

comment

"Is the government applying the Nolan principles during the pandemic?" **DAVID OLIVER**

"It is not surprising some PCNs are not recruiting additional roles" **HELEN SALISBURY**

PLUS The Sewell race report will widen health inequalities

TAKING STOCK Rammya Mathew

Women leaders—not just an unattainable ideal

Last month, as part of International Women's Day celebrations, the BMA hosted a webinar with an impressive line-up of eminent female GPs, who spoke openly and passionately about their individual leadership careers. I was on the edge of my seat, refuelling on their energy and soaking up their words of wisdom. At the end of the 90 minutes, however, I was still waiting to hear the secret to maintaining a fast paced leadership career while also managing the demands of home and family life.

Of course, this reveals my own biases: would I expect a panel of men to talk about how they make World Book Day a success? But it's also true that women (and not men) are the ones being told that they can be anything they want to be in their careers, while also continuing to be society's carers and homemakers. Is the notion of "having it all" oppressive? Quite possibly so—but, if we live by our own definition of what it means to "have it all," we can liberate ourselves from the pressure of living up to an unattainable ideal.

At this point in time I couldn't manage a wild and unpredictable schedule or be away from home a lot of the time, but work is also a huge part of who I am, so neither could I imagine dropping my career ambitions or not using the skills I've spent years developing. Everyone's version of balance is different and, just as leadership is about learning to be your authentic self, it's also about being comfortable with your life choices. We can all help each other in this by recognising that there's no single right way and by respecting people who make life choices different from our own.

It's also the case that leadership comes in many guises. If we stop thinking about leadership as a position to earn and instead think of it as

"contribution," success then doesn't need to depend on us giving up aspects of our lives that are important to us. We may not all believe we're able to put ourselves forward for the position of college chair, but we can all demonstrate leadership within our own sphere of influence.

None of this means we shouldn't be ambitious or should be ashamed of wanting to climb the career ladder. Quite the opposite: I hope that, in my lifetime, women taking up positions of power will not be a celebrated event but will become the norm. But, for this to become a reality, it's also got to become normal to expect a panel of male leaders to speak openly about how they thrive in their careers alongside juggling the demands of parenting and caring, in all their forms.

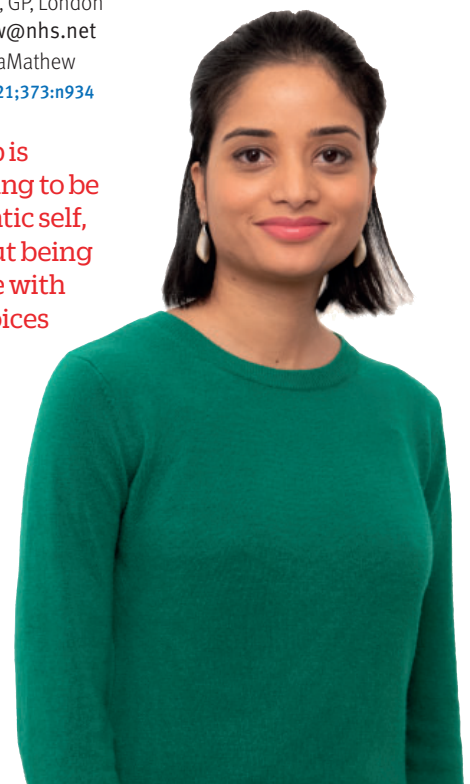
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If leadership is about learning to be your authentic self, it's also about being comfortable with your life choices



PERSONAL VIEW

Mohammad S Razai, Azeem Majeed, Aneez Esmail

Structural racism is a fundamental cause and driver of ethnic disparities in health

The UK government report on race is a missed opportunity and will lead to a worsening of systemic inequalities

That structural racism is an important factor in ethnic disparities in health will come as no surprise to anyone who has looked at the evidence. Several decades of research clearly show that racism in all its forms—in particular, structural racism—is a fundamental cause of ethnic differences in socioeconomic status, adverse health outcomes, and inequities in health.

The much delayed government report on race disparities has devoted 30 pages to disparities in health. The report claims that “for many key health outcomes, including life expectancy and overall mortality, ethnic minority groups have better outcomes than the white population.” It further claims that “genetic risk factors” along with cultural and behavioural factors have led to the disparities seen during the covid-19 pandemic.

Cherry picked data

The report’s section on health claims to undo several decades of irrefutable peer reviewed research evidence on ethnic disparities, previous governments’ reports, and independent reviews all reaching similar conclusions: ethnic minorities have the worst health outcomes on almost all parameters. The report’s conclusions, recommendations, and cherry picked data support a particular narrative that shows why it should have been externally peer reviewed by independent health experts and scientists.

Furthermore, we would expect that a report with ambitions of presenting a “new race agenda” would have at least one health expert or a biomedical scientist on the commission. It included a space scientist, a retired diplomat, a politics graduate, a TV presenter, and an English literature graduate, but no one with an academic background in health inequalities.

The report also concludes that deprivation, “family structures,” and geography—not ethnicity—are key risk factors for health inequalities. It ignores, however, the overwhelming evidence that systemic racism, in particular residential segregation, which is rising in the UK, is a major driver of ethnic differences in socioeconomic status. There is a wealth of evidence that segregation also affects health because of poorer quality education, employment opportunities, and poorer access to resources to enhance health.

