

comment

Media's disregard for the old, unwell, disabled, and poor is abhorrent **DAVID OLIVER**

Easy access has lowered threshold of what people ask their GP about **HELEN SALISBURY**

PLUS What is behind covid-19 caseload in UK; encouraging vaccine uptake

THE BOTTOM LINE Partha Kar

Holding up a mirror to racism in the NHS

Listening to Azeem Rafiq's testimony to MPs about institutional racism at Yorkshire County Cricket Club, it all rings true—and it burns. What Rafiq has gone through could be the story of many an NHS doctor or nurse. The banter, the jokes, the sly comments, the racial slurs, the obstruction to career progression... they've been a constant presence during my career in the NHS.

It's easy to brush these off as "sins of the past." But swathes of clinicians across the NHS will tell you that these things aren't just old and that they haven't gone away. A big problem is the insidious nature of the racism. The people who are openly racist are easier to tackle than the doors that are closed, the subtle changes in tone, and the differential treatment meted out. But many in the health service still don't realise how common racism is in the NHS. Many leaders from minority ethnic backgrounds, driven by a desire to progress their careers and protect their jobs, forget to step up. They end up pulling up the ladder behind them rather than fostering equality.

You'd think that being in a "position of power" lessened the brazenness. I can personally confirm that it doesn't. The people from whom I've received differential treatment—with zero awareness about speaking in a wholly unacceptable manner—include leads of clinical commissioning groups, senior NHS England staff, and chief executives of trusts. There's a growing realisation that NHS staff are as much blighted by racism, sexism, homophobia, and other prejudice as the rest of society. If you find the phrase "the NHS is racist" uncomfortable, step up and help to change the data.

The day isn't far off when someone will be the Azeem Rafiq of the NHS. As the voices grow louder, this isn't going away. To those who face racism: speak up. I know how tricky it can be, but without that voice we can't change anything. If people need to be shocked into changing their behaviour, let's do that.

My recent role is director of equality for the medical workforce in the NHS, and the use of a racial slur will bring a trip to see your medical director or chief executive. With the more insidious ones, we need people to raise their voice—in the public domain, if necessary. Maybe we need a hotline for people who can raise these issues, without fear of retribution, to act as a deterrent to management layers that work without fear of reprisals.

Finally, to those who are still not convinced, take time to listen to Rafiq's testimony. Then ask yourself, "What am I doing to prevent this in the NHS?" If you can't answer that, and if you still don't believe that racism is a problem, the issue is staring right at you when you look in the mirror.

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The day isn't far off when someone will be the Azeem Rafiq of the NHS



Covid-19 caseload in the UK

What do the data show about underlying causes?

It is a truism that as we approach the second anniversary of the start of the covid-19 pandemic, certainties over our management of the pandemic have become ever more elusive. This makes good policy making even more challenging and nuanced than in the early days of the pandemic.

Few foresaw the planet we now inhabit, with populations differentially under threat from a spectrum of variants of concern—especially delta with its more pernicious mix of transmission and immune evasion mutations—and variable access to and uptake across the age range of diverse vaccines. A look through any of the global dataset portals shows very starkly the diverse state of play in different countries. The map of Europe, colour coded for caseload, indicates the “dark” outlier—the countries currently faring particularly poorly, notably Romania, Ukraine, Latvia, Lithuania, Estonia, and the UK. It surely seems pertinent to pause and consider these datasets. Do they reflect events accurately or is there an ascertainment bias in the counting? And, if they do faithfully reflect the situation, what can be learnt about underlying causes?

Some argue that the UK data are unfairly skewed by the high volume of tests, especially in schoolchildren. While testing disparities

can indeed skew the colouring of a simple caseload heatmap, the inescapable point is that the UK has been a European outlier for hospital admissions and deaths. The ongoing, low level debate about tolerance levels for “living with the virus” is currently conducted against an estimated backdrop of 50 000 excess deaths per year due to covid-19. The expectation for 21st century healthcare provision is to resist rather than tolerate early death from avoidable disease. It is a given, though rarely voiced, that living with this virus, high volume hospital admissions, and excess deaths, come at an egregious daily cost to medical professionals, the NHS, and the population. There is a temptation to normalise these figures as being like annual flu mortality which has averaged around 20 000 over the past decade. However, an additional 50 000 deaths is more in line with all annual coded mortality in the UK for ischaemic heart disease.

The variables feeding into the complex equation of covid-19 caseload and mortality include a number of baseline cases, prevalent variant sequences, connectivity with other countries and populations, population demography, health status, levels of deprivation, healthcare resource allocation, specific vaccines in use, timing since vaccine rollout, vaccine uptake and coverage across



There is a temptation to normalise these figures

the age range, stringency of and timing since lockdowns, and use of “vaccines-plus” mitigations such as vaccine passes, masks, social distancing, ventilation, filters, and working from home where possible.

While there is much to be learnt from meta-analysis of successes and failures with these measures across the globe, no two countries have pursued the same course and there has been little attempt to benefit from evolving a best practice. Among countries in western Europe, the UK has been at the lower end of the mitigation spectrum, although there are also other differences to consider. The UK was initially one of the more rapid to roll out relatively extensive vaccine coverage, using both Oxford-AstraZeneca and Pfizer vaccines, in adults. This has meant that, along with Israel, it has been among the first

Encouraging covid vaccine uptake—an uphill struggle against government complacency



Like many doctors who had stepped back from clinical practice, I volunteered to return to the NHS to help during the covid-19 pandemic. After much bureaucracy, my contribution has been as a volunteer, working with two other doctors to give training and information as part of the Community Champions programme. This initiative arms local volunteers with facts about covid-19 and vaccines, so that they can encourage vaccine uptake and safe behaviours in their community. Yet it is increasingly frustrating to see our efforts undermined by government messaging.

