comment

"The term 'front line' for clinical staff is snappy, effective shorthand" **DAVID OLIVER**
"NHS Digital needs to find a better plan for data security" **HELEN SALISBURY**
PLUS Focus has to be on local public health teams; gambling and primary care

CRITICAL THINKING Matt Morgan

Whose leg is it anyway? Ownership and medicine

Both surgeons wanted the best for the patient. Unfortunately, they disagreed about what "best" really meant.

The on-call consultant argued that an emergency operation could save the patient's leg. Meanwhile, the surgeon who had known the patient for years believed that the risks involved in an operation would be greater than any benefit. Sadly, the patient couldn't decide for themselves as they were unconscious, critically ill, and on a life support machine. All of this made me wonder, "Whose leg is it anyway?"

Shared decision making in medicine is typically shared between the patient and the doctor. But what if sharing is also needed between the competing viewpoints that exist in the healthcare team? It made me think about the ways in which the language of medicine often uses terms of ownership.

"Whose patient is this?" is often asked.

"Mine," is often the answer.

Although these terms of possession may sound paternalistic, "ownership" also brings responsibility. It encourages healthcare workers to act as advocates for someone they want the best for. The "named consultant" is responsible for holding the sometimes heavy rope that ties them directly to the care and wellbeing of another person, even when they are far apart. Ownership, like sharing, also goes both ways. Patients can often feel as though we belong to them.

"Who did you see?" is often asked.

"My own consultant," is often the answer.

Who does a patient really belong to? And who does a doctor belong to? As I wrote earlier this year in *The BMJ*, in the complexity of modern healthcare we need an entire village of people to care for us, not one sole trader. Sometimes we need the butcher, sometimes the baker, and sometimes the candlestick maker too. Sometimes we even need help from people whose names we may never know. As a result, patients should belong to the whole healthcare village, the system in which they put their trust.

Is it perhaps time to change the name on the end of the patient's bed to a team rather than an individual?

We need shared ownership to allow shared decision making, not only between doctors and patients but sometimes between doctors and other doctors. Ultimately, of course, patients don't belong to anyone other than themselves. As doctors, we simply take them under our care from time to time, hoping to look after them well and return them safely home—just as patients each borrow us for a time, before hopefully returning and recycling us for the next patient.

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In modern healthcare we need an entire village of people to care for us

PERSONAL VIEW Maggie Rae

The UK must help its communities to tackle covid

Working with locally led public health teams is key to delivering an efficient, sustainable strategy to tackle covid-19 in the long term

With vaccination programmes driving forward in all four UK nations, we've seen much progress in efforts to tackle covid-19. Public health professionals know, however, that we're far from the end of our work in tackling the wide ranging impacts of the pandemic.

Many problems of the past 18 months remain unresolved, and because we'll live alongside covid-19 for some time—especially as new, more potent variants emerge—these must be tackled with a sense of purpose and urgency. The delta variant is now the dominant strain in the UK: Public Health England figures show that it accounts for 90% of cases. Research indicates that it is 60% more transmissible in household settings compared with the already highly infectious alpha variant. Hospital admissions and ICU occupancy are rising, but at present are still much lower than the peak in January 2021.

Recognising the threat of the delta variant, the UK government has delayed easing restrictions further from 21 June to at least 19 July in England. While the government may be right to continue restrictions in the face of rising infection rates, it must use this time to tackle the flaws in its strategy. In September 2020, Ellis Friedman and I wrote that an efficient test and trace system isn't simply a numbers game. What was needed was a targeted testing strategy, led by local intelligence and prioritising groups and settings where the virus can spread quickly.

Inefficient strategy

Unfortunately, this message rings as true now as it did 10 months ago. The government continues to pursue an eye wateringly expensive mass testing strategy, dependent on private contracts, which is less efficient than testing programmes led by local public health teams. We should instead focus on more effective testing of symptomatic people, especially in areas with high infection rates. We must also prioritise testing in health and care settings, particularly for staff working with unvaccinated patients; in school settings; and, of course, at our borders.

This targeted testing must be led at a local level by public health specialists and directors. Despite the challenges these teams have faced in tackling the pandemic, and 10 years of austerity preceding it,

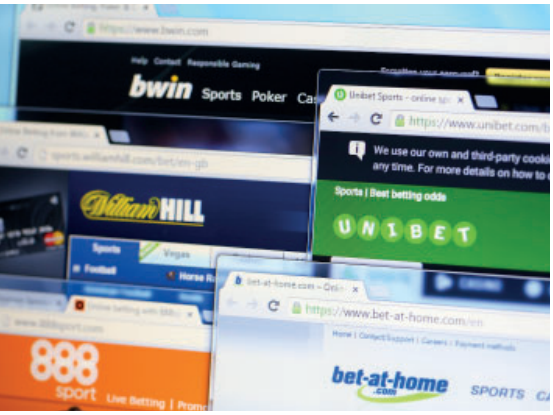
Targeted testing must be led at a local level by public health specialists and directors

local and regional public health teams have delivered for their populations. These public health specialists have worked across many sectors including schools, universities, hospitals, policing, care homes, and workplaces to support prevention and management of covid-19 outbreaks. They have been essential in effective contact tracing, supporting access to personal protective equipment, and delivering our vaccination programme. Their contribution must be woven into future planning.

If we're to be successful, we must hardwire cooperation between local, regional, and national public health teams and the NHS, local councils, and government. The new integrated care systems framework offers some hope, recognising the vital leadership of local and regional public health teams. These specialists also understand the importance of tackling health inequalities in the UK's pandemic response. This is a commitment we haven't yet seen from the government.