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, and greater exposure to undesirable social and environmental conditions. Previous research also shows that segregation is independently associated with late diagnosis and inferior survival rates in lung or breast cancer.

The report says that health data are inconsistent and incomplete, but still concludes that life expectancy is improving for ethnic minorities. This is not true. It cites two reports on life

The report lacks the scientific credibility to be used for major policy decisions

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expectancy in Scotland where only 3% of UK ethnic minorities live.

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, who have higher rates of deprivation and poorer health outcomes. The report’s data, which show lower life expectancy in black and South Asian people compared with people with white ethnicities, does not support its own conclusions.

The devastating effects of covid-19 on ethnic minorities have exposed and aggravated the structural socioeconomic disadvantages experienced by ethnic minority communities. There is no evidence of “genetic risk factors” for covid-19 as the report claims. There is now sufficient evidence that ethnic disparities in covid-19 are partly because of high risk public facing jobs, living conditions such as multigenerational households, poverty, and chronic comorbidities, as well as racial discrimination and the effects of structural racism such as residential segregation.

Wider adverse consequences

Black and South Asian men are, respectively, 4.2 times and 3.6 times as likely to die from covid-19 as their white counterparts. A similar trend is seen for other covid-19 measures, with higher rates of infection, hospital admissions,





and intensive care admissions for these groups. Ethnic minorities also continue to experience wider adverse consequences of the pandemic including mental health problems, unemployment, financial insecurities, and housing evictions.

Ethnic disparities in covid-19 are part of the historical trend of poorer health outcomes in marginalised ethnic groups with higher rates and earlier onset of disease, more aggressive progression of disease, and premature death. Empirical analyses show that ethnic differences in health persist even after adjustment for socioeconomic status. In the UK, for example, black women are five times more likely to die during pregnancy than white women and black people have a greater risk of detention under the Mental Health Act than white people.

This report is a missed opportunity. It lacks the scientific credibility and authority to be used for major policy decisions. Its methodology and language, its lack of scientific expertise, and the well known opinions of its authors make it more suitable as a political manifesto than an authoritative expert report.

The new government approach on race, divorced from reality, fails to provide any solutions to ethnic disparities in health. Its attempts to undermine the well established and evidence based role of ethnicity on health outcomes will lead to a worsening of systemic inequalities, putting more ethnic minority lives at risk.

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ACUTE PERSPECTIVE David Oliver

Is there a point to the Nolan principles?

In 1995 the Committee on Standards in Public Life published seven principles for public office holders, commonly referred to as the Nolan principles, after the committee's chair. These standards for ethical conduct are still officially endorsed by the government. We still have a public standards committee. But events during the pandemic make me question whether ministers, special advisers, and some public officials even pay lip service to the principles any longer.

Last November the committee's chair, Jonathan Evans, delivered the Hugh Kay lecture, "Are we in a post-Nolan age?" He argued, "These principles are not a rulebook. They are a guide to institutional administration and personal conduct and are given a hard edge when they inform law, policy, procedure, and codes of conduct.

"We expect office holders to use public funds for the common good, and not to enrich themselves or their families. We expect elected representatives to work for their vision of the common good, rather than acting for their own advantage. And we take for granted that there should be fairness in the decision making processes—in areas such as policy, planning, and procurement—that will shape our future."

But has this applied during the pandemic? Both the National Audit Office and the Public Accounts Committee have criticised ministers for a lack of transparency and integrity in awarding large contracts to provide PPE, test and trace, and consultancy. Many have gone to party donors or to politicians' friends, former colleagues, or spouses.

Do ministers even pay lip service to the principles any longer?

In February the High Court ruled that Matt Hancock, the health secretary, had acted illegally by failing to disclose details of procurement contracts within the required 30 days. Yet he brushed this off as a mere technicality, excused by the pressing exigencies of the pandemic. It took the threat of legal action by Moosa Qureshi, a frontline NHS doctor, to force the release of partial details of the pandemic planning exercise, Operation Cygnus.

Government ministers have been caught making misleading statements about care homes guidance or about actions taken. For example, Hancock claimed we'd "thrown a protective ring around care homes," when around a third of all covid deaths had occurred in care homes and staff couldn't get hold of the right tests or equipment.

The chief nursing officer, Ruth May, said on the record she'd been dropped from a press briefing for saying she'd be critical of No 10's defence of its chief adviser, Dominic Cummings, after his alleged breach of covid travel restrictions. Cummings was defended by ministers—yet research has shown a loss of public trust in behavioural restrictions and a change in behaviour. My list could be a lot longer, but you get the point.

In his lecture, Evans concluded the Nolan principles remained "the standards and tools we need to map a clear route through"—but only after he himself had cited various examples where public figures had been casually ignoring them.

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Additional roles won't cut GPs' load

I love being a GP, but right now it feels like an impossible job. Demand is growing, both in volume and complexity, so even though the days are getting longer, I still leave work after dark. The pressure feels particularly acute now, as many patients who have been sitting at home with their symptoms and worries for most of the past year are feeling confident enough to seek help.

