comment

"Are the press and public ready for a frank discussion on rationing?" **DAVID OLIVER**
"My practice's vaccine supply has dwindled to a trickle" **HELEN SALISBURY**
PLUS Risks of an app to show immunisation status; doctors need more legal protection

WOUNDED HEALER Clare Gerada

Tips for surviving leadership

My New Year's resolution was to declutter paper and create order among my bookshelves and cupboards. As I did so I came across a sheet of paper given to me in 2010, when I became the Royal College of General Practitioners' first female chair for 50 years.

The sheet was entitled *Surviving*. The advice helped me immensely, and these are the points I would like to pass on:

- Find like minded people from within your organisation. Ask them for feedback and early warning if there are any problems.
- Create a support group of trusted friends or colleagues, or find a mentor, or even a therapist. A problem shared often really is a problem halved.
- Be a role model who others can follow, and make sure that you don't pull up the ladder after you.
- Before any significant meeting, think about what you want to achieve. Write down your aims at the top of your papers for the meeting.
- Have your own red lines that you won't cross, based on your values.
- When you're trying to convey really important messages ensure that they're properly recorded.
- Recognise that some discussions will take place in spaces you can't access—pubs, clubs, social events. It's important that you have sufficient informal one-to-one meetings with people of influence.
- Deal with overt discrimination. A good technique is successive questioning: "Could you clarify what exactly you mean?" And keep your cool.
- After a difficult meeting or media appearance, especially in the public domain, it's normal to feel upset. Try to give yourself some downtime to recover.
- There will be times when you haven't handled yourself well. Reflect and learn from them, but don't beat yourself up. Be open about your failings.
- If something has gone badly, ask others close to you not to comment immediately. You know that it didn't go well; what you want from them is support.
- When speaking publicly try not to speak too quickly, don't raise your voice, prepare in your head what you want to say, and be aware of your body language.
- If you're being bullied, step back, recognise the tactic, and devise ways of countering it—as you would in a difficult consultation.
- Be prepared to be a (subtle) self-publicist.
- Keep personal issues to yourself. Don't gossip.
- Keep a diary: it helps you afterwards to reflect, learn, and understand what really went on.

I do hope that this list helps. Good luck with your leadership journey. You will not only survive but thrive.

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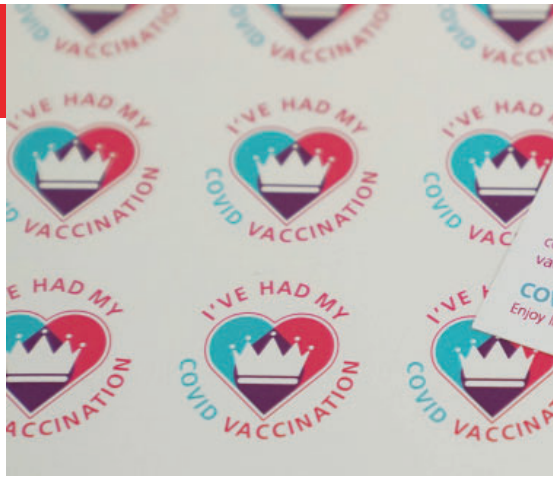
When you haven't handled yourself well, reflect and learn, but don't beat yourself up

YANKEE DOODLING Douglas Kamerow

Immunised against covid? There's an app for that

We need to ensure that a digital "yellow card" is not a means to a new social divide led by private companies with too little regulation



If you're of a certain age, or if you travel to exotic places, you'll be familiar with the "yellow card." Issued by the World Health Organization originally for use in yellow fever epidemics, this folding, pocket sized card displays an individual's immunisation history for international border crossings. Fast forward to 2021. Now we're digital, of course, so we need a mobile phone app to document whether we've been tested for—and soon, immunised against—covid-19.

Ideally, we would have a universally adopted credential to securely document and share negative coronavirus tests and, ultimately, immunisation status. This would facilitate the safe reopening of public transportation and venues where many people gather. To this end, an international non-profit organization, the Commons Project, convened a meeting last July, co-sponsored by the World Economic Forum and the Rockefeller Foundation. They're now testing an app called the CommonPass (thecommonsproject.org/commonpass), which is intended to be "a secure and verifiable way [for travellers] to document their health status as they travel and cross borders."

Airports and sport venues

United Airlines has tested the CommonPass on flights to London and is reportedly planning to use it regularly on some international flights, as are four other airlines. Passengers download the app, get directed to an approved testing centre and, after testing negative for coronavirus, receive a confirmation code to show before boarding. In the future, we are told the app will also securely display verified immunisation status.

