The bumps on the road out of the tunnel

At the start of this new year, even as we’re buffeted by news of a more infective strain of covid, it feels at times as if we’re nearing the end of a long tunnel, with light just around the corner. Vaccines are being approved, and the health service is ramping up systems to ensure that vulnerable groups are protected.

The controversy around who is prioritised for vaccinations was probably to be expected, given all of the opinions, vested interests, politics, and stupidity surrounding discussion of the pandemic. While we dithered, weighed up evidence, and debated, more healthcare professionals lost their lives.

What’s surprised me is the reluctance of many organisations to highlight this issue. Any modelling should have shown the risk to hospitals, especially as the main thing the health and social care systems could ill afford to lose is staff. Yet, a month or so after the fanfare of being the first in the world to administer the vaccine, the NHS still doesn’t have its staff fully covered.

Another tricky area has been prioritising people from ethnic minority backgrounds, whether healthcare staff or the population at large. Casual comments that the disproportionate impact of covid among ethnic minorities was simply linked to deprivation brought back memories of April, when data started emerging about increased risk to this population group. Many people wonder what “white privilege” is. In this instance, it’s a national committee making recommendations for vaccine prioritisation that make only a cursory mention of ethnicity (and even then not in criteria for prioritisation) and a system believing that this would suffice; that ethnicity would be taken into account anyway, even if it’s not highlighted specifically in national recommendations.

The absence of a national steer always opens things up to variation from local leadership. And, sure as clockwork, we now have variation in vaccination rates, depending on local leaders’ willingness to recognise ethnicity as a risk factor. When we know about the increased risk to people from ethnic minority backgrounds, and the lack of senior healthcare workers from those backgrounds, the silence from many, yet again, has been deafening.

Add the conundrum of Public Health England’s decision to space out one vaccine’s dosing schedule based on data from another vaccine, and any nervousness is understandable. Undoubtedly, supply constraints have forced these decisions, but the dosing delay could turn out to be a masterstroke or a tumble of epic proportions.

And, yet, still there’s a palpable sense of hope and pride in how the NHS continues to step up. There is hope that, come springtime, we may be in a significantly stronger position. For everyone involved in the fight against covid, the past year has been an effort and a half, and we’re due a big party to celebrate. Let’s hope it’s just a whisker away.

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While we dithered and weighed up evidence more healthcare professionals lost their lives
PERSONAL VIEW Stephen Reicher and John Drury

The misrepresentation of covid rule adherence

Not following the rules is a matter of practicality, not psychology

The notion of behavioural fatigue associated with adherence to covid restrictions (“pandemic fatigue”) has been a recurrent theme throughout the crisis.

It was invoked before the first wave last March as a reason to delay restrictions. It was invoked in October as a reason to delay the imposition of the circuit breaker called for in September. It was invoked in December as a reason to loosen restrictions over Christmas.

In October, a Google search found some 200 million mentions of the term “pandemic fatigue.” The figure has risen to over 240 million. It is a term that has entered the academic and the popular lexicon.

Linked to the notion that people find it hard to adhere to the rules because of psychological frailties is the idea that personal failings lead individuals to break the rules. They are either too weak, too stupid, or too immoral to do the right thing. Hence, terms like “covidiots” have become as familiar as “pandemic fatigue.”

This feeds into a narrative of blame whereby the spread of infections is explained in terms of those who choose to break the rules. They are either too weak, too stupid, or too immoral to do the right thing. Hence, terms like “covidiots” have become as familiar as “pandemic fatigue.”

This narrative is exemplified by politicians. For instance, in his address to the nation on 22 September, Boris Johnson spoke of people “flouting” and “brazenly defying” restrictions. It is also exemplified in a media focus on particularly egregious examples of violations, such as large house parties. This narrative explains the worsening pandemic in terms of widespread non-adherence to rules which is a function of poor psychological motivations, which in turn are particularly prevalent in some people and some communities.

Each of these assumptions is both problematic and dangerous.

Extremely high adherence

Let’s start with levels of adherence. To the surprise of many, adherence has remained extremely high (over 90%), even though many people are suffering financially and psychologically. Equally, despite anecdotal observations both self-reported data and systematic observations of public behaviour suggest adherence stayed high in the second lockdown. At least 90% of people adhere to hygiene measures, to spatial distancing, and to mask wearing most of the time. Moreover, people generally support the rules and, if anything, believe they should be more stringent and introduced earlier. In the past few days, 85% of the public have endorsed the January lockdown and 77% think it should have happened sooner.

The way in which adherence has been portrayed and understood has been spectacularly wrong

Even among those groups who have been singled out and blamed for irresponsible behaviours, such as students, systematic analyses reveal another picture. ONS data reveal very high levels of adherence to social distancing, very low levels of social mixing, and that students were far more likely than the general population to avoid leaving their accommodation altogether.

The discrepancy between what people are doing and what we think people are doing points to the “availability effect.” That is, we judge the incidence of events based on how easily they come to mind—and violations are more memorable and more newsworthy than acts of adherence. So, we develop a biased perception of the level and type of violations, which runs the risk of becoming a self-fulfilling prophecy. If we believe the norm is to ignore the rules, it may lead us to ignore them too.

