Social media can be a fascinating part of the medical world—an intriguing cocktail of joyousness and apathy, good and dark intentions, facts and counter facts. The platforms have also become places of dynamism and activism, where things can happen a lot more quickly than in traditional systems.

For many, social media sites can be a place of solace, somewhere to spend time with friends—even if they’re nameless or you haven’t met them in person—away from our busy roles. They also provide a channel for people to create a profile and promote themselves.

When it comes to policy, the power of social media remains very much untapped. Without it, we wouldn’t have had the progress we’ve seen in type 1 diabetes care in recent years—access to technology, awareness raising, and the gathering of like minded colleagues. Social media can also form the basis of a great deal of learning for people with type 1 diabetes. This progress would otherwise have been lost in the wheels of bureaucracy or in waiting for approvals from individuals who care more about organisational reputation.

I can’t think of any other medium that can draw attention to a lack of access to technology so quickly and help bring speedy resolution when cases of discrimination gain wide support. Yet the darker side of social media is always just a whisker away. Nuance is lost, aggressive attitudes emerge, misinformation spreads like wildfire, and personal attacks abound. This shows what I’ve always believed—NHS staff are no less racist, homophobic, or misogynous than the rest of society. Some people make their medical accounts anonymous, probably to hide from vexatious referrals. When that anonymity is used to attack colleagues, however, this may reflect broader problems in the working culture.

I’d recommend that everyone in medicine engage with social media, to learn, interact, and counteract misinformation. My engagement has brought me some personal attacks and abuse, yet it’s also brought me joy and success. My output now mostly involves cascading information, interacting with people I may be able to help, and posting pics of my wonderful dogs.

To people in policy roles, I’d say that if you don’t think that you need social media to craft policy and ideas, you’re not interacting enough with those whose lives you try to influence.

Find accounts to follow that inspire you or make you smile. And take breaks from social media when you can: I do now, simply because the world outside has much to smile at too.

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Cite this as: BMJ 2022;379:o2916

In praise of social media for doctors
**OPINION** Sabine Goodwin

### Ending the food bank paradox

People can no longer rely on charities—they need higher incomes

Britain's food insecurity crisis was worsening before we'd heard of covid-19. In the year up to March 2020, Trussell Trust food banks had distributed 1,909,156 emergency food parcels across the UK.

This accounted for a fraction of wider food insecurity—according to the Department for Work and Pensions Family Resources Survey, 43% of households on universal credit reported severe or moderate food insecurity in that same year. In January 2020, the Independent Food Aid Network (IFAN) revealed that food banks in Scotland had distributed 1,000 emergency food parcels a day over the previous 18 months.

Following a huge spike in need for support at the start of the pandemic, food banks saw continued, unprecedented demand through to 2021 despite a 16% reduction in food insecurity in households relying on universal credit because of the £20 uplift. And then came the cut to universal credit in October 2021 resulting in increasing and relentless pressure building on households and, in turn, food banks. This pressure continues unabated as the winter sets in and costs rise.

However, there’s a new and potentially game changing twist to the latest reports on the growing need for food banks. Since May, independent food banks have reported in survey after survey about the growing need for their services, pushing their teams to “breaking point.” Food and financial donations were falling, financial reserves were being used, and depleted frontline teams were struggling to cope.

### Reduced food parcels

IFAN's October survey found 82% of contributing organisations had been affected by supply issues and more than one in four had needed to reduce the size of their food parcels over the previous three months. Surplus food supply has been drying up, volunteers are having to work to pay for the cost of living, and people who used to donate are needing food banks themselves. Independent food banks are having to compromise on the diversity and scale of the support they can give.

Similar reports came from food aid providers working with other networks such as Feeding Liverpool and the Shropshire Food Poverty Alliance. By summer even Trussell Trust food banks were reporting the strain.

Recent months have clearly demonstrated that the charitable food aid status quo is both unsustainable and unacceptable. Relying on dwindling surplus food supplies, the public’s ability to donate, and the willingness of volunteers is clearly not the answer. It’s become more obvious than ever that ensuring adequacy of income through social security payments and wages is the

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**ACUTE PERSPECTIVE** David Oliver

### Have senior doctors really “pulled the ladder up” behind them?

With the BMA set to open a ballot on 9 January on possible industrial action by junior doctors over terms, conditions, and pay, some online comments have become combative. The debate has taken on a flavour of intergenerational doctor-on-doctor culture wars, often using the phrase “pulling up the ladder.”

I’ve written before in this column in strong support of junior doctors’ concerns and the need for solutions. My views are unchanged. But I’m not sure that attacking or blaming senior medics en masse is helpful.

Last month the Nuffield Trust published an analysis of how real terms pay for different NHS staff groups has been eroded over time. And although consultants are relatively high earners, they’ve seen the biggest hit to their relative remuneration over the past decade, by around 12%. Fully qualified GPs have also seen real terms income fall by a similar amount over that period. And pension tax rules have left senior doctors facing repeated annual charges running well into five figures and often a large percentage of their net income.

Many senior doctors are burnt out by at least three decades in the job, compounded by the impact of the pandemic on their working lives and their health. These have made what was once a rewarding and enjoyable role into one that’s unsustainable. The wider factors of an under-resourced and over-pressurised system that affect junior doctors’ working lives are the same ones that affect consultants and GPs.