The UK does not have enough GPs, and many of us are already choosing to work "less than full time" in our surgeries. If a full day consists of 12 or 13 hours, a five day week is impossible. In the absence of a "magic doctor tree," one proposed solution is to employ people with other skills and qualifications in primary care. To this end, primary care networks (groups of practices serving 30 000-50 000 patients) have been recruiting pharmacists, physiotherapists, and social prescribers, among others. The cost is covered (in theory) by the Additional Roles Reimbursement Scheme. But take-up has been slow: the lightening of the load for GPs has yet to materialise for many of us.

This is partly because these staff are thin on the ground. There is huge competition for clinical pharmacists, which has pushed the market salary above the rate at which the scheme will reimburse. For other roles, it is not clear we need them in our surgeries. I would be happier to refer a patient quickly and easily to a podiatrist or a dietician than having to employ one (which also means finding them a

space to work). Given the amount of training and supervision required by recruits of all types coming from different clinical settings, it is not surprising that some primary care networks have been slow to take advantage of the scheme.

The scheme may yet mature and bear fruit. After all, a pandemic is not the easiest setting in which to recruit and train staff, and delivering vaccinations has taken up much of the energy needed for strategic planning. But there are puzzling omissions from the list of reimbursable roles. The most obvious of these is mental health workers—we would welcome someone with these skills to our team.

But the thing that would most help make my hours shorter is more doctors able to take responsibility for a list of patients. Our practice is relatively well staffed, with 2000 patients for each full time GP (compared to the national average of 2253), but the amount of work generated in terms of letters, prescriptions, referrals, and results is huge.

We have been slow to recruit, and I look forward to having a physiotherapist and a pharmacist on site in the near future, as they will improve the care we give. But I still don't see that they will substantially lessen my workload. Without a solution that reduces our administrative load, we will fail in the crucial task of retaining our older doctors and recruiting new ones.

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The thing that would most help make my hours shorter is more doctors



LATEST PODCASTS



Vaccines and headaches

A headache and fever are common symptoms after vaccination. Yet with concerns about the potential link between AstraZeneca's covid-19 vaccine and blood clots, exacerbated by the recent frenzy of media coverage, clinicians may find that a greater number of patients want to discuss vaccination side effects. In the latest episode of Deep Breath In, Heather Angus-Leppan, a consultant neurologist, discusses how GPs may safely assess for cerebral venous sinus thrombosis in a patient presenting with a headache post-vaccination:

"The red flags that we use for headache assessment really do apply here. If we're thinking of this particular scenario of cerebral vein thrombosis, you can have a headache because of raised intracranial pressure—so as well as a headache, you'll have visual symptoms, you'll have swelling of the optic disc, and it'll be a progressive worsening headache. You can have focal seizures. You can have focal deficits such as speech disturbance or weakness, and you can have progressive encephalopathy or a reduced level of consciousness—simply drowsiness. Those are the main sorts of symptoms you'll see."

Healthcare's economic impact

To clinicians, the link between health and the economy is pretty clear, but how much do we know about the extent to which particular interventions have broader impacts? This podcast hears from some economists, including Till Bärnighausen, about this evidence gap:

"We have strong knowledge on some general aspects, but we have surprisingly little specific knowledge on what particular diseases cause a loss in economic functioning, in educational attainment, and cognitive development in children. We care about these things deeply as societies, as individuals, as families, but we know surprisingly little about what particular diseases cause in terms of those outcomes."



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

ANALYSIS

Preventing the next pandemic: the power of a global viral surveillance network

Dennis Carroll and colleagues call for a worldwide early warning system to detect viruses with pandemic potential

The covid-19 pandemic has exposed failures to respond effectively to the emergence of a highly contagious and lethal microbial threat. Covid-19, however, is not the first pandemic this century due to an emergent pathogen and is unlikely to be the last.

Over the past 20 years a number of high impact pathogens have emerged or re-emerged, such as three new coronaviruses—severe acute respiratory syndrome (SARS) in 2003; Middle East respiratory syndrome (MERS) in 2012; and the current covid-19 pandemic (SARS-CoV-2). We have also seen several highly pathogenic influenza A viruses (eg, H5N1 in 2003; H7N9 in 2013; and the H1N1 pandemic in 2009), the Zika virus in 2016, and the continuing rise and spread of Ebola in West and Central Africa since 2013.

All these pathogens have jumped from transmission among non-human animals to transmission among humans. During this century, the frequency of epidemics and pandemics might continue to increase, driven mainly by demographic trends, such as urbanisation, environmental degradation, climate change, persistent social and economic inequalities, and globalised trade and travel.¹⁻³



KEY MESSAGES

- Covid-19 has exposed considerable weaknesses in the ability of global health systems to detect early, and respond effectively to, emergent pathogens
- An early warning system that detects new viral spillover well before it becomes a local outbreak is needed
- A global, risk based, multisectoral viral surveillance network would focus on detecting new “high consequence” viruses in humans and animals in hotspots for emerging risks
- For sustainability of an early warning system, strong political commitment, a sound governance structure, and long term financing will have to be assured
- The opportunity exists to leverage political and financial support to establish and implement a global early warning surveillance network to detect emerging threats

Current systems are not equipped to deal with pandemics

Past epidemics with pandemic potential were mainly identified through an unusual cluster of severe cases or deaths in humans. This means of identification is weak, and is often missed by classic surveillance systems.