For-profit companies are also eager to enter this market. Clear, a US security company that uses biometric data to confirm people's identities at airports and other venues, is now documenting negative coronavirus tests for sports teams with its Health Pass app and has plans to validate immunisations when they become available. Besides airports, Clear already operates at large sports arenas in the US. I've used it myself for expedited security clearance at baseball games in Washington, DC.

What if you don't have a mobile phone? Or you don't have a good internet connection?

You can see where all this is heading. The availability of secure digital health credentials could speed reopening of offices, schools, and businesses. In the name of health security, we will evolve into a two class society: people who can document their covid immunity with an app, and those who can't.

But what if you don't have a mobile phone? Or you don't have a good internet connection? Or the app isn't working for you? As long as you've got the magic ticket you

BMJ OPINION Jane Dacre

Doctors need legal protection as covid pressures grow

On 2 November, just before the third national lockdown, Boris Johnson warned that if the NHS is overwhelmed we could face a "medical and moral disaster" where doctors and nurses could "be forced to choose which patients to treat, who would live, and who would die."

Since then, many hospitals have been pushed to breaking point.

During normal times, health professionals have a range of guidance they can refer to on administering and withdrawing treatment. But this guidance does not consider factors specific to covid-19, such as if and when there are surges in demand for resources that temporarily exceed supply. There is no national guidance, backed up by a clear statement of law, on how clinicians should proceed in such a difficult situation. The guidance does not provide, nor claim to provide, legal protection for those ultimately making the decisions.

The first concern of a doctor must be for their patients: providing the highest and

An emergency law would be a temporary response to the pandemic

safest standard of care at all times. It does not feel right that they or other professionals should suffer from the moral injury and long term psychological damage that could result from having to make decisions on how limited resources are allocated, while at the same time being vulnerable to the risk of prosecution for unlawful killing.

The Medical Protection Society has been campaigning for emergency laws since the start of the pandemic, to protect doctors and others from inappropriate legal challenges when treating patients with covid-19 in good faith and in circumstances completely beyond their control. The Doctors' Association UK, British Association of Physicians of Indian Origin, Hospital Consultants and Specialists Association, BMA, Royal College of Surgeons of Edinburgh, and Medical Defence Shield have now added their voices to this call, amid concern for their members.

get express entry onto your flight, into your office, to the football game, and maybe soon into the local pub. If not, you're out of luck.

Civil liberties advocates are expressing concerns about the implications of immunity apps. The private companies—non-profit or for-profit—producing them are outside government control or verification. It is not hard to imagine possible bad outcomes from a future split between haves and have-nots: perhaps denial of access to public transportation, decreased job opportunities, and even housing discrimination.

Immunity apps seem to be a great idea in need of serious regulation. I would feel a lot better about them if some government agencies or WHO were leading this activity.

Douglas Kamerow, senior scholar, Robert Graham Center for policy studies in primary care, professor of family medicine, Georgetown University, and associate editor, *The BMJ* dkamerow@aafp.org

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Healthcare professionals should not be above the law, and the legislation we propose should only apply to decisions made in good faith, in circumstances beyond their control, and in compliance with relevant guidance. It would not apply to wilful or intentional criminal harm, or reckless misconduct. Such an emergency law would also be a temporary response to covid, applying retrospectively from the start of the pandemic.

We do not underestimate how difficult this is. There will be a time in the future when we will need to debate the range of legal and ethical challenges that have been raised by this pandemic, and these discussions will not be easy. In the meantime, this crisis is upon us now and healthcare professionals need immediate action. Support for doctors enhances their ability to support their patients.

Jane Dacre, president at the Medical Protection Society, professor of medical education, UCL Medical School, and physician and rheumatologist at the Whittington Hospital in London

ACUTE PERSPECTIVE David Oliver

Can we handle the truth on rationing?

As the pandemic has exceeded last spring's peak, many NHS leaders warn it is overwhelmed. What we really mean is that hospitals are overwhelmed. In extremis, that may mean battlefield-type triage: deciding who gets to live or die, with intensive care units already running at twice their normal bed base.

The Medical Protection Society has called for emergency legislation to protect doctors if they have to decide how limited resources are allocated. With oxygen delivery systems under pressure and record numbers of patients on non-invasive ventilation, it may prove necessary—as happened in northern Italy last spring—to choose between patients, or groups of patients, who might benefit from potentially lifesaving treatment.

This is different from what we usually do—prioritising treatment depending on whether a patient has much chance of benefit or whether the risk of harm is greater. We also take patients' and families' views into account. And even this can prove problematic with a media and public not always ready for an open discussion of these realities. Still, surely it's better to have this openly rather than using a system with no chance for discussion, public engagement, or consultation, with no explicit guidance or decision support tools.