There is, however, one key area where perception is not at odds with reality. That concerns levels of self-isolation in those who are infected or their contacts which are estimated to be around 18%. Unlike hand hygiene and social distancing, self-isolation routinely ignored, distorted, or manipulated

The virus thrives as our government steadily loses public trust. The UK is seeing over 1000 covid-19 deaths a day, our policies are failing, and we are doing as badly as anywhere. Meanwhile, our government consoles us with rosy pictures of vaccination bringing normal life within months. It’s another optimistic projection disguising negligent failure.

Failures veiled by hopeful half truths have been our diet for nearly a year now. Vaccination will of course be a relief for many people but it will not be enough on its own. Nor can it disguise the inexusable lack of effective, basic public health tools. We don’t test effectively, find enough contacts, or support enough people to isolate. Basic principles of science and public health are routinely ignored, distorted, or manipulated by a government seduced by new technology and privatisation. Both the media and scientific and medical professionals can see the poor public health policy and bad science happening before us, but they too often fail to call out these obvious deficiencies.

The new covid-19 variant is exploiting public health failures. We have good surveillance but we don’t have the tools to use the data. In March we had no proper strategy, a delayed lockdown, inadequate personal protective equipment, and discharge to care homes, and we gave up on contact tracing. Now, we still have no

BMJ OPINION Bing Jones

The virus thrives on half truths and lies

Basic principles of public health are ignored, distorted, or manipulated

The virus thrives as our government steadily loses public trust. The UK is seeing over 1000 covid-19 deaths a day, our policies are failing, and we are doing as badly as anywhere. Meanwhile, our government consoles us with rosy pictures of vaccination bringing normal life within months. It’s another optimistic projection disguising negligent failure.

Failures veiled by hopeful half truths have been our diet for nearly a year now. Vaccination will of course be a relief for many people but it will not be enough on its own. Nor can it disguise the inexusable lack of effective, basic public health tools. We don’t test effectively, find enough contacts, or support enough people to isolate. Basic principles of science and public health are...
requires support from others, most obviously in the form of shopping. It also requires material support in the form of an income and sufficient space. The lower adherence rates for self-isolation suggest the problems may have less to do with psychological motivation than with the availability of resources. This accords with data from the first lockdown showing that the most deprived people were six times more likely to leave home and three times less likely to self-isolate, but that they had the same motivation as the most affluent to do so. Non-adherence was a matter of practicality, not psychology. It also accords with the fact that in those places where support is given (as in New York, where people are provided with money, hotel rooms, food, mental health support, and pet care) adherence is as high as 95%.

The way in which adherence has been portrayed and understood has been spectacularly wrong. If anything, the headlines should not highlight fatigue and covidiots but the remarkable and enduring resilience of the great majority even in the absence of government support and guidance.

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strategy; have only flawed, slow testing (waiting for patients to come forward is silly); flawed, slow tracing; a gross lack of support for people to isolate; unsafe schools; and a dubious Moonshot mass testing programme. Test and trace is heavily privatised and local services have only token powers.

We will get through the pandemic. But government misrepresentation is a threat to modern society that must be excised for the sake of this and future crises.

Any government addicted to half truth is dangerous. But an even greater threat is for scientific and medical professionals to tolerate these falsehoods. We must learn to speak the whole truth.

Bing Jones, former associate specialist in haematology, Sheffield

**ACUTE PERSPECTIVE**

David Oliver

Is filming on covid wards a good idea?

Simon Stevens, NHS chief executive, has publicly condemned undercover filming on camera phones inside NHS hospitals. Footage has been posted online in a twisted attempt to show that covid-19 pressures are exaggerated, fake news. Stevens was visibly angry about the impact on staff doing difficult jobs and the spread of disinformation.

Many healthcare workers, whose morale is suffering at the hands of people who think covid is a hoax, were encouraged to hear him speak out so strongly. Since then the Times has published a story about organised groups of secret filmers claiming the pandemic to be a “hoax,” and Facebook has taken down one of their sites.

In parallel, I’ve seen calls in social media to “let the cameras onto wards so the public can see what’s going on.” Those calls are not just self-interest. Professional journalists know that infographics or talking heads never have the same visceral impact as footage of sick and dying patients attached to masks, drips, and tubes, with full wards and stressed staff in PPE.

Self-appointed citizen journalists with smartphones post from outpatient areas (where ambulances are handing over patients to wards is necessarily a good idea. If you take away the heavy PPE and the greater use of oxygen and ventilation than in a normal winter, a full and buzzing emergency department or ICU looks the same as ever.

There is real impact from interviewing sick patients still suffering with covid. Sadly, this seems more impactful if they’re young and previously fit (although Glasgow University researchers have found that covid takes an average 10 years off life expectancy in the people it kills). Staff looking broken and tearful, and speaking from the heart about their distress, can also be powerful.