Estimates suggest that 1.7 million viruses exist across 25 high consequence viral families, of which 500 000-700 000 are likely to be zoonotic. Few viruses are likely to have the ability to infect humans and even fewer the ability to spread.⁴ Even if the likelihood of spreading is low, the impact, as illustrated by the covid-19 pandemic, might be disastrous and justifies investment in systems that can prevent such events.

Attempts to strengthen global health security over the past decade have been welcomed, but existing capacities, processes, and institutional arrangements, such as the International Health Regulations⁵ and the Global Health Security Agenda,⁶ have been insufficient to prevent events such as those caused by SARS-CoV-2.

Existing capacities, processes, and institutional arrangements have been insufficient to strengthen health security

The experience of the covid-19 pandemic underlines the need to create global strategies, policies, and regulatory frameworks that deal directly with the multisectoral aspects of disease emergence and improve our collective ability to prevent, rapidly detect, and respond to, threats.

In addition to strengthening existing health systems, key to these efforts is building a surveillance system that spans wildlife, livestock, and human populations.⁷⁻⁹ Such a system would use known geographical “hot spots”^{10 11} for early detection of any viral transfer into human and livestock populations, and pre-emptively disrupt further transmission of the virus locally.¹² Pre-emptive action would contribute to an enhanced ability to forecast future threats and enable early intervention.

Current surveillance operations are nearly all event based, syndromic in nature, or focused on a single pathogen

Global syndromic and viral surveillance systems

Much can be learnt from ongoing surveillance systems.¹³ For example, the global early warning and response system is a formalised monitoring and reporting platform for outbreaks of disease, established in 2006 by the World Health Organization (WHO), the Food and Agriculture Organization (FAO), and the World Organization for Animal Health (OIE).¹⁴

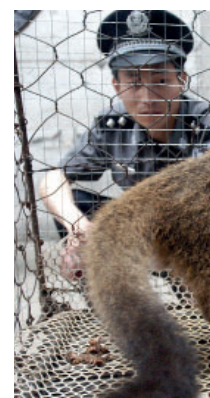
This early warning system aims to combine the strengths of three organisations to enhance a public and animal health early warning system intended to reduce the incidence and effects of emerging infectious diseases in animals and humans. Partners from all over the world working in the animal and public health sectors share real time information on disease outbreaks; conduct rapid cross-sectoral risk assessments; and support the forecasting, prevention, and control of emerging diseases.

In addition, for more than 50 years, WHO's global influenza surveillance and response system has been monitoring the evolution of influenza viruses to inform the development of the annual influenza vaccine, and to serve as a global alert mechanism for the emergence of influenza viruses with pandemic potential.¹⁵ This system with its national, regional, and global partners identifies and analyses influenza strains isolated from clinical specimens and conducts detailed characterisation of unusual virus isolates. This information and the web based data reporting and mapping system FluNet¹⁶ provide information on circulating seasonal influenza viruses. FluNet is further supported by WHO FluID, a global platform for data sharing that integrates regional influenza epidemiological data into a global database.¹⁷

The 2009 H1N1 pandemic showed that real time monitoring for viruses without information on the severity and impact of the disease was inadequate for mitigating the effects on health of an epidemic. Therefore, from 2009, most influenza surveillance systems around the world started to include standardised case definitions for influenza-like illnesses and severe acute respiratory influenza, and real time modelling. Similarly, OFFLU, the name of the OIE/FAO network of expertise on animal influenza, was established in 2005 to collaborate with the existing WHO influenza network.¹⁸ OFFLU promotes the collection, exchange, and characterisation of animal influenza viruses within the network and the sharing of such information more widely.

These collaborations are important examples of current surveillance operations, but nearly all are event based, syndromic in nature, or focused on a single pathogen. For example, the scope of the global early warning and response system concentrates on early detection of disease outbreaks and does not monitor the detection of emerging pathogens in animals and humans. The global influenza surveillance and response system and OFFLU are excellent examples of robust, multisectoral global viral surveillance systems, but they focus mainly on influenzas. In these systems, pathogens are predominantly detected and isolated from outbreaks.

Apart from the West Nile virus and other arbovirus surveillance activities,¹⁹ no formal system is in place in any country that routinely conducts active viral surveillance in humans and domestic animals combined with rapid clinical assessment for a list of priority emerging and re-emerging viral diseases.²⁰



Strategic sampling in wild animals, livestock, and humans would preclude the need to conduct viral surveillance worldwide

It's now time to build a sustained, multisectoral global viral surveillance network

The magnitude of the health and socioeconomic effects of the covid-19 crisis reinforces the need to establish a formal global surveillance network specifically to prevent pandemics. Such a network would conduct viral surveillance for the early detection of spillover from wildlife to livestock and humans well before development into localised outbreaks, and thus pre-empt high consequence epidemics and pandemics.

Although such a formal network has never been set up, it would not necessarily constitute an entirely new undertaking. Rather, it would build on existing multisectoral surveillance operations, leveraging the systems and capacities that are already operational. These operations would be aligned through the adoption of standardised protocols and a commitment to data sharing to inform a global database.