The *Daily Telegraph* recently ran the headline "Crisis triage protocol is a brave attempt to ensure what happened in northern Italy is not repeated in Britain," saying that "doctors need an ethical system for rationing critical care if hospitals are overwhelmed . . . currently there is no national guidance." It also reported, "Covid rationing plan tells doctors to pick patients to save by lottery," next to a story on "twice as many critically ill patients in hospitals as at the peak of the first wave."

The meat of the story was a paper—"Ethical decision making when demand for intensive care exceeds available resources"—in November's *Journal of Medical Ethics*. It had described the multidisciplinary process in developing a local document for "fair allocation of critical care resources in the setting of insufficient capacity." The authors, based at the Royal United Hospital in Bath, had argued it was better to have a transparent, standard decision tool, with strong ethical and legal components, than to leave such decisions to clinical teams on the day. Bath hospitals responded to the *Telegraph* that "it is a research document for purposes of wider discussion . . . when resources are sufficient, decisions are based solely on what is best for each individual patient."

But the perceived need for such a hasty rebuttal, as well as the tone of a newspaper report, risked undermining a brave and clinically led attempt to do the right thing, to foster transparency about prioritisation or rationing of scarce care. It left me wondering whether the press and public were ready for this frank discussion, especially when we're all emotionally spent. It reminded me of the line from *A Few Good Men*: "You can't handle the truth."

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The media and public are not always ready for an open discussion of these realities

PRIMARY COLOUR Helen Salisbury

Pedalling vaccines door to door

After the excitement of running big clinics at our surgery with the Pfizer vaccine, things have gone quiet on the vaccination front in our primary care network. We've now given at least one dose of covid vaccine to 88% of our practice's over 80s, with only a handful declining the offer. Despite some reports of mild fevers and sore arms as expected, no one has needed medical attention for a reaction to the Pfizer-BioNTech or the Oxford-AstraZeneca vaccine.

We'd like to vaccinate all vulnerable patients, but we must pause until other areas catch up. Practices at the less advantaged end of the city need it more, but the algorithm for determining where supply goes doesn't seem to consider deprivation. In England's poorest areas average life expectancy is well below 80, so supplies based on age alone are limited precisely where the risk of covid death is highest.

Our supply has dwindled to a trickle, and it takes only a single afternoon to use the 300-400 doses delivered each week—a far cry from the 12 hours a day, seven days a week we signed up to in December. We'll receive none at all this week. A few vials have been held back for home visits, and I recently spent a happy afternoon vaccinating housebound patients. We have a spreadsheet of all such patients in our network. There are fewer than we anticipated, as being housebound isn't a fixed concept: some patients who require huge efforts and the help of several relatives to leave the house were nevertheless transported to the surgery when we first started vaccinating. Others are truly unable to get to us, so we take the vaccine to them.

It takes a little preparation: patients or their carers need to know I'm coming, and if they live alone I may need a keycode to gain entry. I put my mask on at the door and introduce myself if we haven't met before; then it's coat off, apron on (one of those flimsy plastic ones I can't see the point of) before I apply hand gel, clean the vial, and draw up the vaccine. After giving it and filling in the documentation I pack everything away, with liberal use of antiseptic wipes, and say goodbye. Then I climb back on my bike and trundle to the next address, feeling a bit like Mrs Armitage in Quentin Blake's wonderful book (what my bike really needs is a holder for the sharps box and an extra pannier for the clinical waste bag).

Even with short distances between patients I manage only three or four visits an hour. But the effort is worthwhile, as people with multiple carers are at high risk. Finding time is an issue, and we've dealt with this so far by doing home visits on what should be GPs' afternoons off. This isn't a long term solution, but the work is a high priority right now, so we just get on and do it.

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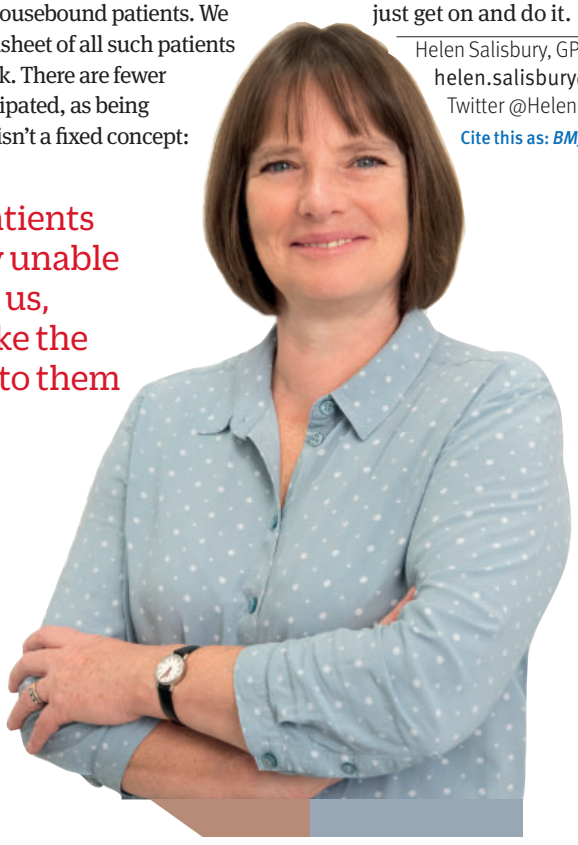
Some patients are truly unable to get to us, so we take the vaccine to them