We know that the virus is still with us. Despite the magical thinking of the government, infection rates, mortality data, and the strain on the NHS tell their own story. Although the vaccination rollout has been very successful, we still need more

It is increasingly frustrating to see our efforts undermined by government messaging

people to come forward for vaccination and boosters. Indeed, the government’s entire plan for managing covid now rests on vaccination. Only this month the prime minister, Boris Johnson, resisted calls for any further mitigation measures, saying that the “key thing” was for people to have their booster vaccines. There is a snag in this approach, though. When so much of the government’s messaging and policies over the past four months has minimised the risks of covid-19, how can we still expect the public to grasp the importance of getting a vaccine against it, or to adopt behaviours to reduce transmission?

It is getting increasingly difficult to



CHRIS BATSON/ALAMY

to experience the consequences of widescale breakthrough infections as at 5-6 months, post-vaccination antibody waning dips to sub-protective thresholds. Support for this as a key factor in delta caseload comes from the fact that countries such as Germany, which vaccinated a little later, are now entering their own spike of cases.

The government's covid-19 strategy in the UK has focused on whether or not to adopt the more stringent level of mitigations within Plan B. From the data, it should be clear that it is a simple matter of pragmatism and survival, not of politics. Current measures are not sufficient and vaccines across the age range (including third doses), masks, greater tolerance of work-from-home, ventilation, and even use of "green pass" certification may be needed to get us safely through the winter.

Daniel Altmann, professor

Rosemary Boyton, professor, Imperial College London

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engage with the wider public who want to think it's all over.

As volunteers at the Community Champions programme, we carry on, knowing that the virus is still with us. It does, however, feel like a drop in the ocean—a contribution, but not enough. What we need is considered and consistent action from central government: their continued laissez faire attitude, lack of messaging about safety measures, and reliance on the vaccination and booster programme will see more deaths and illness. A government's first responsibility is to protect its population, but this one seems to have abandoned that duty for a strategy that is both inadequate and foolhardy.

We have a hard winter ahead.

Linda Patterson, retired consultant physician

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ACUTE PERSPECTIVE David Oliver

Dismissing unwell people is abhorrent

On 12 November the *Daily Telegraph* headlined with "Six healthy children died of covid in a year, but lockdowns fuel youth health time bomb." It explained that, of 3100 child deaths in the 12 months since March 2020, only 61 were "with covid," 24 were "from covid," and six were in children with no underlying health conditions.

Although the stories centred on the serious issue of worsening access to care and worse outcomes in children with serious conditions other than covid, the headlines and graphics were clearly designed to push a message that our focus on covid protection measures had been disproportionate and unjustified for a condition unlikely to harm otherwise healthy children. It didn't mention the role of children as unwitting spreaders of infection.

The casual dismissal of people with underlying health conditions repeated a chilling pattern I've observed throughout the pandemic.

The reason I find all of this so problematic is the utter disregard for the rights or human value of older people, people with disabilities, or those with underlying conditions—not least in ethnic minority groups or deprived areas, given that inequalities played a huge part in poor covid outcomes.

In some quarters there seems to be a desire to blame people who are overweight or obese for their own increased risk. I've seen people online take it further by

boasting that their own fitness regimen and diet will give them natural immunity and that protection measures—including vaccination—are therefore not needed.

Statistical analyses have shown that covid takes, on average, a decade off the life expectancy of the people who die. Most people who die from or with respiratory infectious diseases have underlying long term conditions, covid or otherwise. Are we going to write all of them off too, on the altar of individual freedoms?

Besides, the "underlying health conditions" in people admitted to hospital or killed by covid are disorders such as hypertension, asthma, diabetes, obesity, or cancer—and many people live, work, and function with these for many years. Indeed, the millions of citizens who live with these conditions or are older than working age encompass half the adult population. People with these conditions or others such as dementia or frailty are someone's husband, wife, mother, or father. Would you want to see them written off, just so that you could carry on life as if there were no pandemic?

The attitude shown by some sections of the media and society seems deeply selfish, and it casually disregards the human worth of anyone unfortunate enough to be old, unwell, disabled, or poor.

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People who live with these conditions or are over working age are half the adult population



E-consulting raises the GP workload

Easy and convenient access to a GP must be a good thing, and that's arguably what the switch to remote consulting has facilitated. With the move to more telephone consultations, people can talk to their GP anywhere without having to make a journey or take time off work. They can also avoid waiting on the phone by booking appointments online or filling in an online consultation form. However, this assumes that they speak and read English and have computer access or data on their phone.

The problem is that this ease of access seems to have lowered the threshold of what people feel the need to ask a GP about. In the past, the personal cost in terms of time and disruption to attend an appointment was enough to persuade many patients to hang on through a few days of cough, earache, or diarrhoea, in the hope that they'd get better untreated (which they often did). But now, although actually getting an appointment may still be a problem, patients know that they'll get some sort of answer by filling in a form. As a result, we're deluged with requests.

Any recommendation of barriers to GP access is problematic. Most people don't know whether their symptoms are serious, and it's a doctor's job to determine that. Furthermore, if we make it harder to see a GP, precisely the wrong patients will stay away, presenting too late with symptoms of serious disease because they didn't want to bother the doctor or couldn't navigate the system.