But, if the purpose of letting cameras in is to win over covid deniers, conspiracy theorists, and lockdown sceptics, it simply won’t. Wouldn’t we be better deployed doing our jobs without the hindrance of camera crews and reporters—however professional and sensitive—than trying to combat disinformation among a vocal minority who routinely refuse to believe the experts?

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Secret films are a nasty attempt to undermine confidence in health protection measures
Primary Colour Helen Salisbury

Keeping vaccinations local

The vaccination rollout began with intense activity, as we prepared to use a whole pack of Pfizer-BioNTech vaccine (1170 doses) within 3.5 days of delivery, with short notice about when it would arrive. Late on a December evening our GPs worked through lists of older patients, ringing to offer appointments to use the precious sixth dose in each vial that had just been sanctioned.

Anxiety kept some of us awake the night before our first clinic: could we really vaccinate 900 people in a day? We had 55 chairs, spaced two metres apart throughout our building, and six vaccination teams consisting of an admin person and a clinician. We had two dilution teams, two organisers, and greeters from our patient participation group. After hearing many reports of problems with Pinnacle (the IT package we were meant to use to record the vaccinations) and fearing that glitches would slow us down, we opted for an old fashioned but reliable paper system, inputting the data later.

It was a long, tiring, joyous day. I hadn’t realised just how much I missed the waiting room hubbub and seeing patients and colleagues from other practices face to face. Since then we’ve delivered our second Pfizer batch, with fewer staff now we know what we’re doing.

We’re now receiving the Oxford-AstraZeneca vaccine, which is much easier to handle. It can be stored in an ordinary fridge for six months, and we can use one vial at a time, containing 10 (or possibly 11) doses. Best of all, there’s no requirement to observe patients for 15 minutes after they receive the vaccine, so we can set up walk-through clinics. This cuts the risk of transmission and speeds up delivery. It also takes up less space, so we can have vaccine clinics on weekdays with less disruption to normal work.

The limiting factor is now supply. We’ll receive 300 doses this week, but we could use many more. There are reports on social media of primary care networks that have had no supply at all. I understand the vaccine should be shared out evenly if there’s a supply problem, so the most vulnerable people are treated in each area. What I don’t understand is the rationale for mass vaccination centres. Patients are receiving invitations to centres many miles from home. Unless they can drive, journeys will require sharing a car or public transport, both of which are infection risks.

GP have excellent databases of their patients, as well as knowledge about their particular needs—who is deaf, who needs help with mobility, or who has cognitive impairment—and contact details of relatives or carers where relevant. We are trusted, local, ready and willing, waiting to give vaccines. If supply is limited, why is it going to distant, anonymous mass vaccination hubs, rather than the practice down the road?

Why are patients receiving invitations to centres many miles from home?

Emotional support during the pandemic

With many NHS and social care staff taking on greater burdens at work during the pandemic, the Samaritans have launched a dedicated support line just for them. In this podcast, Ben Phillips, head of service programmes for the Samaritans, explains how the charity is there to help, however people are feeling:

“We’re there to take calls from people if they’re in crisis, but not just from people who are in crisis. We’d much rather people engage early and use the service. In terms of healthcare professionals, there is still that almost self-inflicted stigma about coming forward sometimes and how they may see themselves as caregivers rather than care receivers. But we are all human, and I don’t think it’s ever a sign of weakness for you to be self-aware, to consider, and to reach out for help or support from someone else.”

Transmission and testing

The latest Talk Evidence podcast focuses on transmission of SARS-CoV-2, with Allyson Pollock, professor of public health, arguing that the narrow focus on asymptomatic mass testing has been misplaced:

“A test is a test, but what is the intervention that follows? The only intervention that can follow is isolation and contact tracing from that. And that means that you have to give people financial support and adequate housing because we know most transmission is occurring within households, especially at the moment. So you have to ensure that people actually do isolate and are supported to do so, and that is what is not happening. It has been another failure of contact tracing. If we had just got the basics right, we wouldn’t be in this mess now.”

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

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The Covax Facility (Covax) is a multilateral initiative aimed at ensuring that all countries have “fair and equitable access” to covid-19 vaccines. Co-led by Gavi, the Vaccine Alliance (Gavi), the Coalition for Epidemic Preparedness Innovations (CEPI), and the World Health Organization (WHO), Covax is a voluntary arrangement that enables countries to pool their resources and risk by collectively investing in vaccine candidates while developing the political and logistical infrastructure needed for distribution. Most importantly, Covax ensures vaccines financed through the initiative will be allocated in a transparent and coordinated manner.

In September 2020, WHO delineated its plan for allocating vaccines through Covax. Under the plan, vaccine doses would initially be allocated to participating countries in proportion to their population size. Only after each country receives vaccine doses for 20% of its population would countries’ covid risk profiles be considered in a subsequent phase of distribution. Countries participating in Covax are permitted to pursue bilateral contracts with vaccine manufacturers like the one between the UK and Pfizer-BioNTech. Many countries, high income and even low-middle income countries, such as Indonesia and Vietnam, have secured vaccine through bilateral agreements. Proportional allocation of vaccines through Covax is fairer and more efficient than an uncoordinated approach in which countries compete in the market to secure as much vaccine as possible for their own citizens. But proportional allocation fails to meet WHO’s own ethical principles for vaccine allocation.