LATEST PODCASTS

Tips on rolling out the vaccine

This episode of our Deep Breath In podcast focuses on the practicalities of administering the covid-19 vaccine, with guest Julia Marcus, an epidemiologist, emphasising the importance of having a prioritisation strategy that ensures equitable distribution:

"In general, in public health, policies and messaging are not necessarily driven by the communities that they are trying to reach. This has been really salient during the pandemic in that restriction based policies or lockdowns are quite easy to some extent for people who can comfortably work from home. But the people who are continuing to go to work, continuing to be exposed, are not the ones who are designing those policies, and they don't really have a voice. The best way to lose trust is to have these top-down interventions that don't come from a place of empathy and don't recognise the impact they have on the community you're trying to serve."

Second Wave: vaccinations and lockdowns

In the latest Second Wave podcast, Nisreen Alwan, a public health consultant , talks about why our plan for managing covid-19 needs to rely on more than vaccination:

"We need to go back to trying to have a comprehensive strategy of suppressing infection after the lockdown is lifted because at that time we won't have most of the population vaccinated.

"We don't want the virus to spread uncontrollably because of the morbidity, even if you're young and healthy, but also, very importantly, because of the risk of mutations, and we've seen how the virus is capable of that and that might mean vaccine resistance. So we need to keep it under control after this lockdown is lifted so that we don't have any further lockdowns."

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

ANALYSIS

Mitigating ethnic disparities in covid-19 and beyond

Although socioeconomic status partly explains the outcome discrepancies seen with this coronavirus, cultural and structural racism also adversely affect health, argue **Mohammad Razai and colleagues**

PRIYA SUNDRAM

The disproportionate effect of covid-19 on ethnic minorities in some high income countries throws into sharp relief the effects of racism on health. On almost all health measures, ethnic minority groups, especially black and South Asian people, have the worst outcomes.[1-6] The covid-19 pandemic is just another example.[7] This is a moral issue that has outraged civilised societies.

The effects of racism and social determinants of health are intertwined. Racism both shapes social determinants of health and has its own effect on the health of ethnic minorities. To understand race and health, we must understand the role of ethnicity and racism within modern societies. Everyday acts of interpersonal discrimination, implicit biases, cultural and structural racism will over time lead to worse health outcomes, including higher rates of chronic diseases and lower life expectancy.[8-11]

KEY MESSAGES

- Ethnic disparities in covid-19 are part of the historical trend of poorer health outcomes seen in marginalised ethnic groups
- Ethnic inequities in health are not accounted for by socioeconomic status alone
- Racism in its various forms is a fundamental cause and driver of ethnic differences in socioeconomic status, adverse health outcomes, and ethnic inequities in health
- Mitigating the impact of covid-19 and other health inequities in ethnic populations requires a recognition of the causes, a commitment to openness and honesty, leadership, and resources

Effect of covid-19

Covid-19 has disproportionately affected ethnic minority groups in developed countries. In the UK, people of black ethnicity have had the highest diagnosis rates, with the lowest rates observed in white British people.[7] Data up to May 2020 show 25% of patients requiring intensive care support were of black or Asian background.[12]

According to a Public Health England report, the mortality risk from covid-19 among ethnic minority groups is twice that of white British patients after potential confounding factors such as age, sex, income, education, housing tenure, and area deprivation have been taken into account.[7] Data from covid-19 inpatients in England showed that South Asian people had the highest death rates (350 deaths/1000 compared with 290/1000 for white people).[13] Ethnic minority groups were also more likely to need intensive care and invasive ventilation than white patients despite similar disease severity on admission, similar duration of symptoms, and being younger with fewer comorbidities.[13]

Black and Asian staff represent only 21% of the NHS workforce, but they accounted for 63% of deaths among health and social care workers

Another study has shown a higher rate of covid-19 cases among ethnic minorities independent of comorbidities and socioeconomic risk factors.[14]