The network's focus on strategic sampling in wild animals, humans, and their livestock in predefined hotspot regions^{10 11} would preclude the need to conduct viral surveillance worldwide. In practice, the latest diagnostic technologies would be required to detect early spillover in real time and to test samples for many viruses from priority pandemic viral families, and other new viruses originating from wild animals. In parallel, a globally agreed protocol and decision support tool would be needed to ensure the elimination of new viruses from infected humans and animals as soon as they were discovered.

Technically, such an approach is feasible with rapidly evolving multiplex diagnostic methods and affordable next generation DNA sequencing technologies that enable a generic approach to virus identification, without a priori knowledge of the targeted pathogens, delivering a species/strain-specific result.²¹

A global viral surveillance network would become more efficient in detecting early viral spreading into humans as new genetic data of zoonotic viruses in wild animals from viral discovery projects,



GETTY IMAGES

such as the Global Virome Project,⁴ and associated metadata, are deposited in global databases. These data could also contribute to improved diagnostic reagents and their use through new, and more widely available, cost effective pathogen detection and sequencing devices. The targeting of proposed viral surveillance would also be enhanced with the refinement of current hotspots. These analytics, combined with bioinformatic tools, artificial intelligence, and big data, would help to prevent pandemics by progressively strengthening the capacity of a global surveillance system to improve infection and transmission dynamic models and forecast.

Establishing such a network for longitudinal surveillance has considerable challenges, particularly in under-resourced, hotspot regions, where basic health and laboratory capacities are weak. Technical and logistical challenges exist in designing sampling frames for viral surveillance, establishing mechanisms for information sharing about rare spillover events, training a skilled workforce, and ensuring infrastructural support across public and animal health sectors for the collection of biological samples, transportation, and laboratory testing. A regulatory and legislative framework would be necessary to deal with the challenges of handling, standardisation, analysis, and sharing of large volumes of multidimensional data.

A formal surveillance network would also require its own governance mechanism and membership of public and private sector organisations, similar to the Global Alliance for Vaccines and Immunisation. It should also be fully aligned with existing United Nations structures, such as the FAO/OIE/WHO.²² To ensure long term sustainability of the network, innovative financing strategies, such as a combination of endowment, grants, and contributions from financing institutions, member countries, and the private sector, will be needed.

These investments should also be linked to incentives, especially for the global south, including technology transfer, capacity development, and the equitable sharing of information about new viruses detected through the global surveillance programme.^{23 24}

The approach we describe is fundamentally different in scope and scale from syndromic, passive, or single pathogen surveillance from disease outbreaks, requiring the collaboration of multiple sectors and a strong political commitment from most countries in the global north and south. Although an integrated surveillance system is critical, ultimately, a multipronged, multisectoral approach will be necessary to prevent zoonotic transmission. Efforts must focus on dealing with the root causes of spread, reducing risky practices, improving livestock production systems, and enhancing biosecurity along the animal food chain.²⁵ At the same time the development of innovative diagnostics, vaccines²⁶ and therapeutic agents must continue.

The world is now well aware of the devastating health and socioeconomic impacts of the covid-19 pandemic. We have an opportunity to leverage political and financial support to establish and implement a global early warning surveillance network to deal with emerging threats in a sustainable way.^{23 24} Coordination among international agencies, relevant national and regional partners across sectors, and financing institutions will be essential for the progress of such an important global initiative.

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Domestic violence during the pandemic

Healthcare systems have failed to respond adequately despite increased need globally

Domestic violence and abuse is a violation of human rights that damages the health and wellbeing of survivors and their families. Although both men and women are affected, incidence and severity are much greater for women: the World Health Organization recently estimated that a third of women worldwide experience domestic violence or abuse in their lifetime.¹

Domestic violence has been magnified by the covid-19 pandemic in two senses: incidence has increased globally, and the presence of domestic violence within all societies has also been revealed more clearly, alongside other adversities and inequalities. The societal response must be multisectoral. Here, we focus on challenges to the healthcare response.

Meeting the needs of survivors and their families requires additional healthcare resources and must be informed by accurate data on the incidence and effect of domestic violence and abuse, and by an understanding of the experience of survivors seeking support. Uncertainty remains about the size of the increase in domestic violence globally during the covid-19 pandemic. Calls to support services and to the police have varied over the past year, with large increases in most countries, including the UK,³ Brazil,⁴ and Nepal. Yet, emergency department attendance for domestic violence and non-partner sexual violence has fallen substantially, along with general emergency department attendance.⁵

We have no data yet from population surveys, and administering these during



Healthcare settings should be safe places for disclosure of abuse

lockdowns is challenging as it may not be safe for someone to disclose violence or abuse when perpetrators are likely to be present.⁶ In the UK, domestic violence includes abuse by an adult within a household or family who is not a spouse or intimate partner. This type of abuse is also likely to have increased, but we have no supporting data. Nor do we understand how children's exposure to domestic violence interacts with other adversities amplified by pandemic restrictions.⁷

Need for privacy

Healthcare settings should be safe places for disclosure of abuse, for managing the direct effects on health—including both physical and mental harm—as well as for referral for specialist support, when available. This can be problematic in facilities with insufficient privacy or when the victim is prevented from seeing a doctor or nurse on their own.