When the language of intergenerational blame is deployed, it’s sometimes asserted that things are more difficult now than they’ve ever been for juniors, or it’s been forgotten that those senior medics were once juniors themselves. Many of the concerns raised by this generation of junior doctors are familiar to their seniors: rotas causing disruption to evenings, nights, and weekends; lengthy postgraduate training involving constant rotation between specialties, hospitals, and towns; multi-stage exams with expensive fees; bottlenecks in some specialties between grades; patchy or inconsistent mentorship, supervision, and pastoral support; a skewed balance between experiential training and training that comes from focused supervision with dedicated time for feedback; and discrimination based on race, sex, or social background.

I’m not suggesting these concerns aren’t justified or should be minimised just because things have “always been that way.” But it’s not helpful to speak about long serving doctors as if they’ve never been in similar positions—just as it’s unhelpful and toxic when senior doctors make disparaging remarks about the resilience or work ethic of newer entrants. I realise much of the dissatisfaction stems

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**The charitable food aid status quo is both unsustainable and unacceptable**

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Recent months have clearly demonstrated that the charitable food aid status quo is both unsustainable and unacceptable. Relying on dwindling surplus food supplies, the public’s ability to donate, and the willingness of volunteers is clearly not the answer. It’s become more obvious than ever that ensuring adequacy of income through social security payments and wages is the
real solution. The chancellor’s decision to uprate benefit payments in line with inflation alongside further energy support and a rise in the benefit cap in April are welcome, but there are still the winter months to get through. With debts building up and costs rising, the autumn statement is unlikely to make a substantial difference to food insecurity while huge damage is being inflicted.

Food bank teams are caught in a brutal paradox, and there’s a feeling of endlessly treading water as poverty levels continue to soar. Meanwhile the catastrophic impact of worsening food insecurity is blighting the lives and mental and physical health of more people across age groups. The health, and ultimately wealth, of our society is being compromised by policy decisions that ignore the huge damage is being inflicted.

Substantial difference to food insecurity while the autumn statement is unlikely to make a real solution. The chancellor’s decision to uprate benefit payments in line with inflation alongside further energy support and a rise in the benefit cap in April are welcome, but there are still the winter months to get through. With debts building up and costs rising, the autumn statement is unlikely to make a substantial difference to food insecurity while huge damage is being inflicted.

Food bank teams are caught in a brutal paradox, and there’s a feeling of endlessly treading water as poverty levels continue to soar. Meanwhile the catastrophic impact of worsening food insecurity is blighting the lives and mental and physical health of more people across age groups. The health, and ultimately wealth, of our society is being compromised by policy decisions that ignoring the huge damage is being inflicted.

Sabine Goodwin, coordinator of the Independent Food Aid Network

Cite this as: BMJ 2022;379:o2919

We all manipulate others all the time

John Launer, GP educator and writer, London

Cite this as: BMJ 2022;379:o2907
Safety netting needs easy access

Our waiting rooms are full of anxious parents, with children sitting listlessly on a lap or running around doing aeroplane impressions. This is one of the reasons I like to walk out to collect my patients: that first glance helps me sort the ill child from the merely shy when they then spend the consultation with their head buried in their dad’s jacket.

Right now, it must be more frightening than usual being responsible for a young child, with so much in the news about the rise in hospital admissions for respiratory illnesses and about fatal invasive group A streptococcal infections. This is also worrying for GPs, who know the impossibility of picking out the child with a sore throat whose health will suddenly deteriorate, from all the others who will make a rapid recovery with paracetamol alone.

As we can’t routinely review every feverish child to look for signs of worsening illness, we must rely on “safety netting,” a concept first clearly articulated by Roger Neighbour in 1987. Safety netting involves explaining to the patient what to look out for and when to come back, and it’s now deeply ingrained in GP training and other areas of medicine—but we’re probably still not as precise as we could be. After effective safety netting the patient or carer knows what the expected course of recovery should be and what features would be a cause for concern. “Come back if he doesn’t get better” is some help (it gives the parent permission to re-attend), but it’s not nearly as useful as: “I expect this sore throat to improve over the next five days, but we need to see your child again straight away if they develop a rash, are unable to eat and drink, or become unusually tired or irritable.”

We might perceive all parents attending our practice as being worried (that’s why they’re here), but their concern turns out to be a valuable metric in picking out the most unwell children. When someone who has looked after a child through various childhood ailments and coughs and colds tells you that “this illness is different,” you need to listen.

But the safety net works only if you have easy access to your GP. The worry is that someone with inadequate training will look at a child’s notes and think that, because they were seen a few days ago and had a viral illness diagnosed, they don’t need to be seen again. Serious illness in children is thankfully rare, and usually all that’s needed is a quick examination, reassurance, and advice. However, a child’s condition can change rapidly and unpredictably, so we need to be sure that our systems are responsive enough for the safety net to do its job and prevent tragedies.

Parents’ concern is a valuable metric in picking out the most unwell children

“I'm a (phobic) medical student...get me out of here!”