These differences are highlighted in the covid-19 cases among key workers. Although black and Asian staff represent only 21% of the NHS workforce, early analysis showed that they accounted for 63% of deaths among health and social care workers.[15]

This picture is reflected internationally. In the US, the case and admission rates are at least 2.5 and 4.5 times higher, respectively, among black, Hispanic, and Native American populations compared with white populations.[16] The American Public Media Research Laboratory has estimated a death rate of 61.6/100 000 population for African Americans, 1.7 times greater than that of indigenous Americans and 2.3 times that of white and Asian Americans.[17]

Possible causes of ethnic disparities in health outcomes

Several potential reasons have been proposed, including higher rates of comorbidities (box) such as cardiovascular disease and diabetes in patients of South Asian ethnicity and hypertension in the black population.[7]

Ethnic minority groups are more likely to live in urban, overcrowded, and more deprived communities and to work in lower paid jobs, many of which carry a high risk of exposure to covid-19.[7 18] Moreover, negative experiences within a culturally insensitive healthcare service may create barriers, inhibit access to healthcare, and influence healthcare seeking behaviours among ethnic minority groups.[7 19] The UK government's report on ethnic disparities in covid-19 states that some of the excess risk remains unexplained despite accounting for socioeconomic and geographical factors such as occupational exposure, population density, household composition, and pre-existing health conditions.[20]

A Public Health England report found that racism and discrimination may have contributed to the increased risk of exposure to and death from covid-19 among ethnic minority groups.[19] Ethnic minorities have poorer access to healthcare and poor experiences of care and treatment[21] related to racial discrimination and marginalisation.[8-22] Additionally, ethnic minority staff in the NHS are less likely to raise their concerns about testing and personal protective equipment.[23]

However, ethnic disparities are not unique to covid-19 outcomes. Historically, marginalised ethnic groups have had higher rates and earlier onset of disease, more aggressive progression of disease, and poorer survival rates.[6] Empirical analyses show that ethnic differences in health persist even after adjustment for socioeconomic status. In the UK, black women are five times more likely to die during pregnancy than white women[24] and black people have a greater risk of detention under the Mental Health Act than white people.[25] Research has also shown falling health in immigrant communities over time. For example, Mexican Americans and Mexican immigrants who had resided for 20 years or more in the US had a health profile similar to that of African Americans.[26]

Evidence accumulated over decades shows that racism is a fundamental cause and driver of adverse health outcomes in ethnic minorities as well as inequities in health.[8-11]

Causes of ethnic disparities in covid-19 outcomes

- Racism
- Structural (institutional) racism
- Cultural racism
- Discrimination
- Social determinants of health
- Socioeconomic status
- Living in urban areas
- Poor and overcrowded housing
- High risk occupations
- Higher burden of comorbidities (eg, cardiovascular disease and diabetes)
- Cultural barriers

Racism is a fundamental cause of adverse health outcomes in ethnic minorities as well as inequities in health

Racism is a social construct that uses nationality, ethnicity, phenotypic, or other markers of social difference to maintain, capture, and justify the differential access to power and resources in society.[27] It functions on multiple levels.[9] Structural racism has the most deleterious effect on health. For example, a recent systematic review found that segregation was independently associated with late diagnosis and inferior survival rates in African Americans with lung or breast cancer.[28] Although there are many forms of structural racism, residential segregation in the US, is the most studied.

Segregation affects health in multiple ways.[9] First, it is responsible for ethnic differences in socioeconomic status. A US study showed that the elimination of segregation would eliminate ethnic differences in income, education, and unemployment and reduce ethnic differences in single motherhood by two thirds.[29] All of these stark differences are driven by access to opportunity at the neighbourhood level. Less than 5% of black children live in neighbourhoods with good resources.

Segregation has also been related to access to poorer quality education and employment opportunities. Segregation can also adversely affect health because it creates communities with poor quality housing and neighbourhood environments. The concentration of poverty in these areas leads to exposure to higher levels of multiple chronic and acute psychosocial stressors, greater clustering of these stressors, greater exposure to undesirable social and physical environmental conditions, and reduced access to resources that enhance health.