An alternative approach to vaccine allocation, which we call the Fair Priority Model, would be better aligned with WHO’s stated values and better suited to realising Covax’s promise of fair and equitable access to covid vaccines. Overcoming vaccine nationalism

The commitment to international cooperation embodied in Covax is critical to preventing a future dominated by “vaccine nationalism,” in which rich countries bid against each other to secure bilateral contracts with vaccine manufacturers and stockpile vaccine doses for their own citizens. Such vaccine hoarding by high income countries would be unfair because it would profoundly disadvantage people living in low income countries that lack the resources to procure vaccines for their citizens. It would also be inefficient because it would fail to allocate vaccines to countries with the greatest need and greatest potential for harm reduction, unnecessarily prolonging the global pandemic and causing many preventable deaths.

Compared with vaccine nationalism, the WHO plan for proportional allocation would be a major improvement in fairness and efficiency. First, it would ensure that each of the more than 170 countries participating in Covax would receive some vaccine in the initial phase of distribution—first for 3% of their population, with priority to health personnel, then for 20% of their population, with priority to high risk groups—regardless of their ability to pay. Second, modelling suggests that proportional allocation would be more efficient than an unregulated market and is likely to reduce preventable deaths due to covid-19. Modellers recently compared a
scenario in which the first two billion doses of covid-19 vaccine (assumed to be 80% effective two weeks after administration) are hoarded by the 50 wealthiest countries to one in which vaccines are distributed to all countries proportional to their population. They concluded that proportional allocation would avert nearly twice as many preventable deaths as hoarding by rich countries. Although there are substantial uncertainties about the effectiveness in real life circumstances of the vaccines that will eventually be produced—whether they will reduce the risk of transmission or death, in which groups, and how long immunity will last—these results support the comparative efficiency of the Covax model.

Limitations of proportional allocation

Despite its fairness and efficiency advantages over vaccine hoarding, proportional allocation falls short of key ethical principles in the WHO’s Strategic Advisory Group of Experts’ (SAGE’s) own ethical framework for covid-19 vaccine allocation. Covid vaccines ought to be distributed according to their most likely function to reduce death and serious economic and social harms. Distributing vaccine in proportion to a country’s population might be a plausible way to implement equal concern in other contexts, but it is unjust for covid-19. The SAGE framework incorporates six fundamental values: human wellbeing, equal respect, global equity, national equity, reciprocity, and legitimacy. Proportional allocation is poorly aligned with many, particularly the most substantive, of these ethical principles.

First, human wellbeing aims to “reduce deaths and disease burden” and “societal and economic disruption” due to covid-19. WHO’s proportional allocation would require sending substantial quantities of vaccine to countries that have a relatively low risk of death, disease, and social and economic disruption due to covid-19, such as New Zealand, Kenya, Senegal, South Korea, and Thailand instead of prioritising countries most affected by the pandemic, where the potential for harm reduction from a vaccine would be far greater, such as Mexico, Brazil, Iran, and Ecuador.

Second, equal respect aims at treating “the interests of all individuals and groups with equal consideration.” Treating people identically regardless of their circumstances is not equal respect. Rather, this principle requires responding to people’s different needs with equal consideration. Those living in countries hardest hit by the pandemic have greater need for vaccines, in terms of both health and the economy, than those living in less severely affected countries. Proportional allocation fails to account for these differences in need and thus fails to treat people with equal respect.

Finally, global equity requires ensuring “that vaccine allocation takes into account the special epidemic risks and needs of all countries, particularly low and middle income countries.” Ironically, proportional allocation disregards countries’ special risks and needs. It pays no particular attention to the situation of individuals in low and middle income countries, who may have greater need for a vaccine than those living in other countries that are able to mitigate the most serious risks of the pandemic through effective public health measures.

The Fair Priority Model

As an alternative to WHO’s proportional allocation scheme, we developed the Fair Priority Model (box). This model is better aligned with the SAGE group’s fundamental ethical principles of human wellbeing, equal respect, and global equity. The Fair Priority Model has three stages of vaccine distribution. The aim of the first stage, assuming that vaccines will reduce mortality risk, is to reduce premature deaths caused directly or indirectly by covid-19 using standard expected years of life lost (SEYLL) averted per dose as a metric. SEYLL is commonly used in global burden of disease estimates. It calculates life years lost compared with a standardised global reference life table. Allocating vaccine on the basis of SEYLL averted promotes the principle of human wellbeing by directing vaccine to the countries where it will save the most life years. It promotes the principle of equal respect by valuing a life saved at a given age identically, regardless of the country in which it occurs. Finally, because SEYLL’s are standardised to the world’s highest life expectancy, the lower life expectancy in many poorer countries is not taken as a reason to deprioritise those countries, which would violate the principle of global equity. Instead, by saving more life years, using SEYLLs would prioritise those living in the most disadvantaged countries.