How does having a phobia as a medical student affect your time on placements? This episode of the Sharp Scratch podcast explores how certain phobias can be challenging when studying and practising medicine, and how students can conquer them. Expert guest Digby Quested, a general adult psychiatrist, describes what happens when you have a phobic response to something:

“It’s a combination of a psychological and physiological expression of fear to a specific stimulus. The symptoms are therefore those that most people will recognise if they’ve ever been in a threat situation, so it might be heart racing, breathing rapidly, perspiring, and the psychological sense of impending doom. So phobias can be thought of as a specific fear reaction to a stimulus, and that is manifested by physical symptoms which are the equivalent of a panic attack. But what then happens is that phobias lead to avoidance because people don’t want to have those physical symptoms. In terms of people who self-refer or have a GP referral, social phobia tends to be the leading one.”

Foundation doctor Lily Copping talks about her phobia of needles and how she set parameters to help her adjust as a medical student:

“Control is such a big thing. The worst thing is if you’re feeling quite scared, a needle’s come out that’s bigger than you thought it was going to be, and you don’t feel like you can leave. That makes it 10 times worse because you go into a spiral and panic. Whereas if you feel you have an exit strategy, actually having the strategy helps you not need it. Knowing I can leave means I can stay.”

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

NICE’s new methods: putting innovation first, but at what cost?

Traditionally the gatekeeper to the NHS, the guidelines body has increasingly moved towards facilitating access to innovative technologies. This change has clear benefits for some patients, but the price for others is going unacknowledged, say Victoria Charlton and colleagues.

Deciding when a new drug merits funding and when it does not—often to the displeasure of clinicians and patients alike—is an unenviable task. In England and Wales, it falls largely on the National Institute for Health and Care Excellence (NICE), whose recommendations shape the NHS’s adoption of new technologies.

Traditionally, NICE has based its binding recommendations primarily, although not exclusively, on cost effectiveness: the amount of health a technology generates per pound spent compared with current practice. Under this approach, technologies that have not reliably demonstrated their clinical effectiveness will generally be rejected—for example, amantadine (Lysovir/Symmetrel) for the treatment of influenza. Also rejected are technologies considered insufficiently cost effective, a point generally defined by NICE as £20 000–£30 000 per quality adjusted life year (QALY). In 2016, NICE rejected the cystic fibrosis drug lumacaftor-ivacaftor (Orkambi) on the grounds that its likely clinical benefits did not justify its cost of £200 000–£350 000 per QALY.

This approach to priority setting is not without its critics. But it is generally accepted as sound because it gives due weight to the interests of all patients—both those who will benefit from access to a new technology and those whose health will be adversely affected by the reallocation of resources from which they were benefiting. In recent years, however, NICE’s emphasis on cost effectiveness has come into conflict with the drive to secure access to innovative health technologies, the benefits of which are often both costly and uncertain. NICE’s rejection of lumacaftor-ivacaftor, for example, was later disregarded by the NHS, which, in the face of pressure from patients and politicians, negotiated a price discount with the manufacturer to secure access to the drug.

We describe here how NICE’s approach has evolved in response to such challenges and consider the implications of its January 2022 methods update, both for those who benefit directly from NICE’s recommendations and the NHS as a whole.

Making the exception the rule

Over time, NICE’s approach to technology appraisal has evolved in two main ways. The first relates to the cost per QALY threshold used to define cost effectiveness. The second relates to NICE’s evidential requirements.

NICE’s cost effectiveness threshold

NICE has always acknowledged that, in the interests of fairness, its decisions cannot be based on cost effectiveness alone. Accordingly, its appraisal committees have shown willingness to exceed the usual £20 000–£30 000 per QALY threshold for individual cases when justified by special considerations such as disease severity or major innovation. In recent years, this treatment of

KEY MESSAGES

- NICE’s new methods indicate its priorities and values have shifted from its traditional gatekeeper role to focus on facilitating access to innovation.
- Higher cost effectiveness thresholds and lower evidential standards will benefit some NHS patients and drug manufacturers, but other NHS patients will be disadvantaged.
- NICE should be as transparent as possible about the reasons for its revised approach and the trade-offs entailed by its decisions, so that patients and the public can evaluate its legitimacy and engage fully in societal debates about healthcare priorities.

Campaigners stage a protest outside Downing Street in 2017 over the lack of availability of the cystic fibrosis drug lumacaftor-ivacaftor in the NHS after NICE rejected it.
The new methods manual accepts the use of non-randomised studies as the primary source of clinical evidence despite acknowledging their “high risk of bias”

“special cases” has become normalised through NICE’s routine use of modifiers: pre-defined multipliers that increase the value of some QALYs relative to others, effectively raising the cost effectiveness threshold for some technologies. 7

Most notably, since coming under criticism for its rejection of several life extending cancer drugs in the late 2000s, NICE has used an end-of-life modifier to increase the threshold for eligible drugs to £50 000 per QALY. 8 Between 2009 and 2011, drugs recommended using this modifier delivered an estimated 12 401 QALYs a year to NHS patients with late stage cancer. But to fund these drugs, the NHS had to divert substantial resources away from other activities, at an estimated annual “opportunity cost” to other patients of between 18 330 and 27 696 QALYs. 10

NICE states that such trade-offs should be made only in “exceptional circumstances.” 10 But the end-of-life modifier was applied in 19% of appraisals between 2011 and 2019, 11 and NICE’s new methods seem likely to increase further the number of exceptions made. The new methods incorporate three modifiers. 12 The end-of-life modifier is replaced by a broader modifier for severity. This allows technologies that treat moderately severe diseases, such as type 1 diabetes, to be evaluated against a threshold of £36 000 per QALY, increasing to £51 000 per QALY for very severe diseases, such as multiple sclerosis, severe rheumatoid arthritis, and many advanced cancers.