BMJ OPINION Jenny Blythe and May van Schalkwyk

Screening for gambling harms in primary care



In recent months, some of the now widely adopted online consultation questionnaires for primary care have started asking patients about personal or indirect exposure to gambling harms as part of their screening questions. A positive response to the question currently signposts the patient to organisations that can offer support and guidance.

This initiative is to be welcomed and is an important step in building greater recognition among the medical community of the harms associated with gambling.

Although it is good news that these questions are being asked more widely, at present they are routinely asked only through online questionnaires. Therefore, this screening method does not capture those who are "digitally excluded" (more likely to be people who are older, disabled, homeless,

Gambling problems can be shameful to disclose

migrants, and those living in institutions). There is significant overlap in groups that are digitally excluded and groups that are at increased risk of gambling related harms. As such, some of our most vulnerable patients who use "land based" gambling fall into groups that experience disproportionate gambling harm, and will not be picked up by this current screening intervention.

Further opportunities to screen for gambling related harms must be sought to complement digital platforms in order to avoid widening of inequities. Possible solutions include recognising that gambling problems co-occur with other mental health conditions, including alcohol and drug misuse. Clinicians

MARK KERRISON/ALAMY

As PHE's disparities review showed last year, minority ethnic and marginalised communities have a much higher risk of serious illness and death from covid-19.

The government has not taken adequate steps to tackle these severe inequalities, and these communities are left requiring much more committed support in protecting themselves against the virus. Government must work with local public health teams to engage with these communities, ensure that vaccine centres are easily accessible, offer fully paid time off for people to get vaccinated, and give proper support packages to people required to self-isolate. Without these steps, health inequalities will be exacerbated further by the pandemic.

So, while progress has been made in the UK's response to covid-19, our domestic agenda still requires close examination. Government must listen to public health experts at the spearhead of the pandemic response and act to deliver an efficient, sustainable strategy to tackle covid-19 that supports communities across the UK.

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could ask about the possibility of gambling problems when patients are reviewed for other mental health problems. Recognising the "all harms" spectrum of harm caused by gambling, clinicians could ask directly about gambling in consultations when money worries are expressed. We need to recognise that gambling problems can be shameful to disclose for people and their families, and offer both support and signposting to local and national services. With these digital and in-person interventions, and a review of the Gambling Act, there is a real opportunity to establish an effective approach to preventing gambling harms.

Jenny Blythe, GP and NIHR doctoral fellow

May van Schalkwyk, specialist registrar public health and NIHR doctoral research fellow, London School of Hygiene and Tropical Medicine

ACUTE PERSPECTIVE David Oliver

Has the term "front line" had its day?

In March the Royal College of Physicians' *Commentary* included an excellent essay by Derek Macallan, an infectious diseases specialist, arguing against using the term "front line" in a medical context. He asked what, if anything, could replace it.

Macallan was concerned that battle metaphors mis-described our roles in caring professions, that they implied that self-sacrifice and personal risk were part of our professional identity, and that being "on the front line" of a "battle" could be used to legitimise an unacceptable drop in standards.

Similarly, in discussions of burnout or moral distress in healthcare professionals because of workload and staffing constraints, some argue against using the term "moral injury." It originally referred to people in combat or emergency service roles who may have to kill or harm others and are at risk of death or serious injury. Short of working in war zones, doctors are mostly not in that group. And, Macallan argued, while clinical staff have a raised personal risk of catching or dying from covid, the mentality should be one of adequate precautions to minimise risk, rather than bravery and self-sacrifice.

I sympathise with Macallan's reasoning, but I'll offer some friendly counterarguments. First, we should differentiate those who do hands-on, patient facing clinical work from the rest of the workforce. This is not to disparage other important groups. But the core business of healthcare is direct clinical care for people who are sick, distressed, or dying, for whom our actions and omissions have palpable consequences. Similarly, combat troops, firefighters, and police officers rely on other support roles, but the exposure to personal risk is theirs.

Second, data clearly show that staff in clinical areas caring for patients with covid-19 have had a much higher risk of contracting it, being admitted as patients, or dying than other healthcare staff.

Third, these roles can't be carried out remotely. They require physical presence with the patient. Even if we can minimise personal risk—much like the firefighters or police, with the right equipment and procedures—we stand to be traumatised. We see the distress, death, and grief at first hand, and we were overwhelmed by the sheer volume of very sick patients at the peak of the pandemic, especially in services that went well beyond normal capacity.

Fourth, a "them and us" divide persists, as seen in endless stories of staff failed by inadequate access to personal protective equipment or testing, by staffing gaps, or by incompetence and mendacity higher up the NHS management chain.

The public and press understand that there's something different about clinical staff who put their welfare on the line and take on unique responsibilities. "Front line" is snappy, effective shorthand. I share the reservations about it but, like Macallan, I'm not sure that another term works better.

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Even if doctors can minimise personal risk, they stand to be traumatised

PRIMARY COLOUR Helen Salisbury

Data sharing needs a clear plan

Medicine is usually an activity that involves consenting adults, or adults consenting on behalf of their children. Before surgery, especially if the patient will be unconscious, we ask for written consent, but in most other situations verbal consent is enough. Sometimes it's sought informally ("Shall I examine you now?"), and sometimes consent is implied (by the patient climbing on a couch or rolling up a sleeve for a blood test). Here, consent is presumed and, crucially, the patient can withdraw it at any time to stop the procedure.

How formal we need consent to be depends on the situation; asking for written consent before every interaction would be impractical. But, whether it's written, verbal, or implied, for consent to be valid it needs to be informed. Patients must understand what they're agreeing to, although the depth of explanation required will vary. If I arrange to take a blood test, I'll paraphrase what I'm looking for: "I'm going to check that you're not anaemic and that your liver and kidneys are working normally" is probably enough for most patients. But my surgical colleagues need to be formal and detailed, so that the patient understands the risks and benefits before going under anaesthetic and the knife.