In the second phase of distribution, the model takes serious economic and social
harm caused by covid-19 into account by adding two socioeconomic metrics to SEYLL: improvements in gross national income (GNI) per dose and reduction in absolute poverty gap per dose. These indicators ensure that even after covid related deaths are brought relatively under control, vaccine will continue to be allocated in a way that prevents serious economic and social harms due to the pandemic while prioritising disadvantaged people by focusing on narrowing the poverty gap. Earlier vaccination can, for example, allow a poor country to relax lockdown measures that often hit the poorest part of the population hardest.

In the third phase of distribution, the model aims to end community spread of covid-19 by prioritising countries with the highest transmission rates, ensuring that even as the pandemic begins to abate, priority is given to preventing harm and to people in countries most affected by the pandemic.

Thus, at each phase, the model gives priority to reducing the most harm to health and the economy with extra priority to those in the most disadvantaged countries. Moreover, it does so using well established metrics that can be transparently and consistently applied on the basis of available data.

Pragmatic considerations

Some people might argue that, despite its ethical limitations, proportional allocation is defensible on important pragmatic grounds.

First, it might be claimed that the only way to assure the global community that the Covax mechanism will not arbitrarily favour some countries over others is to use a simple metric such as distribution by population size. Any vaccine allocation plan must be based on clear metrics that can be consistently and transparently applied. But a mechanistic distribution of vaccine by population size is not the only way to satisfy this standard. The Fair Priority Model relies on metrics—SEYLL, GNI, and poverty gap—that are widely understood and already extensively used in global health. Additionally, under the current WHO proposal, the second phase of vaccine distribution is intended to take countries’ covid risk profiles into account. Thus, it will eventually require metrics assessing the health and economic effects of covid, which will entail needing to use similar projections as the Fair Priority Model.

Second, some people claim a major advantage of proportional allocation is that it gives high income countries an incentive to participate in Covax. Ensuring all countries will have guaranteed access to a share of vaccines when they become available, might increase the likelihood that rich countries will agree to purchase vaccine through Covax. Acknowledging concern about wealthy nations’ willingness to participate without such an incentive, WHO’s chief scientist said there was “a big, big risk that if you propose a very idealistic model, you may be left with nothing.” Covax leaders must be sensitive to political realities. Nevertheless, this pragmatic defence of proportional allocation seems flawed. Guaranteed access to doses for 3% or even 20% of their populations in an initial phase of vaccine allocation is unlikely to be a major incentive for high income countries. These levels of vaccination are too low to achieve herd immunity, not helping them escape the pandemic. More importantly, high income countries, such as Canada, Germany, Switzerland, and the UK, can secure doses for a much larger portion of their populations through direct, bilateral deals with drug companies—and in many cases already have.

In addition, even if high income countries do participate in Covax out of a sense of “enlightened self-interest,” they would have reason to favour an allocation scheme like the Fair Priority Model that would prioritise them if they experience an outbreak and have an urgent need for vaccine, rather than one that provides them with a fixed quantity of vaccine regardless of their level of need.

Leaders of Canada, Germany, Switzerland, and the UK might reasonably ask why hundreds of thousands of very scarce vaccines held by Covax should go to Taiwan, which has had seven deaths, or New Zealand with 25 deaths, rather than their own countries with thousands of deaths.

Conclusions

Covax is a useful example of international cooperation. It will distribute vaccine more fairly and efficiently than vaccine nationalism. But Covax’s proportional allocation fails to realise a fair and equitable distribution, and it cannot be defended on pragmatic grounds. To ensure fair and equitable access to vaccines, Covax should consider adopting the Fair Priority Model.

A renegotiation of Covax’s terms of disbursement seems politically feasible especially because countries know more about the global spread of covid and the needs of each country. This would require Covax to work closely with public health experts and modellers to decide where vaccines should be sent when they are manufactured, but this is entirely feasible and indeed necessary given the rapidly evolving dynamics of the pandemic.

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Families experiencing everyday hardship during a pandemic

The pandemic has amplified long-standing socioeconomic and health inequalities, and exposed both the fragility of the social security system and the growing reliance by so many on charitable food provision.

It should not, however, have taken a global pandemic to get us talking about the endemic insecurity and everyday hardship that characterises social security receipt. The shortcomings with provision, which has been hollowed out by successive governments, have long been clear. In direct response to the deterioration of social security provision charitable food provision increased.

Through the Covid Realities research programme (covidrealities.org), we have been working with more than 100 parents and carers to document life on a low income during the pandemic. By keeping online diaries and participating in virtual discussion groups, parents are sharing their experiences and taking part in conversations about what needs to change.

Their accounts reveal the shortcomings with the social security system before the pandemic, but also the profound limitations of the government’s economic response to covid. Changes such as the temporary £20 uplift to universal credit, while welcomed by those who receive it (many don’t because of being on legacy benefits or subject to the benefit cap) are often insufficient for families with rapidly rising costs related to lockdown. What their diaries also reveal is how the strategies they had in place to get by—such as shopping regularly to find low cost items; deliveries from cheaper supermarkets; visiting friends and family for meals; and making use of community support—have been made impossible by covid-19.