Two further modifiers are for use specifically in NICE’s highly specialised technologies programme, which evaluates technologies for very rare, and often very severe, diseases. These establish the basic cost effectiveness threshold for such technologies at £100 000 per QALY, increasing to £300 000 per QALY for those expected to deliver especially large health gains. NICE’s definition of cost effectiveness has thus become considerably more generous.

NICE’s evidential requirements

NICE has historically required the technologies that it recommends to have reliably shown their benefit, strongly preferring evidence from randomised controlled trials and advising its committees not to recommend technologies when “evidence of clinical effectiveness is either absent or too weak for reasonable conclusions to be reached.” 13 The seemingly cost effective flu drug amantadine, for example, was rejected in 2003—and again in 2009—because its clinical effectiveness was not “sufficiently proved.” 14

Over the past decade, however, NICE’s evidential requirements have eased. The new methods manual accepts the use of non-randomised studies as the primary source of clinical evidence, despite acknowledging their “high risk of bias.” 8 It also encourages committees to accept “a higher degree of uncertainty” when considering technologies deemed “innovative and complex” or indicated for rare diseases or paediatric populations—a potentially large proportion of appraisals. 15 Under these more lenient standards, some technologies that NICE would previously have rejected might be made available, sometimes to large patient populations; for example, the “innovative” obesity drug nalirexone-bupropion (Mysimba), which was rejected by NICE in 2017 owing to uncertainty over its long term effectiveness. 16

NICE has also extended its use of managed access arrangements, a mechanism embraced by many countries to allow technologies with uncertain benefits to be provisionally adopted while research continues. 17 18 Initially used in the NHS for a handful of technologies, primarily in the context of the Cancer Drugs Fund, such arrangements are now the intended norm for all promising technologies that cannot currently demonstrate clinical or cost effectiveness.

NICE positions these changes as improvements designed to “deliver excellence for patients, the NHS, and the life sciences industry.” 19 But not all patients stand to benefit from NICE’s new approach.

Benefiting the few at a cost to many: flaws in NICE’s use of modifiers

NICE has a responsibility to uphold the interests of all patients and recognises that its use of modifiers should be “morally and ethically supported by reason, coherence, and available evidence.” 12 The end-of-life modifier arguably failed to meet these requirements because its narrow application, primarily to patients with terminal cancer, did not properly reflect society’s preference for treating severely ill people. 18 Its replacement by the more inclusive severity modifier partially tackles this issue. But several logical and ethical flaws remain in NICE’s use of modifiers.

First, whenever NICE recommends a new technology, the NHS will likely have to stop doing something else to pay for it. Although access to a new cancer drug might improve the health of some severely ill patients with cancer, other very ill patients might find that their health decreases because funds are diverted away from interventions that were benefiting them, such as high quality palliative care or drugs for other severe diseases. Under NICE’s approach, modifiers are applied to the health gains of the first group of patients but not the health losses of the second group. 13 This is unfair and illogical, as it leads to the health of similar patients being valued differently.

Second, the special treatment of technologies for very rare diseases (highly specialised technologies) does not reflect public preference and lacks coherence. Although there is strong evidence that society supports the prioritisation of severe diseases, evidence of a similar preference for rare diseases is limited: NICE acknowledges that “there is no case for a specific modifier for rarity.” 16 Nevertheless, NICE evaluates highly specialised technologies against a much higher cost effectiveness threshold than other technologies and applies an additional “magnitude of benefit” modifier that has also been shown to lack public support. 17 These modifiers facilitate disproportionate, and potentially unjustified, expenditure on treatments for very rare diseases and are inconsistent with NICE’s approach to other technologies.

Third, modifiers might increase the ease and predictability of NICE’s decision making by decreasing the need for case based deliberation, but reducing ethnically complex scenarios to a few quantified variables is contentious and limits NICE’s ability to balance ethically relevant considerations. 19 In relying on such an approach, NICE risks replacing rather than enhancing the nuanced reasoning for which its appraisal committees have historically received praise and which has been central to justifying its recommendations to those affected.
Giving innovation the benefit of the doubt

NICE’s increasing reliance on modifiers is an understandable—if perhaps unjustified—response to high drug prices. Other challenges for NICE include the demand for earlier access to new medicines, regulators’ willingness to approve drugs based on limited evidence of clinical benefit, and NICE’s commitment to issuing its recommendations “as quickly as possible” after regulatory approval. NICE’s solution to these challenges has been to ease its own evidential requirements at the point of appraisal while compensating for a lack of clinical data through managed access arrangements.