So, how will we explain the latest plans for secondary use of GP held patient data? The rationale recently given in parliament by Matt Hancock, the then health secretary, mixed up data use for direct patient care—which is not what this project is about—and its use for research. He hailed the discovery of dexamethasone's efficacy in treating covid-19 as a triumph of big data, when it was in fact the product of a rigorous, consented, randomised controlled trial. He was either misleading us or misunderstanding the proposals.

As data controllers, GPs must be sure that patients have given valid consent for their data to be processed by NHS Digital before we can hand it over (currently scheduled for 1 September). As it remains unclear what safeguards will be in place for personal medical information, we're not yet in a position to explain to patients the risks and benefits of sharing their data.

There's an old NHS mantra: nothing about me, without me. After three years of planning this may seem a shame, but NHS Digital needs to start again and find a better plan for data security. It needs to produce accurate and accessible information that reaches every patient, as well as easy methods for people to indicate whether they're willing to share their data for research and planning. Patients also need the right to withdraw their consent at any time and to remove their data from any central store.

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NHS Digital needs to start again and find a better plan for data security

LATEST PODCAST

Talk Evidence: GP data and excess mortality

The latest Talk Evidence podcast brings together our regular hosts to discuss what's going on in the world of evidence based medicine. The team begin by considering a new study that looks at different countries' excess mortality over the past year. Joe Ross, research editor at *The BMJ*, argues that framing these types of studies as a comparison of countries' responses to covid-19 is not always the most useful way to understand them:

"It's not about comparing countries. It's about understanding each country's lost opportunity to do a better job of protecting its citizens. Any excess death was an unnecessary death. Obviously, we were all challenged by a new virus with a lot of unknowns, but some countries did better and you can also see that some countries did better over time in the sense that they were learning from one another, whereas others seemed to let their guard down. I don't think it's about comparison, it's more about taking stock of what happened."

Helen Macdonald, *The BMJ*'s UK research editor, also looks into NHS Digital's plans for GP data in the UK. She finds some answers to her questions, but a lot of uncertainties remain:

"One tranche of concern that exists is around the confidentiality of the data.There are some misconceptions and one has been that researchers would be able to read your medical notes. I think we can say that is not true. You can't just go into somebody's medical record and have a good rummage around. You can see codes—so codes for diagnoses, a code to say that you've had a particular test done or been referred to a particular service, that kind of information. And the information is depersonalised, which is somewhere along the road to total anonymisation."

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

ANALYSIS

Future of covid-19 vaccine pricing: the lessons from influenza

Routine use of covid vaccines could strain health budgets if purchase costs follow the same pattern as flu, say **Reshma Ramachandran and colleagues**

The increasing availability of covid-19 vaccines has signalled to many the beginning of the end of a devastating pandemic. Yet evidence is emerging that the novel coronavirus will continue to evolve and that immunity from vaccines is likely to be time limited, requiring use of booster doses or modified vaccines. Bilateral bulk purchasing agreements between individual countries and manufacturers have allowed vaccines to be procured at lower prices and dispensed to patients without charges. After the pandemic, however, the future pricing landscape of covid-19 vaccines remains unclear.

Multiple parallels exist between covid-19 and influenza vaccines with respect to their development history, market, and administration. Their common features may inform manufacturer behaviour and guide policy measures in the US and other high income countries. If the pattern observed with influenza vaccines is repeated, higher prices for covid-19 vaccines set by companies in the future would have important implications for health spending, public health programme budgets, and insurance premiums.

Pharmaceutical executives anticipate returning to "commercial pricing" for covid vaccines as early as this year

KEY MESSAGES

- Uncertainty around future covid-19 vaccine prices has raised concerns about fair and equitable access in the long term
- The influenza vaccine serves as an analogous precedent, in terms of substantial public contribution to its development, need for routine administration, and market with multiple manufacturers
- Prices of influenza vaccines have increased in the US over the past 20 years despite increasing numbers of products available and manufacturers
- If the pattern is repeated, higher prices for covid-19 vaccines will have serious implications for health spending and public health budgets

Pricing landscape for covid-19 vaccines

Substantial public investment has facilitated the rapid development of covid-19 vaccines. Nearly all the development of the Oxford-AstraZeneca vaccine was funded by governments or charities,[1] and the US government initiative Operation Warp Speed alone has contributed an estimated $18bn towards the development and manufacturing of covid-19 vaccines.[3] Legislators and advocates have expressed concern over whether the eventual prices of these vaccines will reflect a fair return on public investment.

Immunologists[5] and manufacturers[6 7] have announced that covid-19 vaccination may need to occur at least annually to sustain sufficient immune response and protect against rapidly emerging variant strains. Uncertainty is further fuelled by the lack of clarity around how to define the "pandemic period"—when companies have promised to supply their products at lower prices or share technology[8] with other manufacturers. For instance, internal documents revealed that although AstraZeneca pledged not to profit from its vaccine during the pandemic period, it also specified that it could declare the pandemic to have concluded by July 2021.[9]

Pharmaceutical executives have also stated they anticipate returning to "commercial pricing" as early as later this year, with one head at Pfizer noting that a normal price outside the pandemic would be "$150, $175 per dose."[10] Already, Pfizer has raised the prices of the European Union's future orders of its vaccine by over 60%.[11]