If we make it harder to see a GP, the wrong patients will stay away



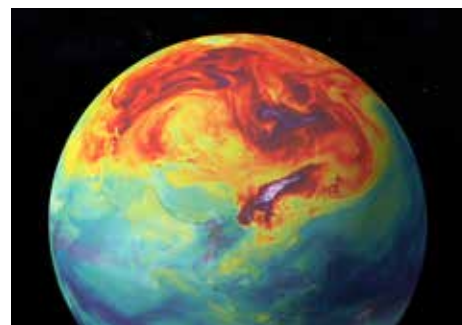
However, we do need to find a solution to rising demands on general practice. My fear is that we're having our time and energy diverted into responding to online consultations about minor problems, many of which don't need a doctor's attention. They may be fairly simple to handle, but they all need to be read, considered, and responded to. Although many older patients do use online access, there's still a skew towards younger, more tech savvy patients. In theory, moving these people online should free up our phone lines for those who need them. But in practice we seem to have generated new demand—or possibly uncovered previously unmet need—which is squeezing out some of the most valuable parts of our job, such as home visits to older, frailer patients.

Some practices have made e-consulting work for them, and they've found it an efficient way to answer simple questions quickly, leaving more time for patients with more complex medical needs. Others, including our practice, have only found their workload increasing, with the dreaded e-consultation forms yet another task to fit in, usually at the end of an already overlong day. Only a few can be answered without at least a telephone consultation, and these calls are mostly on top of the work we already have, rather than instead of it.

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LATEST PODCASTS



Planet Earth on red alert

Our health is inextricably linked with climate change, but what can medical schools and students do to support a greener future? Guest Anna Moore, a registrar in respiratory medicine, joins the Sharp Scratch podcast to discuss how we can reposition our understanding of climate and health in the medical curriculum:

"If we see climate change as a standalone subject, then that's what it will be. But we need to start seeing it in everything. You don't get away with any weeks in medical school not thinking about a full blood count, for example, because as physiology it's just there all the time. That kind of approach needs to be taken in terms of thinking about where our health is situated globally."

The crisis in general practice

It's a challenging time for primary care, with a backlog of demand, perpetual NHS reorganisation, and a shortage of GPs, all on top of a media campaign depicting GPs as lazy. The latest Deep Breath In podcast focuses on how GPs are responding. We hear from GP Lucy Martin, who recently published qualitative research studying the working lives of mid-career GPs. Martin describes how many of these GPs were looking into reducing their clinical hours and why that was:

"A lot was around what I'd call work intensification in organisational psychology terms—the way the day has become much more busy, very crowded, with lots of decision making and interruptions. But then there were other more peripheral things like loss of autonomy, increasing admin, the transfer of work from secondary care to primary care, and regulatory activity. Patient demand featured a lot as well, so the way the culture seems now to be driven by more of a defensive medicine approach."



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

ANALYSIS

Women's wellbeing and the burden of unpaid work

Soraya Seedat and Marta Rondon examine how gender inequities in the time allocated to unpaid work, exacerbated by covid-19, are affecting women's mental health



Women spend a disproportionate amount of their time carrying out three quarters of the world's unpaid work:

11 billion hours a day.¹ Globally women undertake three times more care and domestic work than men, with women in low and middle income countries devoting more time to unpaid work than women in high income countries, although income related differences within countries also exist.²

Unpaid care work is often perceived as low value and is invisible in mainstream economics, underpinned by entrenched patriarchal institutions and national accounting systems that fail to factor in women's total contributions. Unpaid domestic and care work is associated with greater mental health burden and negative effects on quality of life,^{3,4} although most of the evidence comes from high income countries. Internationally, during the covid-19 pandemic, time spent on care and domestic work has increased for both men and women, but the increase and intensity of this work has been far greater for women. The risk of mental illness among women engaged in unpaid work can be expected to rise during the crisis with exposure to greater and more stressful workloads. Urgent action is needed to protect women's mental health.

Sustained high cortisol levels may partially explain some adverse mental health outcomes

Unpaid work, stress, and mental health

Unpaid work refers to services provided within a household for its members, including personal care and housework.⁵ Because of the gendered nature of domestic and reproductive roles, women and girls are often expected to assume unpaid domestic work and care.⁶ Unpaid care work is a major factor in determining both whether women enter and stay in paid employment and the quality of their work.⁷ Although evidence is limited in the context of unpaid work on the effect of individual level factors (eg, perceptions of distress, cumulative stress load, past mental health problems) and ecological factors (eg, household conditions, space constraints, noise) on stress and mental health, the contributions of drudgery and the physical demands of unpaid work need to be considered.

Women's experience of unpaid domestic work and care, and the drudgery associated with these activities, varies a great deal not only between those in high income countries and lower income countries but also between different income groups within countries.² Higher earning women in all countries are able to give more attention to and spend more quality time with their children by outsourcing more onerous household tasks—for example, by using care services and domestic help. By contrast, women who lack the financial means are often burdened by repetitive, time consuming, and physically

demanding domestic tasks.² This drudgery component, which makes up the largest share of poorer women's total unpaid work burden, may cause substantial fatigue and stress, whereas the relational component of unpaid work, such as playing with children, may be stress reducing and fulfilling.²

Stress activates the release of neurohormones, including cortisol. Women who experience household tasks and childcare as highly stressful have been shown to have higher cortisol levels and slower recovery of cortisol than women who report low stress from this type of unpaid work.⁸ This underscores the importance of women's subjective experience of unpaid work, as sustained high cortisol levels may partially explain some adverse mental health outcomes, including depression, in women doing unpaid care work.⁹ For women, higher levels of objective stress may also translate into higher levels of perceived stress (burden and role strain) compared with men.¹⁰ Moreover, the cognitive and emotional involvement and the lack of respite (eg, time for leisure, communication with partners or friends, and self-care) from unpaid work can eventually lead to physical and emotional distress, depression, and anxiety.¹¹