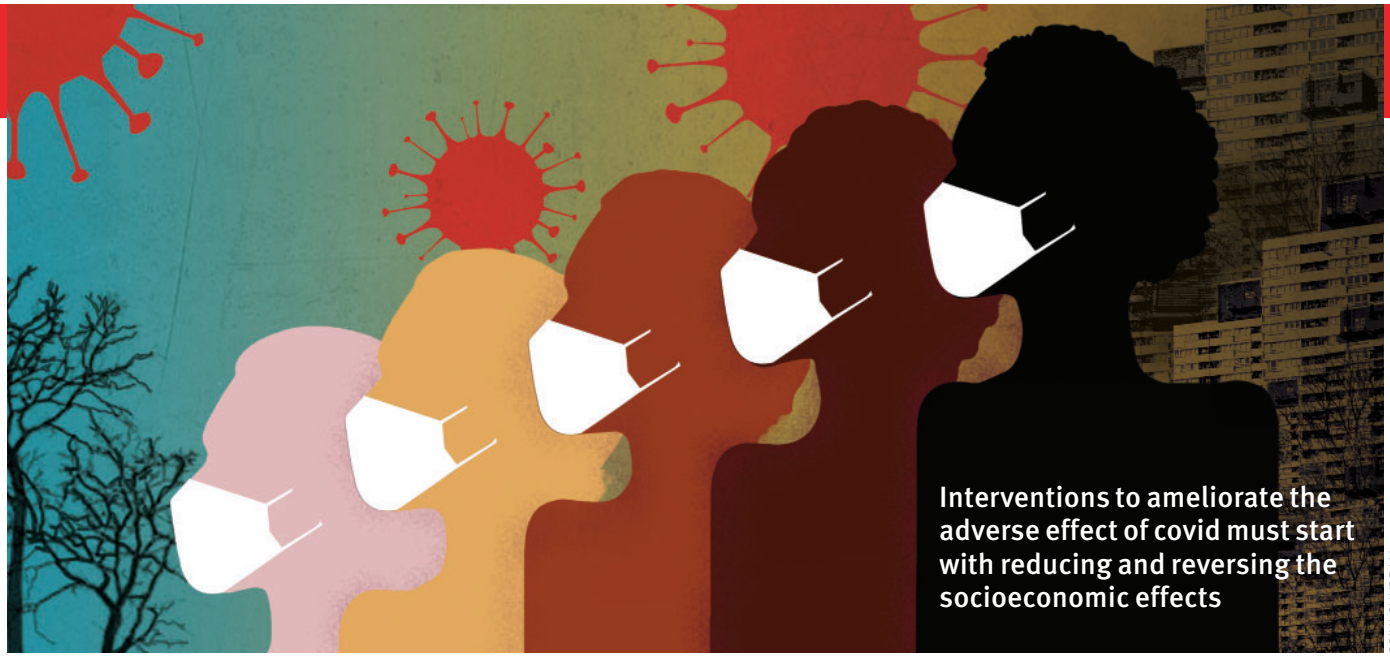
Although levels of segregation are steady or falling in the US, they are rising in Europe, where it is driven primarily by religion.[30] In the UK, Bangladeshi and Pakistani people are the most segregated groups.[30] National data from 2015 also show that socially stigmatised ethnic groups are over-represented in the most deprived neighbourhoods in England.[31 32]

Cultural racism is a reliance on stereotypes. This can give rise to unconscious bias and have a detrimental effect on health. A major report in the US found overwhelming evidence that black and other minority people routinely received poorer quality of care than white people.[33] For example, a retrospective study of 139 Hispanic and white American patients assessed the provision of analgesia for patients with long bone fractures. White patients were twice as likely to receive analgesia as Hispanic patients, even after consideration of individual patient and clinician characteristics and the types of injury.[34] More recent research documents these patterns across a broad range of outcomes[35] and that higher implicit bias scores among physicians are associated with biased treatment recommendations for black patients.[36]

Some ethnic minority patients may process the negative stereotypes in their culture by accepting them as true. This endorsement of negative views is called "internalised racism" and has been associated with multiple health outcomes, including psychological distress and obesity in black populations.[38]

A recent review also found self-reported discrimination is associated with incident disease (eg, diabetes, hypertension, breast cancer, cardiovascular outcomes) and preclinical indicators of disease (eg, coronary artery calcification, visceral fat, heart rate variation, and inflammation), poor health behaviours (eg, binge eating, smoking, and substance use), and lower use of healthcare services and adherence to medical regimens.[39]

One mechanism by which ethnic discrimination affects health is weathering—whereby exposure to discrimination as well as psychosocial, physical, and chemical stressors erodes health and accelerates biological ageing. For example, black women's health deteriorates earlier than that of white women because of the stresses of their environment.[40]



PRIYA SUNDRAM

Social determinants of health

An analysis of early data on covid-19 suggests that both its incidence and effect are distributed unequally, affecting those with material and social deprivation the most.[41] The Marmot review in England shows that health inequalities have widened overall, life expectancy has stalled, and the amount of time people spend in poor health has increased over the past decade. The situation is much worse for ethnic minority groups, which have higher rates of deprivation and poorer health outcomes.[42-47]

Interventions to ameliorate the adverse effect of covid-19 must start with reducing and reversing the socioeconomic effects. In the UK, socioeconomic inequalities were worsened by changes to the labour market, social security system, immigration policy, and insecure employment.[49]

Lack of information on ethnicity in UK health and social care data prevents an understanding of the extent of inequalities and disparities. In the US, New Zealand, and Australia, where such data are collected, they have revealed the multiple ways in which racism can adversely affect health and possible interventions to mitigate those effects. The NHS Race and Health Observatory in England was launched last year to investigate the effect of ethnicity on people's health.[50] The recent announcement that ethnicity is to be recorded as part of the death certification process is a major step forward.