Even before authorisation and approval, countries entered into bilateral bulk purchasing agreements with individual manufacturers to secure doses at lower negotiated prices.[12] Through two separate agreements Moderna secured a $3.2bn contract to provide the US with 200 million doses.[13] This is roughly $16 a dose, compared with the $37-$39 it initially announced. The EU secured doses from Moderna at $18 each. Pfizer also received two separate contracts for a total of 200 million doses at $19.50 a dose,[14] while the EU paid just under $15.[15]

It remains unclear how covid-19 vaccines will be priced in future as more candidates enter the market. Constraints on manufacturing capacity—and therefore supply—as well as the need for mass global vaccination campaigns may allow for a market with multiple, similarly efficacious vaccines. The development pipeline for covid-19 vaccines remains active: as of May 2021, 99 vaccine candidates were in clinical development worldwide with 19 in phase III trials.[16]

Parallels to the influenza vaccine

Although the development and ongoing distribution of covid-19 vaccines is without precedent, the closest analogue is the influenza vaccine in the United States. Similar to covid-19 vaccines, multiple flu vaccines are produced by various manufacturers, largely used interchangeably. Influenza vaccines are administered in various clinical and non-clinical settings, with tens of millions of doses rapidly administered annually over a few

Fig 1 | Average public and private sector prices for influenza vaccines in the United States (2000-21). Prices adjusted to 2020 US dollars, with average prices calculated from reported contract prices in either August or September (or if unavailable, a month that would be representative for that year's full season).[27]

months each year, as will likely continue for covid-19.

Additionally, just as the covid-19 vaccine is being tested and updated in response to rapidly emerging virus variants, the influenza vaccine is reviewed and modified annually to prevent against mutated strains.[18 19] No "game changing" antiviral treatment currently exists for influenza or covid-19, making vaccination the centrepiece of public health measures.

Like the covid-19 vaccine, public funding in a deadly pandemic spurred the discovery and development of the influenza vaccine, in the latter case through the Department of Defense.[20] Even today, federal laboratories have an important role in developing and manufacturing seasonal influenza vaccine.[21 22]

Pricing trends for influenza vaccines

Over the past two decades, the number of doses of influenza vaccine distributed throughout the US has generally risen steadily each year.

As with covid-19, the Centers for Disease Control and Prevention (CDC) and other federal agencies can procure influenza vaccines at lower prices than the private sector through bulk purchasing agreements. It is unclear how many doses the CDC has purchased each year and whether the amount purchased could affect the negotiated price. However, it was reported that for the 2020-21 flu season, in what was described as an "unprecedented move," the CDC purchased seven million doses directly from manufacturers for $100m or $14 each[26]—a higher price than it has previously negotiated.

As the number of influenza vaccine doses supplied in the US has increased over time, it might be expected that prices would also decrease, in accordance with traditional economic principles. However, the opposite was observed from the annual CDC contract (or public sector) and private sector prices. From 2000 to 2021, average prices for the influenza vaccine rose by 149% for the public sector and 163% for the private sector (fig 1). Average private sector prices, which were consistently higher than public sector prices, largely plateaued between the 2015-16 and 2020-21 flu seasons, rising only by 7% during this time. Notably, prices between the private and public sectors further diverge after the 2009-10 flu season. Lower public sector prices may be due to increased government procurement following the H1N1 pandemic in late 2009 and the advisory committee's decision in 2010 to broaden the recommended population for receiving the vaccine.

Pricing trends for the influenza vaccine also do not seem to be affected by the number of manufacturers and products on the market (fig 1). The three manufacturers in the US with the biggest market share[28] (Sanofi-Pasteur, CSL, and GlaxoSmithKline) have seen mean compound annual growth rate over the 10 years from 2011 to 2021 of 2.2% (range 1.1%-3.8%) for average public sector prices and 4.1% (range 2.6%-6.8%) for public sector prices (fig 2). The annual growth rate of the consumer price index for prescription drugs over the same period was just 1.8%.

From 2000 to 2021, average prices for the influenza vaccine rose by 149% for the public sector and 163% for the private sector

To assess whether these manufacturers behaved similarly—that is, if one manufacturer raised their prices, did another manufacturer as well—we measured correlations of their average public and private sector prices over time using the Kendall τ-b (τb) coefficient. We found relatively high correlations between GlaxoSmithKline and Sanofi Pasteur across both sectors (public=0.778; private=0.822), suggesting little price competition between them. CSL prices were poorly correlated with those of the other two companies (public=0.067 (GSK), 0.200 (Sanofi); private=0.466 (GSK), 0.377 (Sanofi)).

This suggests that the influenza vaccine market in the US has little price competition but steadily rising prices, despite growing government purchasing commitments. However, public reporting of supply data for individual products procured by the public and private sector would be necessary to inform price competition analyses further.

Achieving fair pricing

Pricing trends for influenza vaccines in the US since the 2000-01 flu season portend a potentially perilous future for ensuring fair pricing of covid-19 vaccines. Despite having multiple manufacturers selling similar products to an expanding market over time, like the influenza vaccine, the prices of covid-19 vaccines are expected to rise in the coming years. After the immediate pandemic period, the private sector is likely to procure booster doses at higher prices than the public sector. Future higher prices for covid-19 vaccines would have substantial implications for health spending, public health programme budgets, and insurance premiums for those with private insurance.

Some countries have already committed to publicly procuring

additional doses for booster vaccinations potentially needed later this year,[29 30] which may help mitigate price increases. However, companies may still raise prices, as has been seen previously in high income countries during government procurement of influenza vaccines.[31] Another possibility is that countries with smaller populations may be able to negotiate lower prices by sourcing from one or two companies rather than relying on multiple manufacturers to provide adequate supply.