The "double burden" of paid and unpaid work has differential effects, with household stress seeming to affect women more than men.¹² For example, a US study¹³ found that inequities in the division of housework and women's disproportionate share contributed substantially to sex differences in depression. A four wave study that mapped depression trajectories in the Swedish working population between 2008 and 2014 found that women generally worked longer hours overall and spent more time doing unpaid work than men.¹⁴ The link between more unpaid work hours and a higher depression symptom trajectory was stronger for women than men. There was also an association in women (not men) between more total work hours and a "high stable" depression

KEY MESSAGES

- Women have historically carried a disproportionate burden of unpaid domestic and home care responsibilities
- The response to covid-19 has widened the inequality gap and highlighted women's escalating burden of unpaid care work
- The higher risk of depressive and anxiety symptoms among women may be partially explained by this disproportionate burden
- Innovative research is needed to identify policies to reduce inequalities in the unpaid economy

trajectory. Both trajectories are associated with poorer outcomes, underscoring the need for targeted interventions to reduce women's work hours, especially unpaid work hours.

Unpaid work also has other unfavourable deleterious effects. The Korean Longitudinal Study of Ageing (2006–18) showed that middle aged, full time homemakers had five times the risk of cognitive impairments compared with women in other occupations.¹⁵

Furthermore, providing long term or high intensity care for a sick or elderly relative has been associated with an excess of psychiatric morbidity in women (eg, depression, anxiety, and lower life satisfaction).¹⁶ Analysis of three waves of the UK Household Longitudinal Study to compare employment, earnings, and health effects in young people providing unpaid care found that young unpaid caregivers for elderly, sick, and disabled people were mostly women, uneducated, living with a partner, and living in social housing.¹⁷ Compared with young people without caring responsibilities, they had worse physical and mental health, earned less, paid fewer taxes, received more welfare, and spent more on health services.

These findings contribute to our understanding of causal associations between unpaid work and longer term individual and societal outcomes. If we consider that women and girls make up 49.5% of the global population, the direct and indirect costs are staggering.

Although evidence on the adverse mental health consequences of unpaid work in women from high income countries is growing, sex disaggregated data on the mental health effects of unpaid work in low and middle income countries are sparse. This is concerning given that the costs to physical and mental health from unpaid care giving may be even higher in these countries. A systematic review and meta-analysis comparing health outcomes of unpaid caregivers and non-caregivers from Africa, Asia, and South America found that unpaid caregivers had higher levels of anxiety and depressive symptoms than non-caregivers.¹⁸ Women comprised the majority of caregivers in 12 of the 14 included studies, and they included those caring for individuals with chronic health problems (eg, HIV, cancer, diabetes mellitus), disabled family members, or individuals without any apparent medical condition.



Unpaid work during the covid-19 crisis

The gendered nature of unpaid work has become more apparent during the covid-19 pandemic.¹⁹ A rapid assessment survey by UN Women in April 2020 found that among women surveyed in Pakistan, 49% reported spending more time on domestic chores compared with 33% of men. In Bangladesh and the Maldives, 55% and 68% of women surveyed reported spending more time on unpaid domestic work, compared with 44% and 55% of men in these countries.²⁰ In the US and the UK, real time surveys in March and April 2020 found that more women than men had lost paid jobs.²¹

Gender asymmetries during the pandemic have extended to childcare, with mothers doing a greater share of childcare than fathers in response to closure of schools and day care facilities and the unavailability of home help. A UK survey of 4915 parents from two parent mixed sex households conducted early in the pandemic (April-May 2020) found that compared with 2014-15, women were spending substantially longer on childcare and housework than their male partners. Women's paid work had also shrunk disproportionately compared with men's, and their work productivity (measured in interrupted hours) had more steeply declined when working from home. For example, mothers and fathers doing paid work used to be interrupted during the same proportion of their work hours before the pandemic. However, the survey found mothers were being interrupted 57% more during their paid work hours than fathers.²²

A nationally representative household study in the UK during the first covid-19 lockdown (April-May 2020) found that not

The pandemic has magnified these inequities and placed women at an even greater risk of depression, anxiety, and other common mental disorders

only did women do about two thirds of the housework and childcare but they were more likely than men to reduce working hours and adapt employment schedules because of spending increased time on unpaid care.²³ Increased hours spent on childcare and home schooling were associated with greater levels of psychological distress among women than men. One limitation is that the study did not assess change in unpaid care work due to lockdown and how this may have affected levels of psychological distress.

Several other studies, including from Australia, China, the UK and US, have documented a greater rise in psychological distress in women than in men during lockdown. In Australia, for example, a population based study during the first month of covid-19 restrictions to establish the population prevalence of clinically significant symptoms of depression and anxiety among adults aged 18 years and older, showed that women had a greater propensity to develop symptoms of anxiety and depression and were also more likely to be taking care of children and dependent people. These findings suggest that the disproportionate burden of unpaid care giving may be a risk factor for psychopathology.¹⁹ Other factors, such as social isolation, decreased access to health and social services, and increased exposure to intimate partner violence, have also been shown to disproportionately affect women's mental health and quality of life during covid-19 restrictions.^{24 25}



Reducing the burden

Gendered social norms construct women as caregivers and providers, yet unpaid work is clearly associated with poorer mental health for women. The pandemic has magnified these inequities and placed women at an even greater risk of depression, anxiety, and other common mental disorders.

Longitudinal research is needed to improve our understanding of the implications of unpaid care giving for mental health outcomes on a global level, in both pandemic and post-pandemic times. This should include in-depth exploration of the duration, type, and intensity of unpaid domestic work and care giving, the interaction with paid work, and the contribution to mental health outcomes. The interplay between individual level factors and ecological factors in shaping mental health problems also requires further examination. The pandemic has reinforced the need to generate national robust time-use survey data on the gender distribution of unpaid care and domestic work across countries as evidence for policy makers. The UN Women's global programme, Making Every Woman and Girl Count, has spearheaded such an initiative,²⁶ and concerted efforts must be made to ensure the data are prioritised.