Although perhaps pragmatic, this response shifts much of the risk associated with adopting uncertain technologies from industry onto tax payers and patients. Under managed access, the NHS pays an interim price based on “plausible potential” for cost effectiveness given its expected benefits. Ideally, these benefits will be realised and cost effectiveness will be demonstrated at this price. But products typically perform more favourably in industry led trials than in practice, so technologies might end up being less beneficial (or safe) than anticipated.

This puts the NHS in the problematic position of initially overpaying for new technologies and subsequently having either to renegotiate lower prices or withdraw a treatment to which patients have come to expect access. Many of the practical, political, and ethical difficulties associated with this scenario were seen in the early 2000s through the multiple sclerosis risk sharing scheme, in which disappointing clinical results from widespread managed access to interferon β and glatiramer acetate triggered neither a price reduction nor withdrawal.

Managed access, as currently envisaged, might also fail to resolve fundamental questions about the clinical and cost effectiveness of new technologies. Experience from the Cancer Drugs Fund indicates that such arrangements do not reliably tackle the evidence gaps identified by NICE appraisal committees, leaving them unable reliably to assess cost effectiveness. And although the “real world” clinical data typically collected through managed access can provide valuable supplementary information on patient reported outcomes and a technology’s long term effects, such data are ill suited to testing the comparative effectiveness of different treatments and are well recognised as being vulnerable to bias.

Managed access might therefore leave patients, and NICE, unsure about the clinical value offered by many new technologies.

NICE changes, but who benefits?

The effects of NICE’s new appraisal methods on patients seem mixed: some groups of patients might stand to benefit substantially, but others will suffer the costs. By contrast, the benefits to manufacturers are clear: lower evidential standards alongside increased use of managed access allows manufacturers to secure NHS uptake of their technologies earlier in the product life cycle, accelerating profits and extending the period in which a medicine is marketable under its patent. The routine use of modifiers to increase the price at which products are deemed cost effective further supports profitability. Unsurprisingly, industry has welcomed these changes to NICE’s methods.

What is good for industry is sometimes good for patients, and the UK is not alone in offering political support to the economically important life sciences industry through its enthusiasm for “innovation.” But if health systems are to remain fiscally sustainable given competing demands on national resources, new drugs must not come at too high a price. Research indicates that, at current levels of NHS funding, NICE’s basic threshold of £20 000–£30 000 per QALY is too high and considerably underestimates the amount of health displaced to fund new technologies. Consequently, many of the technologies recommended by NICE are likely to lead to a net reduction in population health.

Some technologies—such as lumacaftor-ivacaftor for cystic fibrosis—might justify this opportunity cost, and society has shown itself willing to trade off some population health in the interest of fairness. But truly “game changing” innovations remain rare, with most new technologies offering only small incremental benefits. They might become rarer still if payers do not maintain their expectations that new products must demonstrate both clinical and cost effectiveness to be adopted.

Conclusion

NICE has historically reflected carefully on the ethical implications of its methods and has enjoyed a high level of social and moral legitimacy, even though some medicines are not funded in the UK. Recent changes point to a shift in NICE’s priorities and values and a step away from its gatekeeping role to focus on facilitating access to innovation. NICE owes it to those on whose behalf it acts to acknowledge and justify this shift by refreshing the public articulation of its approach: its existing statement of principles has not been updated to reflect its new methods.

To maintain its reputation as a just priority setter, NICE must also be as transparent as possible about the trade-offs its decisions involve. We do not currently know precisely how the NHS funds NICE’s recommendations or which patients suffer the opportunity costs. But we know the approximate size of these costs.

If NICE has confidence in its approach, it should be open about both the health gains and likely health losses generated by its recommendations. It should also monitor and publicly report how its new methods affect decision making. Doing so would help patients and the public judge the legitimacy of NICE’s approach for themselves and engage more fully in societal debates about healthcare priorities.
The government has left us in no doubt it is willing to violate both in pursuit of its immigration agenda. Public health and human rights must be priorities.

Recent weeks have thrown a spotlight on the UK’s escalating inhumane treatment of people forced to flee their homes because of war and persecution. In the past six weeks alone, a Dover immigration centre had petrol bombs thrown at it; the chief inspector of prisons released a damning report on the state of short term holding facilities; and outbreaks of diphtheria and scabies were reported in an immigration processing centre in Manston, Kent.

The challenges we are seeing are the result of a long term backlog in asylum claim decisions. By the end of 2021, the Home Office had 101,000 outstanding cases. What we are seeing is not a refugee crisis but a political crisis, with vulnerable people paying the price of ministerial decisions.

Despite claims to the contrary by home secretary Suella Braverman, the United Nations Refugee Agency has stated that a “clear majority” of people arriving by boat on the English coast are refugees in need of humanitarian protection.

Exacerbating trauma
People seeking humanitarian protection have often experienced many traumas associated with the circumstances that have forced them to flee their country of origin and make the difficult and often dangerous migration journeys. Many have experienced physical and sexual violence, persecution, torture, human rights abuses, extreme poverty, and exploitation by human traffickers. To arrive in the UK to seek safety and to be exposed to the conditions described in the report on short term holding facilities by the chief inspector of prisons only exacerbates the trauma.