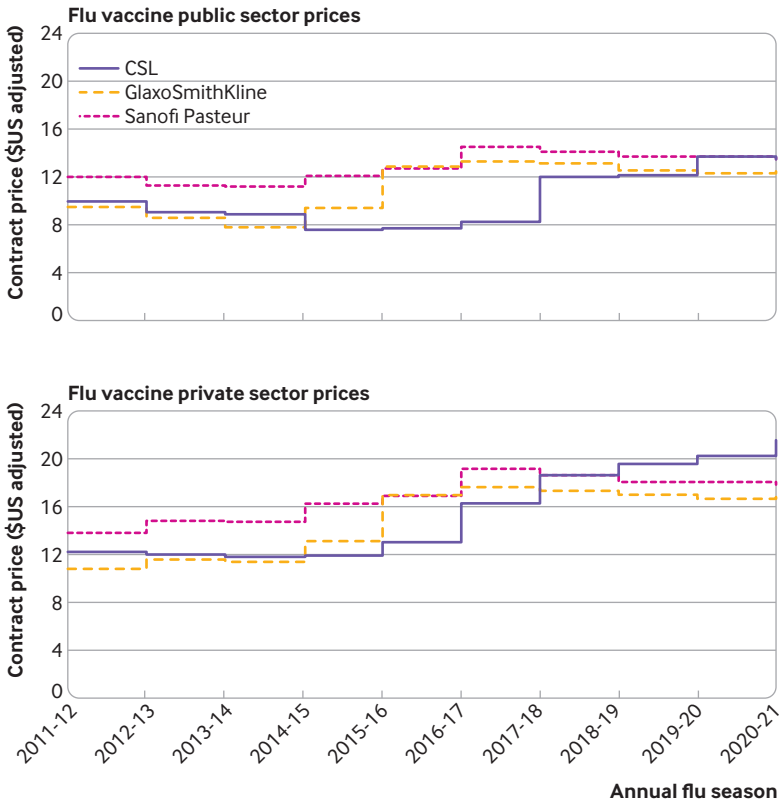
Prices will also vary across countries as some use health technology assessments to determine fair purchasing prices. These value assessments—and their role in influencing prices as well as which vaccines are prioritised for procurement—may be shaped by additional evidence regarding their safety and relative efficacy in preventing infection, transmission, or severe outcomes. Governments and procurement agencies might also consider paying only for vaccines that have received full regulatory approval within a specified time. However, even manufacturers that have set vaccine prices to reflect an ongoing global health emergency[4] are securing substantial profits from current sales.[32]

Vaccine pricing trends may not function according to normal market forces, paralleling trends of some pharmaceuticals. Through monopoly price protections, including intellectual property rights, as well as the lack of transparency around the costs of research and development, manufacturing, and procurement, manufacturers can set and increase prices unless governments and other payers intervene.

Globally, concerns over vaccine pricing have also emerged as countries have secured different prices for the same products through secretly negotiated bilateral agreements. For certain vaccines, some low and middle income countries are paying more than the EU or the US.[35-37] In

Some countries have secured different prices for the same products through secretly negotiated bilateral agreements

Fig 2 | Trends in US influenza vaccine prices for three manufacturers (2011-21) in public and private sector. (Prices adjusted to 2020 $)



response to concerns over vaccine scarcity and pricing, governments and manufacturers have been increasingly called on to waive intellectual property rights, share vaccine technology, and invest in building further manufacturing capacity, particularly in low and middle income countries.

South Africa and India have proposed a temporary waiver of intellectual property rights[38] to prevent any repercussions should countries harness mechanisms such as compulsory licensing or local production of covid-19 health technologies. The US has also indicated support of a limited waiver for vaccines,[39] but other high income countries, including those in the EU, remain opposed.[40]

To facilitate technology transfer, the World Health Organization has created a covid-19 technology access pool and covid-19 mRNA vaccine technology transfer hub.[41 42] The hub has received around 50 expressions of interest, but none from any current vaccine manufacturers.[43]

The Biden administration has also been called on to establish a new licensing agreement for a government owned patent used to produce the vaccine co-developed by the National Institutes of Health and Moderna, which was nearly 100% funded through public investment.[44] The agreement would allow for local manufacturing of the Moderna vaccine, sharing of vaccine technology with WHO to increase global production, and accessible pricing across countries and payers. Continued public procurement efforts could also ensure reasonable pricing terms are included in purchasing contracts, as the US Department of Defense has done in its agreements with Novavax and Sanofi.[45 46]

Amid a global pandemic any price for vaccines may seem reasonable. However, the potential absence of an affordable covid-19 vaccine option after the end of the pandemic period is a looming threat to global health that could threaten efforts to ensure long term control of covid-19.

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BMJ OPINION David Gilbert

Patient directors: the next step in the patient revolution

Six years ago, Michael Seres, a champion for patient centred care; Alison Cameron, a consultant in patient and public involvement; and I gave evidence to the Future of NHS Leadership inquiry. We were part of an emerging community of patient leaders with experience of life changing illness, injury, or disability, trying to influence change through partnership working.

Despite discussing patient leadership in depth and making the case for senior paid roles for patient leaders, the panel (no patients included) "rejected the suggestion that a 'chief patient officer' or equivalent should be appointed to the board of every NHS organisation."

Since then, I've worked as the first patient director at the Sussex Musculoskeletal (MSK) Partnership (Central)—an executive role commensurate with clinical or managing director—to hardwire patient centred systems and processes, and broker dialogue between patients or carers and staff in decision making.