In many parts of the world, the shift to remote (audio or video) consultations makes confidential conversation difficult, inhibiting disclosure. Yet healthcare may be the only contact that an abused person—isolated by the perpetrator from friends and family—has with the outside world. In the UK, resources for clinicians, including specific guidance on remote consultations, are available from IRISI, a social enterprise set up to

promote a better healthcare response to gender based violence.⁸

Global experience

Estimates extrapolated from calls to hotlines suggest that the incidence of domestic violence has increased during the pandemic in Latin America. Domestic violence was increasing even before the pandemic in Brazil because of cuts in social and healthcare funding and to support programmes. Local government and non-governmental organisations responded by launching hotlines and online resources, but the healthcare sector has yet to contribute meaningfully.⁹ Reports of domestic violence from the Brazilian healthcare sector fell by 34% compared with 2019, for example.¹⁰

Calls to Nepal's national helpline doubled between April and June 2020 compared with the previous year.¹² Women who experienced violence disclosed to friends or community based human rights organisations rather than healthcare professionals.¹³ Reduced access to health services during the pandemic made recognition of abuse and appropriate support even more difficult.

Although better data on the incidence of domestic violence during the pandemic are necessary to quantify the resources needed for extra services, we don't need to wait to provide safe spaces for disclosure in healthcare settings, or to invest in advocacy and support services that are fully integrated with healthcare. After the pandemic, we must target resources on improving the healthcare response by building on the increased visibility of this kind of abuse, our improved understanding of its association with other inequalities, and the likelihood that healthcare in many countries will continue to use a blend of remote and face-to-face consultations.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Reporting of AstraZeneca studies, not Brexit, may have led to vaccine negativity



Abbasi asks whether negativity towards the AstraZeneca vaccine in the EU is a political hangover from Brexit (Editor's Choice, 20 March). I think the initial reservations were related to how the results were presented.

Both Pfizer and Moderna had clinical trials based on a single protocol resulting in a single publication with good efficacy in all ages. But the initial AstraZeneca publication was based on multiple protocols and, by mistake, a subgroup of patients had been given a reduced first dose and showed greater efficacy. The researchers initially attributed the higher efficacy to the reduced dose but later suggested it was due to the increased interval between doses.

Neither study provided direct evidence about the efficacy in older people, so some European nations initially decided to use the AstraZeneca vaccine only in people under 65. The United States did not authorise the AstraZeneca vaccine at all. Only the more recent effectiveness studies and the release of the American trial data have provided definitive evidence of efficacy in older people.

Concerns about blood clots involved a non-EU nation (Norway) and resulted in some countries suspending distribution of the AstraZeneca vaccine for a few days. My impression is that there was a need to respond to concerns raised in the media across Europe. Signals from postmarketing surveillance should not be ignored because low frequency adverse events cannot be identified in phase III trials.

The European Medicines Agency (EMA) subsequently concluded that, despite no overall increase in risk of thromboembolic events, the AstraZeneca vaccine could be associated with two rare types. The number of these cases increased, and a common pathogenesis (similar to heparin induced thrombocytopenia) was proposed.

Comparing putative side effects with their natural occurrence is difficult. If risk factors were identified, they could be used as selective contraindications to this vaccine.

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VACCINE HESITANCY AMONG MINORITY GROUPS

Covid-19 vaccination during Ramadan

Vaccine hesitancy has been reported among people and healthcare staff from ethnic minorities (Editorial, 13 March).

This year, Ramadan, the month of fasting, spans April to May. People from some ethnic minority backgrounds, such as black, Bangladeshi, and Pakistani people, may be more hesitant to receive a covid vaccination because they don't want to compromise their fast. It is important for these groups to know that having vaccines intramuscularly during fasting time (dawn to dusk) does not nullify one's fast, and vaccination should not be delayed.

Internationally, healthcare advocates need to work with Muslim faith leaders to disseminate this information. People might also be concerned that the potential side effects of vaccination—myalgia, headache, and tiredness—could make it difficult to maintain their fast. Clinicians and covid-19 vaccinators can advise those fasting to drink more clear fluids and take simple analgesia outside of fasting times to mitigate any side effects.

Faraz Mughal, GP and National Institute for Health Research doctoral fellow, Keele

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COVID ANTIBODIES FROM INFECTION OR VACCINATION

Spectrum bias can underestimate population immunity

A surprisingly low SARS-CoV-2 seroprevalence of 14% was recently reported for the UK (Seven Days in Medicine, 6 March).

One possible reason for this low estimate is the use of self-administered lateral flow tests in the React-2 study. The test performance estimates were based on the analyses of clinically ill people with SARS-CoV-2 infection (cases) and pre-pandemic samples (controls), leading to a substantial spectrum bias. This is a major problem for population studies as many people have had a mild or asymptomatic course, which is more difficult to detect than moderate to severe infections.

Commercially available tests based on venous blood miss up to 40% of infections, and lateral flow tests are even less accurate. In Switzerland, Corona Immunitas chose a sophisticated test, with test performance estimates based on a population based sample. This is more laborious and costlier but gives a more accurate picture of immunity development in a population.