The report describes exhausted detainees being regularly held for more than 24 hours in non-residential detention; detainees unable to use toilets in private in some areas; a failure to consistently record detainees’ vulnerability to inform subsequent assessments; and weak governance of staff security clearances and training to work with children and vulnerable adults. Food provision was described as unhealthy and not meeting all dietary requirements. Detainees are at a high risk of physical and mental health problems, yet governance of healthcare processes at the holding facilities was described as weak.

The overcrowding at the Manston processing centre, which reportedly reached 2.5 times its 1600 capacity of detainees, has left it vulnerable to the additional risks of infectious disease outbreaks and fire.

Doctors of the World UK’s lived experience advisory group has described how short term processing facilities, including Manston, often do not have adequate facilities for people to rest, leaving adults and children trying to sleep between chairs with blankets.

Events in Manston are the latest addition to a growing body of evidence documenting the Home Office’s failure to accommodate people seeking asylum in a safe environment that meets basic human needs.

The association between housing and health is undisputed. Poor living conditions are associated with infection, unintentional injury, poor mental health, vulnerable household relationships, and poor early childhood development. The adverse impact of detention on the mental health of people seeking asylum is well documented, and emerging evidence shows that being housed in contingency accommodation also causes a deterioration in mental wellbeing, with depression and thoughts of suicide a recognised risk.

The right to health irrespective of an individual’s legal or administrative status is enshrined in numerous international treaties ratified by the UK. Yet research has shown that initial and contingency accommodation is unsafe for people seeking asylum—not only as a consequence of the direct risk of harm from its conditions but also the lack of access to appropriate healthcare services.

Fair, humane, effective
The UK should be capable of developing a fair, humane, and effective refugee system, in keeping with our obligations under international humanitarian and human rights law, and which offers safe routes to the UK for people seeking asylum. Instead, the UK government has left us in no doubt that it is willing to violate human rights and harm people’s health in pursuit of its immigration agenda.

The medical community should not stay silent in the wake of these violations. Doctors of the World UK appeals to fellow health professionals to join us in calling on the UK government to take urgent action to ensure that people seeking asylum are accommodated within communities and in a humane way. The use of detention centres and large scale facilities should be put to an end.

Finally, the backlog in asylum claims should be tackled as a priority to ease tension on the asylum accommodation system, enabling people to move forward with their lives and begin the process of recovery from the trauma they have experienced.

Cite this as: BMJ 2022;379:a2709
LETTER OF THE WEEK

Remove the GMC’s punitive role

I agree that something must done about the GMC (Editor’s Choice, 12 November). But, for action to take place, we need an objective. Do we want to get rid of the GMC or do we want to reform it? We need an organisation to oversee doctors’ training and to keep a record of doctors who have the required training to be registered to practise in their specialties. The GMC, or someone else, should keep on doing this.

As for the other functions, there is no evidence that the process of appraisal and revalidation has improved patient care. But it takes resources that the process of appraisal and revalidation should keep on doing this.

In their specialties. The GMC, or someone else, should be reactive rather than proactively tackling early intervention and prevention.

Iqbal Singh

GMC HAS BEEN FAILING FOR 30 YEARS

Suicide in doctors under investigation

In our article about the GMC, we cited a study that found that 29 doctors died while under investigation, and five were confirmed as suicides or suspected suicides (Opinion, 12 November). We confused the figure with data from a GMC report in 2014, which showed that, between 2005 and 2013, 28 doctors died by suicide or suspected suicide while under investigation. So, since 2005, when the GMC started collecting these data, a total of 33 doctors have died by suicide or suspected suicide while under investigation.

It is often difficult to be certain that suicide is a cause of death, so deaths by suicide are probably underestimated in this group. It remains our contention that the GMC needs to rebuild itself as an organisation that is compassionate to patients and doctors and takes a much more proactive role in preventing harm to patients and doctors rather than simply being a final court.

Aneez Esmail, professor (emeritus) of general practice, Manchester; Sam Everington, GP, London

LEARNING FROM THE MANJULA ARORA CASE

GMC must prioritise early intervention and prevention

Singh and Forde make sensible recommendations for managing concerns about doctors at a local level while building trust in the GMC (Opinion, 12 November). The recommendation to classify decisions like the one in the Manjula Arora case by the GMC as “never events” also sends a strong message about the effect such regulatory actions can have on quality and safety of care through their effects on the workforce.

The GMC seems to want to ensure a fairer process for handling complaints and investigations against doctors. But it still seems to be reactive rather than proactively tackling early intervention and prevention.

Most concerns related to doctors can be resolved locally by working closely with GMC employment liaison advisers, medical leads, and human resources and occupational health teams. We can all work together with the GMC to accelerate the pace of change required to make it a fairer regulator.

Ananta Dave, chief medical officer, Black Country Integrated Care Board

Martin Forde

GMC MUST BE REFORMED

How the GMC can do better

Saying that the GMC is “accountable to no one” is incorrect (Editor’s Choice, 12 November). It has some accountability to the Professional Standards Authority (PSA), although this needs to be strengthened.