A first for patient power

Last year, Lesley Preece, a patient partner at Sussex MSK Partnership, and I were expert witnesses for the National Institute for Health and Care Excellence (NICE). NICE guidance on shared decision making (Guidelines, p 30), advises that "every organisation or system, regardless of its size, should consider appointing a patient director (from a healthcare service user background) responsible for raising the profile of the service user voice in planning, implementing, and monitoring shared decision making, especially from those in under-served populations, supporting the embedding of shared decision making at the highest level of the organisation."

The advent of such a role is the first structural and functional accommodation for true patient power at a senior level in the NHS's history. It's the result of extraordinary emotional labour by a growing cadre of patient leaders, "lived experience practitioners," and "experts by experience." We bring wisdom and insight about the lived experience of having illness, injury, or disability. We know intimately what it's like to feel vulnerable and powerless, the impact of pain and suffering on our lives, the primacy of healing relationships in care, and what good and poor services look like. This combination of vision, humanity, and authenticity are essential components of high quality leadership. Add in people's expertise and competence from professional and family experience, then our potential for helping the NHS becomes obvious.

Patient partner and corporate priorities are now intertwined

But involving patients and carers in the NHS means a neutering of that leadership potential. One is left to turn up at focus groups, fill in surveys, or, if you're lucky, make people cry at conferences. You become feedback fodder. Or you wear a suit and become a "representative," without clarity of your role, without support, and slotted into narrowly defined institutional committees—often sheer tokenism.

This is "patients at arm's length," rather than at the heart of care.

The advent of co-design means some get a taste of being "improvement partners." In mental health, there is a welcome evolution of peer support models. But subsequent rungs of the opportunity (and payment) ladder are broken. There have been no embedded opportunities for those wanting to develop their true qualities.

A ladder of progression

When Sussex MSK Partnership made the bold step of appointing a patient director, a few others followed. But a patient director alone won't suffice. Our Sussex MSK Patient Leadership Triangle means the patient director's role is bolstered by a pool of patient and carer partners who are paid, supported, and trained as improvement partners. This has had an impact on policy and practice, for example by prioritising health equity plans, co-researching remote consultations during covid-19, co-designing shared decision making training and pain management programmes, peer led research on shared decision making, and transforming admin systems, as well as ongoing participation in training and recruitment panels.

Patient partner and corporate priorities are now intertwined; patients facilitate staff wellbeing events, and staff say that they have found their authenticity and vulnerability inspiring. Staff have more in common with patients than they thought.

The third apex of the triangle is our patient centred governance mechanisms. We've shifted from a dedicated patient forum to patient partners on each of our core governance structures—quality, operational, and finance. This provides the bedrock of legitimacy and accountability for our patient centred work.

In effect, we have developed an embryonic ladder of progression, from people being feedback providers, to improvement partners, to governance members, and, finally, to senior roles. I want to see that ladder of progression everywhere.

I would have liked the NICE guidance to better articulate the patient director role and embed a model of patient leadership. But it's a great start. And now the NHS must take the next step in the patient revolution. People affected by life changing illness, injury, or disability must now have real power at all levels of healthcare policy and practice. Patient directors are one embodiment of that systemic commitment to shared decision making.

David Gilbert is patient director, Sussex MSK Partnership (Central)

GUIDELINES, p 30

LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Declaring interests: necessary but not sufficient

Abbasi emphasises the serious risks posed by doctors' undisclosed competing interests and extends the principle to scientists, policy makers, and politicians (Editor's Choice, 29 May). He acknowledges the potential relevance of "less tangible" (non-financial) interests but seems to focus on money. This is a practical and achievable first step but is problematic in two respects.

First, drawing the line between financial and other interests is not always straightforward. Benefits such as travel expenses, research support, access to data, and authorship opportunities are significant sources of bias. People receiving such benefits are mindful of competing interests and motivated to downplay any effect these might have. A common example in journal disclosures is the use of euphemisms such as being "unpaid consultants" or receiving "non-financial" support from industry. A register of interests should include a reckoning of material benefits, not just overtly financial ones.

Second, interest disclosure can have unintended consequences—in some circumstances it can perversely exacerbate bias. This might occur because those making disclosures are then less restrained in their opinions or because we are less sceptical when disclosures have been made. An example familiar to many will be conference speakers disclosing multiple industry involvements on briefly presented slides in a small font. Just as with journal disclosures, these presenters almost never explicitly consider how sponsorship or other benefits might have influenced the design of studies and the collection, analysis, or interpretation of data. We like to imagine that we are unaffected by drug and device advertising.

NEIL WEBB

Abbasi contends that "the requirement is not for purity but for transparency," but in some circumstances disclosure is insufficient to manage bias effectively. Leaving aside concerns about misleading and falsely reassuring disclosures, a more fundamental approach requires the exclusion of important competing interests, financial and otherwise, for authors of treatment guidelines.

David B Menkes, academic psychiatrist, Hamilton, New Zealand

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MENTAL HEALTH SUPPORT DURING AND AFTER COVID-19

Non-clinical support makes a difference

Mughal and colleagues say that "around 90% of mental health problems are managed entirely in primary care" (Editorial, 29 May). But that does not mean they are managed well.

Non-clinical support has been applied to a range of problems during the pandemic. Anxiety disorders have emerged as a big feature of this era. Trial data show that a non-clinical but professional intervention (lifestyle review) helped manage even severe symptoms. Returning to work or job hunting is going to become an issue after covid-19. This is where expertise in psychological therapies can make a difference; closer relations between general practice, psychology, and occupational health will make the best use of stretched community resources.

The voluntary sector has shown remarkable adaptability; we need a national plan to develop mental health capacities like mutual aid ubiquitously. Mental health support that makes the local environment more sustainable should also become a key element of primary care.

Woody Caan, retired professor of public health, Duxford

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Exposure to green spaces strengthens resilience

Outdoor recreation in green spaces can restore and improve resilience and complement other means of mental health support, such as that offered by GPs.