Milo A Puhon, professor of epidemiology and public health, Zurich; Arnaud Chiolerio, professor of public health, Fribourg; Jan Fehr, professor of health and travel, Zurich; Stéphane Cullati, senior lecturer in epidemiology, Fribourg. On behalf of the Corona Immunitas Research Group

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CALORIE LABELS AND PUBLIC HEALTH

Restaurants and recovery from eating disorders

I was disappointed but not surprised that the article on calorie labels in restaurants (Analysis, 27 February) didn't mention the potential impact on the thousands of children and adults who suffer from eating disorders.

In most restaurants, food is measured, prepared, and served by someone else out of sight, so the eating disorder is deprived of the rigidity it thrives on. It can therefore become an important exercise in recovery to go to a restaurant and choose a meal based on personal taste and appetite rather than calories or grams of fat. Introducing calorie counts on menus would prevent this.

I know the financial cost of obesity to the NHS vastly outweighs the cost of eating disorders, but in view of the paucity of evidence in favour of compulsory calorie counts in tackling the obesity crisis, we should be considering the potential impact on people with eating disorders.

Lucy Olsen, foundation doctor year 2, Kingston on Thames

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OBITUARIES

Philip Cook Jackson

General practitioner (b 1958; q Sheffield, 1982), died suddenly on 16 December 2020

Philip Cook Jackson

("Phil") was a successful, respected family doctor in Clay Cross. He was

committed to his patients and proud to practise old fashioned family centred medicine. He became senior partner and was instrumental in getting a new health centre built in Chesterfield. He was very proud of this achievement and shortly after took early retirement. During retirement, Phil moved in with his mother to care for her in her later years, during which time she was diagnosed with dementia. Phil was dedicated to his family yet struggled with depression throughout his life. Despite his illness the abiding memory of him in those who knew him is his sense of fun. He leaves a son, a daughter, a grandchild, a brother, and extended family and friends. He will be sadly missed by them all.

Richard Watton

Cite this as: *BMJ* 2021;372:n345



Oonagh Lynch

General practitioner Hanworth, Middlesex (b 1930; q University College Dublin, 1955), died from haemorrhage during a transcatheter aortic valve implantation on 1 December 2020

Oonagh Lynch (née Arbuthnot) was born in Cork, Ireland, but moved to Upminster in Essex as a child when her father, a manager at Ford, was transferred to the Dagenham plant as it opened in 1931. She returned to Ireland to study medicine and qualified in 1955. She married Dermot in 1957 and he took up a GP assistant post in Oonagh's uncle's practice in Hanworth, Middlesex. Oonagh later joined the practice too. She swiftly shook up the stuffy male dominated world that existed there, and the practice continues as a family business. Oonagh retired in 1991. The pillars in her life were her family and her strong Roman Catholic faith. She leaves Dermot, five children, 19 grandchildren, and three great grandchildren.

Brian Lynch

Cite this as: *BMJ* 2021;372:n347



Shaun Michael Gravestock

Consultant psychiatrist in forensic learning disabilities at East London and City NHS Trust (b 1962; q Newcastle 1985; MRCPsych), died from covid-19 pneumonia on 9 January 2021

Shaun Michael Gravestock grew up in County Durham in the north east of England. He moved to London to join the St George's psychiatry training rotation in 1986. Shaun was married to Darren Ward, a nurse he met in London in March 1988. They were together for 33 years. Shaun and Darren also have an adopted son, Patrick, who is now 22. Shaun retired from his NHS work at the end of March 2020. He was a larger than life character, who despite living and working in London for several decades was proud of his County Durham roots. He loved his job and was passionate about improving the lives of people with intellectual difficulties. He leaves his husband, son, family, friends, and colleagues.

Darren Ward

Cite this as: *BMJ* 2021;372:n344



Angus Howard Weir Bain

General practitioner and police surgeon (b 1925; q Westminster Hospital, London, 1948), died from covid-19 pneumonia and pulmonary embolus on 28 December 2020

Angus Howard Weir Bain

was a house physician and house surgeon in Grimsby and Epsom, in the newly formed NHS. He started in general practice at Southend Lane in Catford and later extended the practice into the South Lewisham Health Centre with three partners. He was dedicated, hardworking, and greatly valued by his patients; he retired in 1992. Angus also worked as a police surgeon, covering Lewisham, Catford, and Penge police stations until 1998. He played bridge regularly until lockdown at Beckenham Bridge Club, whose president he was for a while. Angus's wife, Elizabeth, died four days after him. They leave four children, 10 grandchildren, and eight great grandchildren.

Lawrence Bain, Sophie Dear, Catherine Clifford, Janet Cole

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Brian M Davies

Professor of psychiatry (b 1928; q Cardiff 1950; MRCP Lond, MD, DPM), died from complications of prostate cancer on 15 November 2020

Brian Davies trained in psychiatry at the Maudsley Hospital. From 1956 to 1964 he immersed himself in the newly emerging and exciting subject of research into antidepressants. By 1963 Brian had decided to take a position as a consultant in London, but the UK government "froze" all new consulting positions in England. He subsequently applied for "an interesting opportunity" in Australia as the inaugural Cato professor of psychiatry at the University of Melbourne and was duly appointed. To the end of his tenure 26 years later, he steadfastly focused his energies on teaching students and postgraduates, seeing and treating many patients, and facilitating quality research. Predeceased by his wife, Rona, in 2019, Brian leaves two children and three grandchildren.

