, prematurely, to their son, Tony, in November 1924. She was 25. Keable, whose health was failing, returned to Tahiti without the baby, who was deemed too frail for the journey, and he died there three years later, aged 40.

Tony was raised, although never formally adopted, by friends of his parents—Jack Elliott and his wife, Rita. Elliott, like his father before him, was a GP in Stokenchurch, Buckinghamshire, and Tony spent much of his youth going out on calls with him. He decided to add Elliott to his birth name while still a teenager and never, according to one of his sons, considered becoming anything other than a GP.

He went to Sherborne School, Dorset, where he was a house prefect and a corporal in the junior training corps. At Guy’s Hospital Medical School he was assistant editor of the hospital gazette.

His wife Gilian died in a car accident in 2011. He leaves four sons, eight grandchildren, and five great grandchildren.

Keable-Elliott had finance at his fingertips and was a wonderful negotiator

BMJ

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