Exposure to green spaces facilitates recovery from physiological stress, restoration of directed attention, and improvement of cognitive performance. This aids in strengthening mental resilience. Green spaces can also stimulate physical activity and increase physical resilience. Emotional resilience can be improved by purposeful or pro-environmental behaviour and the anticipation of seeing interesting species. And gathering outdoors develops social cohesion and social resilience.

Exposure to green spaces should be prescribed to complement mental health management in primary care, now and after covid-19. The mental health benefits of green spaces often depend more on perceived biodiversity than true species richness, so the pressure on nature could be alleviated by greening and improving recreation infrastructure in cities and rural landscapes. Investing in natural resilience is investing in human resilience.

Raf Aerts, associate professor in biodiversity and human health; Naomi Vanlessen, research fellow; Olivier Honnay, professor in conservation biology, Belgium

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BENEFITS OF QUITTING

More quit, more grit

Morgan's lesson of embracing quitting as a decisive action should ring loudly in the ears of trainees exhausted by the efforts of the past 18 months (Matt Morgan, 5 June). I can advocate for this ethos, having quit medicine to join the Royal Marines. Seven years later, I am bringing a wealth of non-technical skills and life experience back to medicine.

Quitting can be a positive act of self-care and self-improvement. Stepping off the treadmill of medical training should be viewed as taking the time to invest in yourself, acquire new skills, and sharpen your mental and psychological tools in preparation for future career challenges.

Caroline Elton's *Also Human* helped me realise that I hadn't quit—I'd made a difficult decision that was in my own best interests and was now ready and motivated to return with more focus and resilience. I suggest an alternative ethos of "more quit, more grit."

Jacob N Asplin, clinical fellow in rural medicine, Fort William

Cite this as: *BMJ* 2021;373:n1600

OBITUARIES

Geoffrey Norman Marsh

General practitioner (b 1930; q Newcastle 1953; MBE, MD, FRCGP, DObst RCOG, DCH), d 1 February 2021

Geoffrey Norman Marsh, a GP in Norton, Stockton on Tees, helped to transform general practice from its 1950s pattern of doctors working independently to its current pattern of multidisciplinary teams and targeted preventive work. In over 30 papers in *The BMJ* and three books he contributed to many developments including the adoption of remunerated cytology and immunisation targets in the 1990 GP contract as a means of raising the standard of preventive care provided to more deprived communities. He was a GP trainer and a royal college examiner. He sat on BMA Council and on various editorial boards. In 1989 he was appointed MBE for services to medicine. Geoffrey leaves his wife, Jean; three children; and six grandchildren.

Chris Marsh, David White

Cite this as: *BMJ* 2021;373:n963

Shelagh Elizabeth Milne

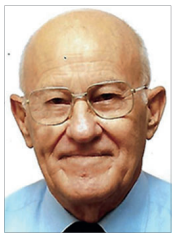
Consultant microbiologist Colchester hospitals (b 1927; q 1951), died from covid-19 on 3 November 2020

Shelagh Elizabeth Marmion attended Girton College, Cambridge, and studied clinical medicine at University College Hospital, London, as one of only two women in her year, facilitated by the intervention of her elder brother. She married Kenneth Milne in 1953 and took a break from her career to support him and raise three sons. However, when Kenneth died in 1973 she resumed her microbiological training at UCH after a 16 year pause, and was appointed consultant to Colchester hospitals in 1979 at the age of 52. As age took its toll, she moved to a residential home, where she passed her final three years. She leaves her three sons, two of whom are doctors; seven grandchildren; and seven great grandchildren.

Andrew Milne, David Milne, Michael Milne

Cite this as: *BMJ* 2021;373:n964

David Stuart



Orthopaedic surgeon (b 1927; q 1953), died from acute spontaneous upper gastrointestinal haemorrhage and ischaemic heart disease on 13 March 2021

David Stuart was born and raised in Kenya. He left at the age of 18 to study medicine at the University of London (Queen Mary College). Without any prospect of a job in the UK, he and his wife emigrated to South Africa in 1954. In 1960 they returned to the UK and David qualified as an orthopaedic surgeon in Edinburgh. In 1965 the whole family relocated to newly independent Zambia, and in 1971 they moved to Kenya, where David took over an orthopaedic practice in Nairobi. He retired to his house in Shimoni in 1986-87, but in his final years he moved to the UK and was looked after by his daughter. He leaves four children; 11 grandchildren; and two great grandchildren (with two more expected).

Melanie Hicks

Cite this as: *BMJ* 2021;373:n974

David Charles Taylor

Professor of child and adolescent psychiatry Manchester University (b 1933; q Charing Cross Medical School, London, 1960; MD, FRCP, FRCPsych, FRCPCH), died from pneumonia on 13 March 2021

David Charles Taylor started at the Institute of Psychiatry at the Maudsley Hospital in 1962 and in 1965 obtained a research assistant post with Murray Falconer to undertake a doctoral thesis on the psychiatric correlates and consequences of temporal lobe epilepsy. David moved to Oxford in 1967 as a clinician scientist and child psychiatrist, and in 1980 he was appointed to the foundation chair of child and adolescent psychiatry at the University of Manchester. He retired in 2001 and leaves a remarkable legacy in the subject of epilepsy psychiatry and in the study and care of the mental and physical health of vulnerable children. He leaves his wife, Karin; their daughter, Hannah; and four sons from his previous marriage to Evelyn.