Covid-19 should be seen in the wider context of ethnic disparities. The mitigation measures must redress the root causes of these disparities as well as the more urgent task of protecting those ethnic groups most at risk of adverse outcomes from covid-19.

Tackling racism and discrimination

Systemic problems such as racism require structural interventions[51] and reforms across the broad spectrum of society, including in healthcare, education, employment, and the criminal justice system. In the US, targeted civil rights policies in the 1960s-1970s narrowed the economic gap between black and white people, reduced health inequities, and improved living conditions and socioeconomic opportunities.[52]

High quality early childhood programmes can reduce crime, raise earnings, and promote education.[53] In one such programme, the Carolina Abecedarian Project (ABC), people in the intervention group had lower levels of cardiovascular and metabolic diseases in their mid-30s compared with controls, with the effects particularly strong for men. Other interventions, including community initiatives to build community capacity around racism, have potential health benefits. Similarly, cultural empowerment among native communities in Canada reportedly resulted in substantially lower rates of youth suicide.[54]

Institutional interventions need concerted political and organisational leadership with funding and investment by the state. In the UK, despite successive reports and inquiries into ethnic disparities,[44-46] their recommendations have either not been implemented or have fallen by the wayside.

The focus of most cultural racism interventions has been on reducing the implicit or unconscious bias and enhancing cultural competence. However, there is little evidence these interventions improve health outcomes or affect health equity.[55 56] Health and socioeconomic benefits have also been shown with values affirmation (enhancing self-worth by reflecting on most important values such as religious values or relationship with family and friendship) and social belonging interventions (creating a sense of relatedness).[57]

Changing policies and processes throughout organisations can reduce workplace discrimination.[58] Research suggests that diversifying the healthcare workforce improves the performance of the entire healthcare system, and ethnic concordance between a patient and a clinician has been associated with better health outcomes and higher levels of patient satisfaction.[59] A broad range of affirmative action policies have been implemented over the past few decades to increase ethnic minority participation in higher education and senior roles.[59] These programmes could be strengthened and supported further. Some early evidence suggests that the NHS Workforce Race Equality Standard initiative is increasing the number of ethnic minority staff in more senior positions.[60]

The tragedy of this pandemic, recent events in the US, and the Black Lives Matter movement have brought into sharp focus the burning ethnic injustices in our societies. Many high income countries with legacies of slavery, imperialism, and colonialism have a moral duty to reckon with the past. We know the problems, and the solutions are mostly in front of us. We must act now.

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BMJ OPINION Helen Crawley

Legacy of hunger proves our need for IFAN

Generous readers have donated over £50 000 to The Independent Food Aid Network, this is why…

RICHARD H SMITH

Ten years of austerity in the UK has pushed increasing numbers of people into poverty. The Joseph Rowntree Foundation recently reported that in 2019, 1,062,000 households in the UK were destitute: that is 2,388,000 people and 552,000 children.

Take a moment to think about this: in the fifth richest country in the world we had significant numbers of men, women, and children unable to meet their basic needs, including food needs, compromising their mental and physical health, and condemning many children to never fulfilling their potential. And that was before the covid-19 pandemic.

We have seen people pulling together over the past year: food banks, community food projects, food aid distributors, businesses, and creative local authorities and other voluntary services groups stepped up to support those plunged into crisis by lockdown, ill health, job loss, and family crisis. No one disputes the importance of this phenomenal response, but food aid is a sticking plaster.

The Independent Food Aid Network (IFAN) works with food banks and community food projects across the UK, but has a vision of the UK as a country where everyone can eat good food and food aid is no longer necessary.

Good practice

We cannot turn our backs on the many who need support, and IFAN connects its members to each other to share good practice and intelligence, and offer practical and financial support. Importantly, IFAN campaigns for the essential structural changes we need to reduce and eventually eliminate the shameful food poverty on this wealthy island.

The charity has a vision of the UK as a country where everyone can eat good food and food aid is no longer necessary

While many of the bigger food aid organisations have had significant government and corporate support, IFAN represents and aids many of those working in more marginalised communities and does this without conflicts of interest. IFAN supports and develops the most effective and least stigmatising forms of emergency food aid provision while it is needed, but in ways that do not further embed or institutionalise what should be seen as a short term solution.