From a policy perspective we urgently need to drive transformative change, especially because the prolonged pandemic and recurring lockdowns in many parts of the world have entrenched gender asymmetries in unpaid work. The increase in unpaid work responsibilities during the covid-19 crisis will also make it more difficult for women who have lost their jobs to find alternative employment and income streams, as well as

making it more challenging to reduce their unpaid work to the level that existed before the pandemic.

We can start to address this by prioritising the continued safe operation of childcare facilities and schools. Social protection measures, such as paid leave for workers who need to care for children or sick or elderly family members, and subsidies for people with care responsibilities must be established—or continued in countries where these measures exist. For example, a covid-19 related measure implemented in Austria grants employees three weeks of exceptional leave at full pay for childcare responsibilities for children under 14 years.²⁷ Peru is another example where women are the default household recipients of a covid-19 stimulus cash transfer scheme that seeks to affirm women as central to families' wellbeing.²⁸

Providing a more extensive menu of flexible working options (eg, teleworking, staggered work hours, flexi hours) that account for women's care responsibilities during the pandemic and beyond is another strategy to support women. Although many low and middle income countries may not have the resources to implement some of these measures, other strategies are feasible. For example, a UN Women analysis using country level data showed that if a middle income country such as South Africa made childcare services available for children under the age of 5 years, two to three million new jobs would be created and unemployment rates would go down by 10 percentage points.²⁹ This is a compelling case for investing in free

Transformative change for women requires policy that recognises, reduces, and redistributes unpaid care work

universal childcare services of high quality to reduce gender inequality in earnings and employment.³⁰

Adopting a life cycle perspective to the more equitable distribution of unpaid care work, starting with policies that grant fathers longer paternity leave, has also consistently been associated with better infant and child health outcomes and reduced mortality.²⁹

The covid-19 pandemic has highlighted the urgency of integrating service delivery and improved access for women to mental and physical health services, income and employee support, social welfare, and legal and justice systems. Access to legal systems needs particular strengthening to protect and support women increasingly vulnerable to intimate partner violence.

Transformative change for women requires policy that recognises, reduces, and redistributes unpaid care work. Government incentives can support this change, such as through "cash for care" subsidies to compensate parents affected by school and daycare closures and for employers that provide workers with paid leave. Ultimately, whole communities and local governments need to be involved in the provision of care. This will free up women to contribute more to the paid work economy, to engage in voluntary and leisure activities, to have more time for themselves, and to safeguard their careers with arguably less compromise to, and negative effect on, their mental health and general wellbeing.

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LETTERS Selected from rapid responses on bmj.com

SUCCESS OF INDEPENDENT SAGE

Independent SAGE deserves recognition, not criticism

Independent SAGE has legitimately blended science with relevant policy advice to inform and influence practice (Cover Story, 23 October). Governments that failed to control the pandemic



will find this uncomfortable. *The BMJ*'s article that seems to disparage Independent SAGE's achievements oddly infers that supposed links with "activist" groups espousing elimination strategies are problematic. But governments espousing herd immunity theories, showing inertia, and ignoring the science are the real threat to public health. The article also cites critics of Independent SAGE who don't seem to accept that public health should be based on precaution and prevention flowing from both evidence and knowledge of data gaps.

Independent SAGE reached a wide range of communities, parents, patients, health professionals, worker groups, and politicians, who used its charters, reports, briefing notes, and meetings to protect their members and the public health of those around them. Independent SAGE's successes deserve full recognition, not criticism.

Andrew Watterson, professor of health, Stirling

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Making more sense than the government

Clarke's article gives some fascinating insights into the creation and functioning of Independent SAGE. The only sensible response is that Independent SAGE has been an outstanding success. It has engaged the press and the public in the assessment of epidemiological data to the extent that we are as likely to hear a member of Independent SAGE on the radio or TV as the minister for health, and we can expect a lot more sense from any member of Independent SAGE.

Moreover, Independent SAGE has made realistic recommendations about airborne transmission and steps that can be taken to reduce transmission, which make almost any pronouncement from our government seem like ill thought out nonsense.

Geoffrey Woodruff, consultant ophthalmologist emeritus, Leicester

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RESPONSE

Independent SAGE replies to *The BMJ*

We read *The BMJ*'s article on whether the Independent Scientific Advisory Group for Emergencies (Independent SAGE) has been a success with interest (Cover, 23 October), as well as a little irritation, given that it began with a major factual error that set the tone for the remainder of the text (as described in our rapid response).

We are not "rebel scientists" but internationally recognised academics and health practitioners seeking to communicate science to the public, press, and policy makers. Our main activity is delivering public briefings through live broadcasting and written reports, in which we seek to present often complex information in a timely manner and an easily understandable form. Key to these briefings is expert interpretation of the latest epidemiological data from the government daily dashboard, NHS England, public health bodies from each home nation, NHS Test and Trace, the Office for National Statistics, the REACT study, and other reputable sources, acknowledging the work of those who do so much to curate them. The people responsible for these data recognise that each has strengths and weaknesses and that they need to be triangulated with each other, a view that we endorse. We have drawn extensively on SAGE's reports, and, as our published timeline shows, we have almost always agreed with their conclusions. A major theme of ours has been to act faster, with more decisive action to control the spread of the virus, accompanied by greater support for those affected—views held by a wide body of scientific opinion. We have supported government policies when they have acted to control the pandemic, even when we were criticised for doing so, as when we endorsed the decision to increase the spacing of doses early in the vaccine rollout.