Unsurprisingly, this has negative health impacts—the aggravation of existing physical and mental health problems, as well as the emergence of new ones.

Against this context, families are often reliant on, and grateful for, food charity, but they also talk of the pervasive stigma they associate with receiving a food parcel or visiting a food bank. What they also tell us, however, is that there are many problems with this form of charitable provision; not only is it stigmatising, but the food received is often inadequate and, in some cases, inedible.

The Independent Food Aid Network (IFAN) has been a leading advocate for dignified, nutritionally adequate, and culturally appropriate charitable food provision. Above all, IFAN argues that charitable food can never be a viable replacement for money to buy food in “normal” ways, a claim supported by Covid Realities’ emergent evidence base.

Through local partnerships, IFAN is pioneering a “cash first” approach to food poverty, aligned to its broader call for a systemic approach to tackling poverty. The work of IFAN, like the Covid Realities’ participants, illuminates the reality that emergency food aid cannot and never will be the answer to the underlying problem of rising poverty and everyday hardship for millions of households. Instead, what is needed is a social security system that invests in adults and children as part of a preventative strategy to reduce poverty and inequality.

If you are interested in supporting IFAN’s work, please donate online.

Support the Independent Food Aid Network’s frontline and advocacy work

Please return to: Independent Food Aid Network, 58 Standen Road, London SW18 5TQ

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IFAN is registered with the Fundraising Regulator.

Registered charity number: 1180382

RICHARD H SMITH

23 January 2021 [the bmj]
**LETTER OF THE WEEK**

**What has the configuration of SAGE got to do with it?**

Thacker’s point about failure to declare conflicts of interest, and especially financial conflicts, is surely correct (Cover Story, 12 December)—but what has the configuration of expertise on the Scientific Advisory Group for Emergencies (SAGE) got to do with that argument? The author implies that modellers are over-represented in the group, illustrating (by innuendo) the malign effects of SAGE’s relationship to government by implying that it is not up to the job. These kinds of remarks represent an undesirable drift towards the use of rhetorical devices, rather than logical argument, to support a position—creating an atmosphere of scepticism about the competence of scientific endeavour as well as about its integrity.

Similarly, the six members of SAGE who represent Public Health England might be bemused by the idea that public health expertise is deficient on the committee. After all, most realistic commentators acknowledge that failure to use the expertise of public health practitioners (for example, in test and trace) is not the result of poor advice from experts but a political decision to favour outsourcing to private companies at whatever cost to effectiveness.

The need for extra “behavioural researchers” is likewise not well made. Two of the most senior members of that community recently acknowledged in The BMJ that “there is almost no relevant evidence on how to promote adherence to behaviours such as distancing from other people and households, hand cleansing, effective use of face coverings, and avoiding touching one’s eyes, nose, or mouth with contaminated hands.” Not a surprise to those who have been dismayed for some time about the unrealistic claims being made for behavioural science in other areas of health research. So why press for more of the same?

Perhaps a minor criticism of an otherwise supportable article, but not a trivial one.

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**LATERAL FLOW TESTS**

**Do the evaluators understand lateral flow devices?**

The relative importance of the sensitivity and the specificity of lateral flow devices (LFDs) depends on the intended use. LFDs for the detection of antigens need to have high sensitivity to detect the virus in those who should isolate. A false positive merely risks someone self-isolating unnecessarily. The reverse is true for LFDs used to detect antibodies against the virus—a false positive might give the illusion of protective immunity where none exists. Low sensitivity would merely lead to erring on the side of caution.

LFDs for use in the detection of active virus (This Week, 12 December) have been evaluated to have high specificity but only modest sensitivity, meaning that many cases would be missed. Nevertheless, these devices are described by evaluators as having the “desired performance characteristics.” Some evaluators of LFDs seem to have the importance of the sensitivity and specificity the wrong way round.

Keith A Moyse, independent scientist, Oxford

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**BEING A GOOD ENOUGH DOCTOR**

**We need to talk about acceptable failure rates**

Salisbury discusses the importance of learning from our errors (Helen Salisbury, 12 December). In my experience, errors that cause adverse outcomes are usually a result of a series of minor errors that individually would have been problematic but that in combination are disastrous. These series of errors are usually not likely to be repeated. Something similar may happen, but solutions will not be applicable.

With our current resources, errors are inevitable. Accepting this has been difficult. I have been trying to quantify acceptable error rates, but the standard response is that there is no such thing. Whether this is political correctness, defensive practice, or a genuine idealistic belief, it is counterproductive.

The NHS is overburdened, and it will never have excess capacity regardless of the resources supplied. Expectations will always exceed performance—for the NHS and for the staff working within it. For sustainability, we need a discussion of acceptable failure rates.

Ebrahim Hassen, specialty doctor, emergency medicine, Wrexham

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**SURVIVING MEDICAL TRAINING**

**The NHS is a tough place to work**

McLachlan and Fleming make valid points about the struggles of medical training (Personal View, 12 December). But they are wrong to blame the “in my days”—we sympathise with current trainees, as many of the support mechanisms that kept us sane have been removed.