Roger Glass

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Robert Booth Tattersall

Professor of clinical diabetes, Nottingham (b 1943; q 1967; MD Camb, MRCP (UK), FRCP Lond), died from heart failure on 23 November 2020

Robert Tattersall studied at Cambridge and St Thomas' Hospital. He pursued his interest in monogenic diabetes with Steve Fajans in Ann Arbor before taking up a senior lecturer post at Barts. The following year he applied for an NHS consultant post in Nottingham, which enabled him to be in the same town as his beloved Nottingham Forest Football Club. Among his ground breaking contributions to diabetes management was introducing blood glucose meters for general use. In mid-career, Robert decided that 25 years in clinical medicine was enough and he took early retirement at 55, to devote himself to medical history. He was a voracious reader of classical English literature and loved cryptic crosswords. Robert leaves his wife, the psychiatrist Bridget Jack; two daughters; and five grandchildren.

Edwin Gale, Rachel Tattersall

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Donal O'Donoghue

Visionary nephrologist and registrar of the Royal College of Physicians

Donal Joseph O'Donoghue (b 15 August 1956, q 1980; OBE, MBCHB, FRCP), died from covid-19 on 3 January 2021

In 1992 Donal O'Donoghue, aged 36, was appointed consultant renal physician at the Hope Hospital (now Salford Royal Hospital) in Manchester, a post he held throughout his career.

At the time, without national protocols, treatments were ad hoc. There was not enough access to haemodialysis, so 50% of dialysis patients were having peritoneal dialysis, although it is less suitable for elderly or frail patients. Keen to improve patient care, in 1993 O'Donoghue became director of the Greater Manchester Renal Network, England's first managed clinical network.

He reconfigured renal services with Salford Royal Hospital and the Manchester Royal Infirmary as the hubs, surrounded

by satellite dialysis centres. O'Donoghue was concerned that kidney failure was associated with poor outcomes and very high costs and wanted to standardise treatment and move the focus upstream to improve rates of early diagnosis.

Renal champion

While continuing to work at the Salford Royal, he took national appointments that put him at the centre of kidney medicine, where he could champion early intervention. In 2000 he became the inaugural president of the British Renal Society, which advanced research and brought specialist professionals together, and from 2006 to 2013 he was the first national director of kidney care at the Department of Health, leading the implementation of the renal national service framework.

Access to haemodialysis and transplantations had been a postcode lottery, but

the framework set national standards. Its quality outcome frameworks for kidney disease required GPs for the first time to identify and keep a register of kidney patients, including calculating their estimated glomerular filtration rate. O'Donoghue would regularly speak to groups of GPs across Manchester about its value and the importance of their role.

O'Donoghue was president of the Renal Association from 2016 to 2018. He oversaw a complete update of governance, which paved the way for the subsequent merger of the British Renal Society and Renal Association. In 2018 he became the registrar at the Royal College of Physicians, where he was instrumental in bringing together different specialties and advocating for covid-19 vaccinations.

Teaching, research, charity work and "Ask Donal"

With his colleague Philip Kalra, O'Donoghue helped train more than 25 specialist renal registrars at the Salford Royal. He also supported research and was a co-author of *The economic impact of acute kidney injury in England* in 2014. It found that around 1000 hospital deaths a month from acute kidney injury could be prevented with better hydration and nursing care and led to quality standards on the condition from the National Institute for Health and Care Excellence.

As UK chair of trustees at Kidney Research UK, O'Donoghue promoted the work of the charity, had an "Ask Donal" blog, and helped fundraise, taking part in fun runs. He had a huge respect for patients' views and loved to emphasise that his OBE, awarded in 2018, was for "services to kidney patients."

Early life and career

Donal Joseph O'Donoghue was born in Manchester in 1956, where his father was the head teacher of a primary school. Both his parents were of Irish descent, and many summer holidays were spent in Kerry. Later, he came to love Seamus Heaney's poetry. He was football mad, and a highlight of his childhood was going to see the European Cup Final in 1968 where Manchester United won their first European cup. He remained a fervent fan all his life, never missing a home match, and in 1999 was delighted to get Alex Ferguson to open a renal unit.

O'Donoghue attended De La Salle College in Salford and in 1974 went to Manchester University, where he studied physiology and medicine, graduating with a first class degree in 1980. After several house jobs, he became a registrar in renal medicine at Manchester Royal Infirmary in 1985 and made this specialty his career.

After a year in Paris in 1989 on a travelling fellowship from the Medical Research Council, he moved to Edinburgh Royal Infirmary to become a senior registrar before taking up his long term post as a consultant physician in Salford in 1992.

O'Donoghue married French teacher Marie Magennis in 1978, and they had three children. In mid-December 2020 O'Donoghue became ill with covid-19. After two weeks in intensive care in Stepping Hospital, Stockport, he died on 3 January. He leaves his mother; his wife, Marie; his brother, Gerard; three children; and four grandchildren.

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O'Donoghue loved to emphasise that his OBE was for "services to kidney patients"

JAMES O'DONOGHUE