With a small team and committed trustees, the charity has become an essential voice in critical discussions about how we manage the crisis we have been plunged into, and plan for a better future. Seeing the UK languishing at the bottom of high income country league tables on how it supports its poorest citizens and topping tables of ill health related outcomes is not what many of us who have worked in food all our lives saw coming.

Many things have been sobering this past year but feeding our population, and particularly our children, and ensuring everyone has the human right to good food has to be a priority we all fight for in 2021 and beyond.

Helen Crawley, First Steps Nutrition Trust

LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Donating our "Christmas bonus"

RICHARD H SMITH

The UK government intends to honour its commitments to pay increases above inflation for NHS workers—doctors' pay will rise by 2.8% in 2020-21, equivalent to £2200-£3000 for consultants and GP partners and £1100-£2100 for specialty doctors.

But many other people will experience major financial hardship in 2021-22, through unemployment, pay freezes, tax rises, and spending cuts. Four million people (2.3 million children) experienced moderate to severe food insecurity in 2020, half of whom accessed a food bank (The *BMJ* Appeal 2020-21). Women, young adults, and people who earn a low salary have been disproportionately affected by unemployment, contributing to measurable declines in their mental health and homelessness.

This disparity presents an uncomfortable moral challenge for doctors, particularly when we remember the overwhelming support and financial generosity shown to NHS staff by the public during the first pandemic wave, often from sources with the least capacity to donate.

Should we collectively refuse our 2020-21 pay rise and allow the government to redistribute the estimated £300m saving? Perhaps, instead, we should individually consider redistributing our "Christmas bonus" to other people who need financial help, with gratitude for their kindness and support during the pandemic.

It would be some collective achievement for doctors to match the £140m (to date) donated to hospitals through the NHS Charities Together Covid-19 appeal, but it is possible if even half of us redistribute our gross pay increase (or all of us £72 a month), through payroll giving or direct donation with Gift Aid.

It's a big ask, but as professionals we're used to performing our duties without the expectation of reward. Perhaps doctors need a way of easing the moral injuries we have sustained during the pandemic, and making donations that would make a real difference to people's lives could help the process of moral repair.

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TO EACH CHILD THEIR OWN CORONAVIRUS

The elephant and the blind men

Martinerie and colleagues' view that SARS-CoV-2 infection is less severe in children is unsubstantiated (House of God, 19 December).

The parable of the blind men and the elephant is useful for describing the subjective experiences of coronavirus for children and might also offer a useful account of long covid itself. Each patient experiences their own version, which has required excellent communication to conceptualise the condition. The recent NICE guideline on long covid is a testament to this, showing that, when all the blind men share their experiences, they do not need to come to blows.

Children's experience of the virus relies on the advocacy of adults to be heard. The children from the Long Covid Kids organisation have made use of film to express their experiences. Let's ensure that responses to the pandemic for children are co-produced by children, their carers, and the official organisations that seek to offer assistance.

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GESTATIONAL AGE AT BIRTH AND CHILDHOOD ADMISSIONS

Obstetric decisions matter

Coathup and colleagues estimate that about 13% of hospital admissions in infancy could have been avoided if babies delivered at 38 or 39 weeks were instead delivered at 40 weeks (Research, 28 November). Previous work has also shown the adverse effects of early term birth on cognitive and educational outcomes.

Findings that link early term birth to poorer health outcomes emphasise the importance of open discussion with prospective parents around the balance of risks and benefits related to the timing of delivery when clinical decision making is not clear cut. Many early term births cannot be avoided, but the critical importance of gestational age at birth, and potentially the factors that precipitate early birth, for health and development across the life course warrant greater recognition. Interventions that improve maternal health and better obstetric monitoring are needed to increase the likelihood that mothers can carry their babies to term safely.

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THE FACE OF CPR

Is Annie still OK?

The story behind Resusci Annie is interesting (Grey's Anatomy, 19 December), but the manikins I have encountered in training have been exclusively male.

A leading manufacturer describes its male model as an "adult patient simulator," whereas the female model is a "female patient simulator." This feeds into a narrative that the male body is the default.

Last year I attended a simulation course that included all male manikins. I was initially pleased to discover the department owned a female model, but I soon learnt that it was designed for obstetric emergencies only. If it is vital to represent the female body in obstetric training, why doesn't this extend to situations beyond childbirth?

With calls to widen the diversity of medical training beyond the white, male experience of disease, perhaps we could extend Resusci Annie's legacy and move to improve diversity in simulation training, leaving behind the romanticised and arguably sexualised identity.

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