We have been critical of some policies; in these situations, many of our concerns have been endorsed by others in official positions. One example is the joint report from the Parliamentary Health and Social Care Committee and

Science and Technology Committee, when we, like them, called for more learning from abroad. Another is our serious concern about the design of the test and trace programme, shared by the Public Accounts Committee, drawing on a report by the National Audit Office. We agreed with the health secretary, who said that daily cases could rise to 100 000 over the summer months, considering that the SAGE models supplied to the government at the time showed that this was a clear possibility. Yet our agreement with him was used to justify *The BMJ* article's argument that "iSAGE [sic] has become a byword for poorly evidenced alarmism."

When we considered what contribution we, as a multidisciplinary group of scientists outside government, might make during the pandemic, we drew on extensive literature on the science policy interface, as well as, for some of us, several decades working at this interface. This literature makes clear that groups such as ours can make a positive contribution, a view subsequently endorsed by the feedback we have received from many members of the public, their elected representatives, and many civic organisations. It also explains why the argument for maintaining a distinct separation between science and policy is at best naive and at worst disingenuous, given the social forces that shape the collection, synthesis, and interpretation of evidence and the importance of scientists listening to those affected by policies.

A serious article on our group would have tackled the topic of Independent SAGE's contribution to the communication of science in a fast moving and often uncertain pandemic in the context of evidence about the process.

Deenan Pillay, chair, Independent SAGE

Anthony Costello, Karl Friston, Zubaida Haque, Martin McKee, Susan Michie, Tolullah Oni, Christina Pagel, Steve Reicher, Helen Salisbury, Gabriel Scally, Kit Yates

on behalf of Independent SAGE

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MPs' COMMITTEE REPORT ON COVID RESPONSE

Test and trace system continues to fail

Not only did the parliamentary committee report find that the shaky test and trace system impaired the pandemic response (Editorial, 23 October), but now the public accounts committee has clearly stated that there is no evidence it reduced levels of infection.

All this at an “eye watering” cost so far of £37bn, around one fifth of the annual NHS budget. Included are the grotesque payments to 2000 management consultants and contractors, some of whom were paid up to £6000 a day, meaning that in one week they earned the average annual salary of a nurse.

An imagined effective test and trace system underpins the present pandemic strategy—rising numbers of covid cases, deaths, and hospital admissions are testimony to its ongoing failure. Total reliance on vaccination, pretending we have returned to normal, and denying that the NHS and care sector are in crisis represent a complete abdication of leadership.

John Puntis, consultant paediatrician, Leeds

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The difference between an apology and repentance

The reflections by Gurdasani and McKee highlight the difference between an apology and repentance.

Leaders in politics, science, or practice are reluctant to make any public apology, such as, “Sorry, thousands of frail older people died because we didn’t consider that all their systems of care are connected.” To apologise requires someone to stick their head above the parapet and face potential derision.

Repentance requires a leader to acknowledge, “We have been going in completely the wrong direction, we are going to stop that and take a different direction from now on.” In any profession, repentance requires integrity, responsibility, and insight.

Woody Caan, retired professor of public health, Duxford

Cite this as: [BMJ 2021;375:n2813](#)



HOLLIE ADAMS/GETTY IMAGES

Rory Stewart's call to learn from overseas was ignored

WHY HEALTHCARE NEEDS REBELS

NICE is not normally described as “rebellious”

Godlee’s call for NICE to keep close to its radical roots is interesting, not least because NICE has never claimed this for itself (Editor’s Choice, 23 October). Radical or not, NICE applies thorough and robust approaches to assessing health technologies.

Inclisiran is an innovative treatment with huge potential benefits. NHS England estimates that it could prevent 55 000 heart attacks and strokes, saving 30 000 lives in the next decade. Our independent appraisal committee concluded that inclisiran was clinically and cost effective using the best available evidence. We will monitor ongoing clinical trials closely.

In response to the suggestion that NICE is hiding its economic analysis, the price of inclisiran agreed with NHS England is commercial in confidence.

NICE is not normally described as “rebellious,” but if this means making evidence based recommendations for innovative treatments that sometimes divide opinion, then we’ll do our utmost to be worthy of it.

Gillian Leng, chief executive, NICE

Cite this as: [BMJ 2021;375:n2831](#)

Rebels imagine better futures

Godlee touches on the often overlooked issues of dissent, resistance, incivility, and rebellion in relation to health. Rebellion might be seen as an act of opposition, but it is fundamentally

about imagining and pursuing something better. We need rebels to imagine better, just futures. Such action comes with risks, but there are also costs in failing to act—the history of medicine is littered with examples of complicity with despots and rights abusers.

Looking to history, we do not see a case to disobey for the sake of it; history shows us that too often we accept inequalities, unfair structures, broken systems, and “truths” that perpetuate injustice, we accept small daily indignities that chip away at health and wellbeing, we fail to question authority and ourselves. Our default should not be obedience. Healthcare needs more rebels—they have had a central role in promoting and protecting health.

Ryan Essex, research fellow, Greenwich

Cite this as: [BMJ 2021;375:n2836](#)



CREATING MORE SUSTAINABLE PRACTICE

PPE: producing polluted environment

Pollution is undeniably having a catastrophic effect on our planet. Wise says that in the first three months of the covid-19 pandemic, trusts used three million masks compared with about 20 000 the previous year (COP26 Feature, 23 October). Rizan and colleagues report that the carbon footprint of personal protective equipment (PPE) in the first six months of the pandemic was 106.478 tonnes CO₂e, mainly from gloves, aprons, face shields, and type II surgical masks. They suggest hand washing gloves and extending the use of masks and gowns to reduce environmental damage.