Ian M Goodyer

Cite this as: *BMJ* 2021;373:n976

Brian Michael Thomas

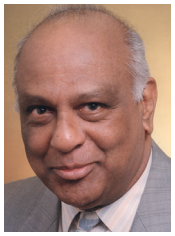
Consultant radiologist St Mark's Hospital and University College Hospital (b 1934; q St Mary's Hospital Medical School, London, 1959; FRCP, FRCR), died from pneumonia on 19 February 2021

Brian Michael Thomas was a distinguished gastrointestinal radiologist with a particular interest in barium enemas in the "old days" before colonoscopy became widely available. Under his management, St Mark's x-ray department was a slick operation; a dozen barium enemas in a session was commonplace. He was a fine teacher and will be remembered with fondness and with gratitude by the scores of radiology trainees who were fortunate enough to get a slot on the "Mark's rotation." He kept a nature diary from an early age, with a particular interest in birdsong. His other great interests were his garden and literature—especially poetry, at which he also tried his hand. Predeceased by a son, he leaves his wife, Jean, and daughter, Beverley.

Beverley Thomas, Richard Mason

Cite this as: *BMJ* 2021;373:n984

Buddhadasa Dharmawansa Weerasinghe



Consultant orthopaedic surgeon Bishop Auckland General Hospital (b 1931; q Colombo Medical School, Sri Lanka, 1955; FRCS Edin, FRCS Lond), died from severe coronary heart disease on 6 February 2021

After qualifying in his native Sri Lanka, Buddhadasa Dharmawansa Weerasinghe ("Das") practised medicine in the USA before moving to England, where he worked in orthopaedics and trauma at Harlow Wood Hospital and then the Royal Victoria Infirmary in Newcastle. He became a consultant orthopaedic surgeon at Bishop Auckland General Hospital, where he worked until he retired. His love of cricket and cooking prompted him to set up an annual charity cricket match between hospital staff and the Bishop Auckland cricket team. The money raised meant that Bishop Auckland Hospital was one of the first in the north east to have its own computed tomography scanner. Das leaves his children and grandchildren.

Rachel Weerasinghe

Cite this as: *BMJ* 2021;373:n985

Cliff Mann

Instrumental in developing new clinical standards for urgent and emergency care

Clifford John Mann (b 1962; q London 1986; OBE, FRCEM, FRCP, FRCA), died from oesophageal cancer on 20 February 2021

Asked by *The BMJ* who was the person in his life whom he would most like to thank, Clifford Mann named his first comprehensive school form teacher. Young Cliff had thought that he was doing well; Mr Graham told him that he was "coasting." The former president of the Royal College of Emergency Medicine and national clinical adviser for urgent and emergency care, Mann said, "I've never forgotten the implied criticism."

Leader

Patients, colleagues, and the NHS at large should be grateful to Mr Graham. Mann became the opposite of a coaster. NHS chief executive Simon Stevens said, "Cliff was an exceptional clinical leader, patient advocate, and source of wise advice, who stayed grounded in the pressurised realities of day-to-day emergency medicine, while at the same time shaping and helping create a better future."

His talents were reflected in his national roles, but the many tributes to him suggest that his humanity was his predominant characteristic. The most often repeated descriptions of him in these memories from a host of colleagues, friends, and patients are gracious, humble, an inspiring mentor, and a gentleman. All testament to a man who took the time to help others professionally and personally in whatever way he could.

Mann had a key role in developing new clinical standards for urgent and emergency care, currently part of a consultation by NHS England. He also spearheaded the rollout of same day emergency care—a new model enabling many thousands of patients to have the right tests and treatments quickly, reducing the need for hospital admissions.

His humanity was Mann's predominant characteristic

RICHARD SMITH

As clinical co-chair of the Getting It Right First Time (GIRFT) programme for emergency medicine, he sought to improve standards in emergency departments across the country. Throughout his national work, he continued to work as a consultant in emergency medicine at Musgrove Park Hospital in Taunton, Somerset.

His biggest inspiration, he said, was the choirmaster at St Peter's Church in Henleaze, Bristol. "From age 7 to 18 he taught me that excellence requires both ability and effort, that loyalty is key to success in any group, and that the cake is more important than the icing."

Work-life balance

After school at St Mary Redcliffe and Temple Colston, Bristol, Mann read medicine at Charing Cross and Westminster Medical School, London. He spent five years as a senior house officer in the late 80s and early 90s while deciding which specialty would be right for him.

In 1993, he obtained an emergency medicine post in Portsmouth, having decided against general practice, believing "mistakenly" that emergency medicine would provide a better work-life balance. As he wryly observed, "By such twists of fate are careers and lives determined." He would go on to become a father figure within the specialty he loved, driving changes that helped make it what it is today. In 2018, he received an OBE for his contributions to emergency medicine.

All doctors yearn for a good work-life balance: many sacrifice it on the altar of ambition, especially those in high profile roles that require total commitment. But Mann was a dedicated family man whose concern for balanced careers extended far beyond his own household to the welfare of the profession at large. Calling, in 2018, for changes in the consultant's contract to make medicine more family friendly, he commented in *The BMJ*, "Extra payment is a weak currency when compared with companionship, hobbies, and relationships."

In 1999, Mann became a consultant in Taunton and was later appointed as head of school of postgraduate emergency medicine, Severn Deanery. His Taunton consultant colleagues included his wife, Rhona Fitzpatrick. They first met at an international emergency medicine conference in Australia in 1996 and married in 2001.

This year, Mann was to become the official ambassador for Health Improvement Project Zanzibar (HIPZ), a charity working to raise standards in medical care and education on the island, founded by colleagues in Taunton. He trained many of the island's healthcare professionals to deliver safe emergency care and helped to develop plans for two new emergency departments, scheduled to open this year.

Mann leaves Rhona and their two daughters.

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