The article refers to a “collaborative team,” but my team can never get together because of shift patterns. We can set up training afternoons, but medicine is an apprenticeship requiring trainees to see patients. We still have excellent junior doctors, but they do not have the same experience, and this inexperience is carried into consultant posts.

Most consultants are “compassionate” with juniors. But the erosion of the influence of consultants, other than those moving into management roles, means there is little we can do to tackle the problems described. I am afraid that the NHS will remain a tough place to work for all of us.

Graham Smith, consultant paediatric nephrologist, Cardiff

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Christopher Hayles Cameron
General practitioner Kelso, Scottish Borders (b 1940; q Edinburgh 1964), died from complications of dementia on 27 September 2020
Christopher Hayles Cameron (“Chris”) entered the arts faculty of Edinburgh University to study languages, but after a year changed to medicine. Having no relevant school science background, he found the first year basic sciences course “pretty heavy going,” as he put it. He persisted and graduated, having formed the intention of entering general practice in the Scottish Borders. As soon as he could, he set about fulfilling this ambition and in due course came to Kelso, where he stayed for the rest of his life. Early retirement allowed him to return to university and acquire an MA in Russian. He was a talented musician and enjoyed rambling in the Scottish Border Hills. He leaves Isobel, his wife of 52 years; three children; and four grandchildren.

K Nesbitt
Cite this as: BMJ 2020;371:m4428

Clare Marlow
Consultant in palliative medicine Royal Wolverhampton NHS Trust (b 1971; q St George’s Hospital Medical School, London, 1994; MSc, FRCP), died from cancer on 27 April 2020
Clare Marlow started specialty training in 2001. While a registrar she completed a masters degree in palliative medicine with Bristol University. She was appointed as a consultant in 2005, working at the Royal Wolverhampton Trust and Compton Hospice. She became the National Institute for Health Research (NIHR) Clinical Research West Midlands joint subspecialty lead for supportive and palliative care. She was passionate about education and training. In addition to her academic interests, Clare was a caring and kind doctor and human being to all of her patients, their loved ones, and her colleagues. Outside work Clare loved musical theatre and spending time with her family and friends. In addition to her extensive palliative care family, she leaves her parents, brother, and two nephews.
Fran Hakkar
Cite this as: BMJ 2020;371:m4384

Christopher Cefai
Consultant microbiologist (b 1956; q Royal Free Hospital School of Medicine, London, 1981; MSc, FRCPath), died from a myocardial infarction on 1 October 2020
Christopher Cefai (“Chris”) started his medical education at the Royal University of Malta Medical School in 1976, before moving to London. He received an MSc in clinical microbiology in 1985 and moved to Newcastle upon Tyne with his wife, Angela, whom he had married in 1984. In 1991 he relocated to Tarporley, Cheshire, with his young family, and took the role of consultant microbiologist at Wrexham Maelor Hospital. Over the following 25 years, Chris took many clinical and academic roles. Despite retiring in 2016, Chris continued to work on a locum basis at Whiston Hospital until May 2020. Despite his many achievements in medicine, Chris took most pride in his family. He leaves Angela; four children; a granddaughter; and a son in law.

Steven Edwards
Cite this as: BMJ 2020;371:m4387

George Morton Reynolds
Area medical officer (b 1925; q Welsh National School of Medicine, Cardiff, 1948), died from heart failure on 19 July 2020
George Morton Reynolds was appointed medical officer of health and chief welfare officer for the County Borough of Dudley in 1961, and area medical officer for Dudley Health Authority in 1974. His special interests were in developing community services, working closely with colleagues in general practice. He was secretary of the local medical committee for several years, held the chairmanship of the Dudley BMA Division, and sat on the Central Midwives Board. In 1979 he moved back to his native Wales as area medical officer for Dyfed Health Authority. After retiring in 1990 he was appointed by the Welsh Office as one of two medical officers for complaints. His wife, Mary, died four weeks after him, and they leave two children, five grandchildren, and a great granddaughter.

John Reynolds
Cite this as: BMJ 2020;371:m4382

Elia Dayan
Consultant general surgeon South Tyneside General Hospital (b 1925; q University of Cairo, Egypt, 1949; FRCS), died at home on 29 August 2020
Born and educated in Egypt, Elia Dayan (“Eliot”) moved to London in 1949 and worked in various hospitals in London to complete his surgical training. He worked in South Shields from 1958 but emigrated to Canada with his young family in 1962. After a petition raised by the doctors in South Shields he was appointed as a consultant surgeon in 1964, remaining in the town until his retirement in 1990. In his early years he undertook all forms of trauma and general surgery before subspecialisation was introduced. Eliot trained young surgeons from the UK and abroad and was invited to the Queen’s garden party in recognition of his work. Predeceased by his wife, Ginette, in 2018, he leaves four children and 12 grandchildren (including four doctors).