In this rapidly evolving crisis, we need a coordinated effort. Strategies are in place on restricting gas emissions, solar panels are being installed on ambulances, and investments are being made in different sources of green energy. But we need systems for safe disposal of PPE, as well as a policy change to reduce use of PPE without compromising safety.

Yuli Guzman-Prado, epidemiologist, Bournemouth

Cite this as: [BMJ 2021;375:n2822](#)

OBITUARIES

Joan Ripley

School medical officer Watford, Hertfordshire (b 1930; q Middlesex Hospital, London, 1954; cert Family Plann, JCC, FRCPCH), died from complications of Alzheimer's dementia on 13 August 2021

Joan Ripley (née Inwald) was born into a medical family. She emigrated to Montego Bay, Jamaica, with her first husband and young family, where she served as president of the Jamaica Red Cross, Western Region. After Jamaican independence she returned to England, where she settled in Radlett, Hertfordshire, and became an active member of Radlett's Medical Circle and University of London's Convocation. She was an avid follower of music and opera, where she met her second husband. When her children were grown up she worked in paediatrics as a school medical officer and in family planning clinics. She took pride in the achievements of her three children—in special education, film, and social housing, respectively. Joan leaves her children.

Godfrey D Ripley

Cite this as: *BMJ* 2021;374:n2118

David Alfred Owen Sutton

Consultant geriatrician (b 1936; q Bristol; FRCP, MA), died from prostatic cancer on 30 September 2020

On qualifying, David married June, a biology teacher, and after training posts moved to St David's Hospital and University of Wales Hospital, Cardiff. Two years later, June died suddenly. Three years later, David married Angela, a pharmacist, and had a post in Bournemouth and Poole, where Helen was born. He returned to a consultant post in Cardiff, and a medical tour of China, an MA in medical ethics, and a charity bike ride in Israel for the Edinburgh Medical Missionary Society in 1999. David and Angela lived in Penarth until they retired and then moved to Bristol for family reasons. David was a committed Christian and a Baptist church elder. His interests included reading, cycling, walking, nature, photography, painting, jazz, and caravanning. He leaves his wife, daughter, and two grandsons.

Angela Sutton

Cite this as: *BMJ* 2021;374:n2119

Stanford Bourne

Consultant psychiatrist (b 1928; q London, 1952; MRCP, FRCPsych), died from congestive cardiac failure on 30 July 2021

Stanford Bourne ("Sandy") specialised in psychiatry and became a psychoanalyst, undergoing his training in analysis for many years with Hanna Segal. Work carried out by Sandy, together with Emanuel Lewis, helped to bring fundamental changes to the way in which the medical and other professions respond to stillbirth and neonatal death and came to recognise the need to allow parents a proper grieving process, giving the baby a name and a funeral. The progress and learning were summarised in 1992 by Bourne and Lewis in *Psychological Aspects of Stillbirth and Neonatal Death*, an annotated bibliography. His work also led to improvements to the system of BMA distinction awards. Predeceased by a daughter in 1986, Sandy leaves his wife, Judith, and a son.

Charles Bourne

Cite this as: *BMJ* 2021;374:n2110



Damian Vincent McGivern

Consultant respiratory physician Hull and East Yorkshire Hospitals NHS Trust (b 1954; q Southampton, 1977; DM, FRCP), died from multiorgan failure on 30 April 2021



Damian Vincent McGivern was appointed to the post of consultant respiratory physician in Hull at the young age of 33. He was quickly recognised as an excellent teacher and an astute diagnostician with wide clinical interests and expertise. His main focus became lung cancer; he led a multidisciplinary team that helped secure Hull's status as a cancer centre. He quickly adopted the technique of staging tumours by endoscopic ultrasound, establishing this as a tertiary level service in the region. He enjoyed travel, marathon running, and long distance cycling. Having retired in 2019, his customary activities were curtailed by health problems, but he still enjoyed daily dog walks. He leaves his wife, Debbie; four children; three stepsons; and seven grandchildren.

John Puntis

Cite this as: *BMJ* 2021;374:n2117

David Michael Roberts

GP (b 1959; q Bristol, 1982), died after a long illness on 14 August 2021

David Michael Roberts ("Mike") became a partner at Rosebank Health, Gloucester, in 1989. During his career he became team doctor, then crowd doctor, for Gloucester Rugby Club in the early 1990s. He developed extensive experience in health service management, serving as professional executive chair for West Gloucestershire Primary Care Trust, as medical professional lead and responsible officer for Gloucestershire PCT, and as a member of Gloucestershire local medical committee. In 2014 he was appointed deputy medical director of Gloucestershire Care Services and later became its director. Outside medicine he took great pride in his tuba playing and he loved music, travel, reading, and cars. Most importantly, he was a family man. He leaves his wife, Jules; four children; two stepchildren; and his mother, brother, first wife, and wider family.

Rhys Watkins

Cite this as: *BMJ* 2021;374:n2111



Charles Wakeley

Consultant musculoskeletal radiologist (b 1959; q Charing Cross Hospital Medical School, London, 1983; FRCS Lond, FRCS Edin, FRCR), died from glioblastoma multiforme on 23 May 2021

Charles Wakeley was appointed as a consultant radiologist with special interest in musculoskeletal and oncological imaging at the Bristol Royal Infirmary in 1995. He was a superb lecturer, published widely, and served as president of the British Society of Skeletal Radiologists, and was a senior examiner for the Royal College of Radiologists. Charles was devoted to his family. Holidays were a highlight, both at exotic locations and at the family home in Anglesey. His interests outside radiology included wood carving, fishing, and water skiing. Soon after planning a detailed road to retirement Charles was diagnosed with a glioblastoma multiforme. He leaves Rachel, his wife of 37 years; two sons; his sister; his brother; and his mother.