The GMC needs substantive reform. Doctors’ deaths that can be linked to being under investigation should trigger an independent external review. Major emphasis is given to “false positive cases” (when the GMC pursues an investigation that it shouldn’t have or has made errors), but “false negative cases” (when the GMC refuses to properly investigate doctors) should also be scrutinised.

There should be a second layer of external scrutiny; for example, the GMC could appear annually before the Health and Social Care Select Committee. There should be no time limit for looking at past cases in which the GMC might have acted incorrectly—the key determinants should be whether key lessons can be learnt and whether those who suffered are still alive.

Narinder Kapur, consultant neuropsychologist, London

Iqbal Singh

Martin Forde
James Guy Edwards
Consultant psychiatrist
(b 1933; q Welsh National School of Medicine, 1958; FRCPsych, FRCP, DPM, FRCPsych(Hon), Hon MFPH), died from idiopathic pulmonary fibrosis on 4 November 2022
After house jobs, James Guy Edwards (“Guy”) gained a year’s experience as a GP and assistant ship’s surgeon, before embarking on his psychiatric career. He worked for three years in the USA and eventually at the University of Southampton (1969-99) and several universities abroad. He was active in the BMA, was seconded to the Department of Health’s health advisory service, and served on Mental Health Review Tribunals and Medical Appeals Tribunals. He combined full time clinical work with clinical research. By the time of his retirement he had about 130 publications to his credit and more than 50 afterwards. Guy’s marriage to Althea ended in divorce. He leaves three children and three grandchildren.
Ben Steinberg
Cite this as: BMJ 2022;379:o2771

Nitin Shripad Pradhan
Associate specialist in orthopaedics Isle of Wight
(b 1951; q Topiwala National Medical College, Mumbai, India, 1976; FRCS), died from complications secondary to interstitial lung disease on 19 September 2022
Nitin Shripad Pradhan (“Nitin” or “Mr P”) came to the UK in 1981. He secured a senior house officer job at Dudley Road Hospital, where he met his future wife, Diane. After completing his surgical rotation he worked in neurosurgery in Leeds. During this time, Nitin and Diane got married and later settled in the West Midlands. In 1984 Nitin joined the orthopaedic department at Good Hope Hospital. The family moved to the Isle of Wight in 1989, where he initially worked as a clinical assistant at Ryde Hospital and subsequently as an associate specialist in the orthopaedic department of St Mary’s Hospital. He retired in 2015. Nitin leaves Diane, two sons, and two granddaughters.
Hemant Pandit
Cite this as: BMJ 2022;379:o2758

Kenneth Gilmour Lowry
Consultant in intensive care medicine and medical director Northern Health and Social Care Trust
(b 1955; q Manchester, 1978; FFA RCSI, MMed Sc Belfast), died from head and neck cancer on 20 April 2022
Kenneth Gilmour Lowry (“Ken”) was appointed as a consultant at the Royal Victoria Hospital, Belfast, in 1988. His career spanned some 30 years of working in the regional intensive care unit. During the troubles he was one of a small team providing care to victims of shootings, bombings, and other injuries caused by the conflict. He became director of intensive care for the Belfast Health and Social Care (HSC) Trust and rose to associate medical director, before taking up the role of medical director in the Northern HSC Trust, his final post. Ken is grieved by his mother, Elizabeth; Heather, David, and Nicola; Dawn-Marie, Peter, and David; two sisters; and his extended family.
G G Lavery
Cite this as: BMJ 2022;379:o2770

Norman Alexander Todd
Consultant psychiatrist
(b 1928; q Glasgow, 1951; DPM, FRCP, FRCPsych), died on 2 January 2022
Bom to schoolteachers, Norman Alexander Todd excelled in classics at school. After national service on a troopship and in a military hospital in Germany, he worked in general practice before switching to psychiatry and meeting his future wife, Susanne. Consultant psychiatrist at Levendale Hospital, Glasgow, until 1990, he published on forensic psychiatry, the effects of abortion, and schizophrenia. Renowned for his dedication and great kindness to his patients, he successfully stabilised many challenging illnesses. Norman climbed all 282 of Scotland’s Munros (summits over 3000 feet (915 metres)) and Mounts Kenya and Kilimanjaro. Arthritis in his 80s stopped his climbing but not campervan holidays with his beloved Susie before she died in 2020. Norman leaves four children, 10 grandchildren, and one step great granddaughter.
Mark Hughston, Allan Todd
Cite this as: BMJ 2022;379:o2836

Philomena Obiageliuwa Uyanwah
Obstetrician and gynaecologist (b 1938; q Aberdeen 1964; MD, FMCOG, FRCOG), died from cancer on 23 October 2019
Philomena Obiageliuwa Uyanwah returned to her native Nigeria after qualifying in medicine. During the Biafran-Nigerian civil war in 1967 she was the chief medical officer for Biafra. She returned to Scotland in 1969 on a Red Cross refugee passport and started a research career at Aberdeen in 1970. In 1982 she had her own television show in Lagos, Nigeria, advising women on safe childbirth.
She was also an adviser to the World Health Organization. From 1988 to 1996 Philomena worked in the Middle East and the United Arab Emirates, but in April 1996 she had a stroke. Back in London she was unable to continue her medical career but lived independently at her home in Baker Street for another 23 years. She leaves her son, Chinwuba Akpom.
Chinwuba C A Akpom
Cite this as: BMJ 2022;379:o2778