Colin Dayan
Cite this as: BMJ 2020;371:m4431

Lucy Doris Sheard
General practitioner (b 1934; q Leeds 1958), died from Alzheimer’s disease on 6 September 2020
Lucy Doris Sheard was a high flier at Leeds. She was awarded a distinction in surgery and prizes in medicine, surgery, and surgical anatomy. Motherhood led to her becoming a part time GP in Scunthorpe and East Yorkshire. She had an interest in osteopathy and was a member of the British Association of Manipulative Medicine. She was a director of the Retreat Hospital in York. In retirement she went to Nepal to assist in gynaecological camps. Christianity was very important in Lucy’s life. Brought up a Quaker, she became a lay reader, a preacher, and a pillar of All Saints Church, North Ferriby. Music was a lifelong interest. She also enjoyed sailing and travel. Lucy leaves two sons, neither of whom followed their parents into medicine, and two grandchildren.

John Keel, Claire Barchard
Cite this as: BMJ 2020;371:m4378

Bereavements
Alan Gibb

ENT surgeon with an interest in hearing loss and diseases of the ear

Alan Gibb (b 1919; q Aberdeen 1941; DLO Eng, FRCS Ed, (Hon) FCS Hong Kong), died from the long term consequences of a stroke on 5 September 2020

On graduating from Aberdeen University, Gibb was first exposed to ear, nose, and throat medicine at Aberdeen Royal Infirmary. He served in the Royal Army Medical Corps in West Africa during the second world war as a specialist ear surgeon, achieving the rank of major.

After his return, he held training posts in Aberdeen and Carlisle before he was appointed consultant to Dundee Royal Infirmary (later Ninewells Hospital), Maryfield Hospital Dundee, Bridge of Earn Hospital, and Perth Royal Infirmary. Qualified as an all round ENT surgeon, Gibb’s main interest was in hearing loss and the diseases of the ear. He once said, “Every ear was an exciting Aladdin’s cave to me as I gazed at the magnified structures.”

His particular interests were tympanosclerosis and the use of dentine for ossicular reconstruction. At the time, the newly introduced operating microscope enabled the development of innovatory precise surgical techniques that revolutionised the reconstruction of the hearing mechanism and the eradication of chronic middle ear and mastoid disease, common in both adults and children, causing years of misery for the patient.

Objective structured clinical examination

He was appointed senior lecturer at St Andrews University and established a department of otolaryngology. Perhaps his most important contribution to students, not just at St Andrews and Dundee but internationally, was the introduction of the objective structured clinical examination (OSCE), which is still used to assess clinical competence in medical, nursing, and midwifery schools.

He married Elizabeth Addison, who had been his theatre sister at Dundee Royal Infirmary, and their marriage produced two children, Andrew and Susan.

Ninewells Hospital

From 1950 until he retired in 1984, Gibb was a consultant at Dundee Royal Infirmary, then later at Ninewells, where he established and headed an outstanding department and an internationally recognised teaching centre. He said, “I always emphasised that you have to let students do things, not just sit through lectures.”

Such was his surgical expertise and enthusiasm for sharing his passion for the ear with students that he became acclaimed as an inspirational teacher, and many of his trainees went on to become leaders in the specialty both in the UK and abroad.

As president of the Royal Society of Medicine Section of Otology (1975), the Scottish Otolaryngological Society (1979-80), and the British Association of Otolaryngologists (1981-84), he lectured extensively at home and abroad, and was adviser to the Medical Research Council on hearing matters. His techniques were widely adopted by other medical and surgical specialties and he was called on to advise the Australian College of Surgeons.

Emma Stapleton, consultant otolaryngologist at Manchester Royal Infirmary, interviewed Gibb for ENT and Audiology News in 2013, when he was 94, and they became friends. She recalled, “By the time I met Professor Gibb, his clinical work was long finished, but he loved to talk about surgery and medical education because they were such an important part of his life.”

Richard Ramsden, retired otolaryngologist and skull base surgeon at Manchester Royal Infirmary, once asked Gibb how he would like to be remembered. After some thought, Gibb replied that he would like to think that anyone, regardless of position, who worked with him would have no fear of approaching him with a problem. He wanted to be “accessible” and never lost the common touch.

When encouraged to retire in the UK in the late 1980s, he went to work for universities abroad, spending eight years teaching in east Asia until he was 78. He set up teaching departments in Hong Kong, Malaysia, and Singapore and lectured in Canada and the US.

Outside interests

Gibb had many interests outside medicine. He was a founder member of the ORL travel club, with which he travelled extensively. He enjoyed a ceilidh and sang in church choirs in Dundee and at Craithie Kirk, where he was an elder for 10 years. In his eventual retirement, Gibb enjoyed salmon fishing and playing golf. He wrote for golf magazines well into his 90s.

Gibb died peacefully at his home in Ballater as a result of the long term consequences of a stroke he had around two years ago, from which he had made a partial recovery.

The Chinese University of Hong Kong has established an annual Alan Gibb prize for the best undergraduate in his honour.

He leaves his wife, Betty; two children; and five grandchildren.

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