David Silver

Cite this as: *BMJ* 2021;374:n2112



Michael Peckham

Professor of oncology and artist

Michael John Peckham (b 2 August 1935; q 1959; FMedSci, FRCP, FRCS, FRCR, FRCPath), died from lymphoma on 13 August 2021

Art was at Michael Peckham's core. He painted and exhibited all his life, and his vibrant artworks cheered each office he inhabited. He said being an artist gave him balance as a doctor and health researcher. "If you're an artist you have to take the holistic view. I think it's prevented me from retreating into overspecialised activities."

Peckham specialised in oncology. He spent two years in Paris, working with Maurice Tubiana on the cell biology of lymphoma at the Institut Gustave Roussy. Returning to London, he took a job as a lecturer at the Institute of Cancer Research, Royal Marsden Hospital, and in 1973 was appointed professor of radiotherapy. He went on to become dean in 1984.

Peckham instigated several clinical and laboratory programmes and furthered the research he had seen in Paris into lymphoma and Hodgkin's disease. He had success with mantle-field radiation for lymphoma to reduce recurrence, in which the radiation field was extended to include nearby lymph nodes that might be harbouring cancer cells. In 1983 he published a paper showing that a combination of bleomycin, etoposide, and cisplatin was successful at treating testicular cancer and less toxic than the prevailing protocol. One patient in his care was the jockey Bob Champion, who recovered from testicular cancer to win the 1981 Grand National. Impressed punters donated their race winnings to the Royal Marsden in his honour, and Peckham persuaded Champion to set up a charity, which subsequently raised over £15m for research.

At the beginning of the 1980s, Peckham hit out at those who thought gynaecologists, haematologists, and others could administer highly potent chemotherapy drugs. He thought oncologists across Europe should band together to have a stronger voice and share expertise and was a founder of the European Society of Therapeutic Radiology and Oncology (1980), the Federation of European Cancer Societies (1981), and the European School of Oncology (1982).

Health management

Peckham's colleague Sally Welham described him as having "a talent for seeing a vision and then creating it. Once it was up and running, he focused on the next big task." At the end of the 1980s the next task in Peckham's sights was to get evidence based treatments more speedily into clinical practice. He noted a gap of 12 years, for example, between thrombolytic treatments being proved to help patients with a heart attack and doctors recommending them.

In 1988 the House of Lords commissioned a report, *Priorities in Medical Research*, which led to the setting up of the National Health Research Authority, with Peckham as its director of research and development. He was tasked with getting the NHS to identify its research needs, commissioning research and disseminating findings, and fostering evidence based medical practice. The strategy was unique at the time and while he was in this role, he backed Iain Chalmers's idea for the Cochrane Collaboration and provided a start-up grant.

After five years at the NHS Research Authority, in 1996 Peckham became founder

and director of the School of Public Policy at University College London, which he built from nothing into a large and respected unit that helped academic researchers and public policy professionals to share expertise. In 1995 he was knighted for services to medicine.

Welsh childhood

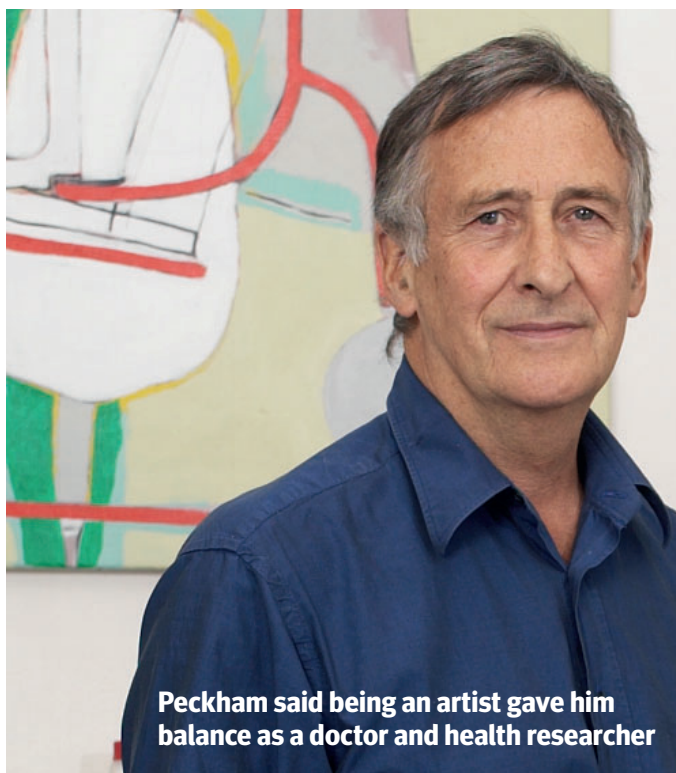
Michael John Peckham was born on 2 August 1935 in Panteg, Monmouthshire. His mother, Gladys (née Harris), was a teacher and his father, William, a train driver and artist, who encouraged him to paint. Peckham occasionally accompanied his father on the night express from Cardiff to London, recalling the early sunrise mist as they drew into Paddington.

After attending West Monmouth Grammar School, Peckham won a scholarship to St Catharine's College, Cambridge, to read natural sciences before going to University College London to study medicine. Here he met Catherine Stevenson King, who later became a professor of paediatric epidemiology. The pair married in 1958 and had three sons, Alexander, Robert, and Daniel.

Peckham had his first art exhibition in Bangor in 1962. Many followed, including one in 2004 at the Royal Academy in London, entitled "Treatments," where he showcased 35 small drawings he had made in patients' notes. He enjoyed retreating to a family house in the south of France each summer, and the Mediterranean colours were a strong influence on his art.

Peckham leaves his wife, Catherine; three sons; and nine grandchildren.

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Peckham said being an artist gave him balance as a doctor and health researcher