Sujeet Jha
Consultant diabetologist
(b 1967; q S K Medical College, Muzaffarpur, India, 1994; FRCGP(Hon)), died during treatment of acute lymphatic leukaemia on 26 March 2022
Sujeet Jha moved from India to the UK in the mid-90s to become a member of the Royal College of Physicians, specialise in endocrinology, and hone his skills as a diabetologist. He worked in training roles across England including West Sussex, Somerset, Cardiff, London, and North Lincolnshire. Back in India he set up the clinical research programme at Max Hospital and collaborated with Imperial College London, the UK Medical Research Council, the UK National Institute for Health and Care Research in the area of diabetes and metabolic diseases. He published in peer reviewed journals, including Nature and Nature Genetics. He leaves his wife, Vinitaa, and two sons.
Arun Chaudhary
Cite this as: BMJ 2022;379:o2757
OBITUARIES

Neville Davis

GP who pushed for clinical forensic medicine as a separate medical specialty

Neville Davis (b 1925 q Guy’s Hospital, London, 1948; MBE, FRCP, FFOM, FRCPG, FFILM, FACBS, FFOM, FEWI) died from a cancer of unknown primary on 5 October 2022.

When Neville Davis wanted to study law in 1939, his headmaster advised: “You may have to leave the UK, like other Jews have had to leave Europe. An English law degree is not going to be of much use abroad.” Conversely, a medical qualification, he suggested, would be useful anywhere.

Young Neville opted for medicine, but his lifelong interest in the dark side of law shaped a remarkable medical career. He became, reportedly, England’s oldest working doctor at the age of 95, in 2020.

A forensic medical examiner, he wrote medicolegal reports and gave oral evidence to the criminal courts from his home in Hove, Sussex, through secure video links.

**Vehement opposition**

Ironically Davis initially faced vehement opposition from the bodies designed to promote professional standards—the royal colleges. He wanted to establish a faculty of clinical forensic medicine at the Royal College of Physicians (RCP), but his standing—he was a GP and a police surgeon—counted against him.

His treatment was not unprecedented. Founded in 1952 the College of GPs also faced hostility from the RCP, which did not like the idea of GPs acquiring “royal status.” GPs had to wait 20 years for a royal charter.

Seventeen years after his failed attempt to set up the RCP faculty, the college finally honoured Davis in 2005, making him a foundation fellow of the Faculty of Forensic and Legal Medicine.

Davis met a far friendlier reception for his educational ideas at the Royal Society of Medicine (RSM). He became the first president of its clinical forensic medicine section, which he founded in 1986.

Davis was an innovator. For example, in 1979 he and a colleague representing the Association of Police Surgeons put forward a proposal for “drunk tanks” to the Home Affairs Committee in the House of Commons. Knowing that hospitals and the police did not want responsibility for people who were drunk, they suggested creating dedicated holding centres staffed by health and security professionals trained in resuscitation techniques. The idea was adopted, but never implemented.

A charming, sharply intelligent, and quietly determined man, Davis’s insatiable appetite for committees made him highly influential. His roles included secretary and later president of the Medico-Legal Society; secretary to the education and training committee of the Expert Witness Institute; vice president to the RSM; a member of the RCP committee on legal aspects of medicine; a member of the RCP working party on prison healthcare; and a council member of Action in Alcohol Abuse and the Association of Police Surgeons.

He also extended his influence as a prolific letter writer, mainly in the *Times* and the *Sunday Times*.

**Early life and career**

Born in London, Davis was the fifth son of a cobbler, David Persky, whose name had morphed somehow into Parsken Davis after he had fled the anti-Jewish pogroms in Russia. His father established a successful retail business with his wife, Dora, at the till.

At the age of 8, Davis went to Whittingehame College, a Jewish boarding school in Hove that accommodated many children of European refugees who had fled Nazi oppression. His father hoped that Neville would join the family business, but he went to Guy’s Hospital Medical School, London, where, as he put it, “Professor Keith Simpson’s lectures and demonstrations set me on the road to forensic medicine.” The first professor of forensic medicine, Simpson wrote the bestselling *40 Years of Murder*. Involved in cases with Simpson, Davis later said, “He never threw his weight about, and his standards were a model I have always strived to follow.”

Davis was also the consummate caring GP. Working from a former ladies’ hairdressing shop in north London, he prided himself on his ability to listen to patients. A member of a group of doctors led by the Hungarian psychiatrist Michael Balint, the highly acclaimed author of *The Doctor, His Patient, and The Illness*, Davis sought insights into his own psyche and its impact on his relationship with patients.

As a GP in the 1960s, when family doctors came close to a national walkout over pay and conditions, Davis turned to occupational health to supplement his income, ultimately becoming chief medical officer to British Gas (Eastern) and occupational health adviser to the National Institute of Research.

Davis had his wild and inconsistent side, which found expression in his passion for cars. Twice married, he was devoted to his second wife, Kathryn, who became disabled with Alzheimer’s dementia. He leaves two children; two stepchildren; and one grandchild.

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Cite this as: BMJ 2022;379:o2611