this week

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Long covid: "It was a very real—and is a very real—phenomenon," says Rachael Evans, a leader of the post-hospitalisation study

Fury over Johnson's "bollocks" scrawl

Clinicians who led research on long covid from early in the pandemic and who met the government to discuss the condition have expressed sadness and anger at messages written by Boris Johnson, then prime minister, describing the condition as "bollocks."

During a UK Covid-19 Inquiry session on 13 October researchers were shown a memo provided to Johnson in October 2020 that discussed a report on long covid and its symptoms. On it he had written: "Bollocks. This is Gulf War syndrome stuff." In February 2021 Johnson wrote in a WhatsApp message, "Do we really believe in long covid? . . . I bet it's complete Gulf War syndrome stuff."

Chris Brightling and Rachael Evans, two of the investigators leading the national Post-Hospitalisation Covid (Phosp-Covid) study, said they were "shocked" and "angry" by the messages and raised concerns over how Johnson's views may have influenced the government's decision making.

Brightling, professor of respiratory medicine at Leicester University, pointed out that the October memo was around the same time that the government was meeting academics and people who had long covid. He told the inquiry, "I'm deeply saddened and extremely angry at the same time. There are people in this room and people who are watching who have either suffered with long covid or their loved ones have."

Brightling said for Johnson to have held that belief and to have suggested that long covid was "something that could continue to be ignored, out of all the things that we see, it's yet another unbelievable thing." He added, "What I don't know is how much this influenced the activity by government, but you would expect that, if the prime minister's view was such, it may well have had an influence on other people in government."

Evans, clinical associate professor and honorary consultant respiratory physician also at Leicester University, echoed his sentiment. "It's shocking. We've heard some clinicians weren't believing [patients]. But to see that your own prime minister has written something like that, I just can't begin to get how people living through it feel."

Evans added that as the notes were being written she and colleagues were "already feeding back very clear descriptions of what this illness looked like." She said, "It was a very real—and is a very real—phenomenon."

The Office for National Statistics has estimated that around 1.9 million people in the UK have long covid.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2023;383:p2406

LATEST ONLINE

- BMA chief urges the PM to engage in strike talks
- Charity accuses health minister of backtracking on pledge over liver scan expansion
- Alcohol treatment services should target health inequalities, say draft guidelines

SEVEN DAYS IN

Consultation is launched in attempt to reduce vaping among children

The government has launched a UK-wide consultation on proposals to reduce vape use by children and teenagers. Selling vapes to children is illegal, but the government said it was clear they were being targeted by cheap, colourful, and sweet flavoured products. The announcement followed plans to raise the legal age for buying cigarettes in England by one year every year, so children who turn 14 this year will never legally be sold a cigarette.

The health and social care secretary, Steve Barclay, said, "Vapes should never be used by children, and we're committed to reversing this trend. We also need to take bold action to protect future generations from the harms of smoking addiction, which damages health at every stage of life and costs the economy billions."

Recent figures show that the number of children and teenagers using vapes in the past three years has tripled, with 20.5% of those aged between 11 and 17 having tried vaping in 2023, said Action on Smoking and Health.

Penelope Toff, chair of the BMA's public health medicine committee, welcomed the government's commitment to restrict the marketing of vapes to children and called for a ban on disposable vapes.

Abi Rimmer , *The BMJ* **Cite this as:** ***BMJ*** **2023;383:p2386**

Public health

Prevention schemes are failing to achieve potential

An analysis by the Office of Health Economics charity of 13 prevention schemes, including stop smoking services, weight management services, and diabetes support, concluded too many are failing because of a lack of uptake, underfunding, or approaches that are too short term. OHE's Graham Cookson said, "A key hurdle is that prevention competes with treatment for funding. Understandably, the immediate demand to treat patients wins, despite evidence prevention's long term benefits of will be greater."

Waiting lists

More people are waiting longer in England

A further 65 000 people in England joined the NHS hospital waiting list in August, bringing the total to 7.75 million. Two fifths (42%) had waited more than 18 weeks, with nearly 400 000 waiting for more than a year, data from NHS England showed. In September more than 33 000 patients spent at least 12 hours in A&E departments waiting for a bed. Thea Stein (right), chief executive of the Nuffield Trust, said, "It's an unavoidable truth that whoever takes power at the next election will need to spend more on the NHS and healthcare."

A&E waits in Wales have been under-reported

The Welsh government has asked health boards to include breach exemptions in A&E waiting time figures after the Royal College of Emergency Medicine found that more than 45 000 patients were removed from the figures for the first six months of 2023 and that from January 2012 to June this year more than 670 000 patients were excluded, 23% of the total. Including breach exemptions (which happens in the rest of the UK) means that 50% of patients waited longer than four hours in A&E in the first half of 2023, rather than the 39% claimed.

Social care

"Workforce plan must be properly funded"

Skills for Care, the strategic planning body for the adult social care sector in England, has said it is looking at a long term workforce strategy to tackle recruitment and retention challenges. It said 440 000 new posts may be needed by 2035 because the number of people aged 65 and over could hit 13.8 million (up from 10.5 million in 2020) and low pay and insecure contracts were contributing to high staff losses and turnover. Miriam Deakin, from NHS Providers, said the plan must be "accompanied by sustainable government investment to ensure the sector can not only recruit but keep much needed staff."

UTIs

Awareness campaign aims to cut hospital admissions

NHS England has launched a campaign to reduce urinary tract infections in a bid to cut hospital admissions. In the past five years more than 1.8 million admissions have involved UTIs. Messages will include the importance of staying hydrated, going to the toilet as soon as possible when you need to, and washing regularly. UTIs are a major contributor to antibiotic resistance, said the UK Health Security Agency. A quarter of urine samples analysed in the first six months of 2023 were resistant to first line treatments.

Cancer

Public awareness of signs in children is poor

Two thirds (68%) of 1000 adults who took part in a survey said they weren't confident about identifying signs and symptoms of childhood cancer. On average, respondents identified only 11 of 42. The most recognised symptoms were a lump or swelling in the pelvis, testicle, or breast (46%), blood in urine or stool (44%), changes to moles (43%), a lump or swelling in the chest wall or armpits (41%), and weight loss (40%), reported researchers in *Archives of Disease in Childhood*. Awareness campaigns should focus more on childhood cancers, they said.

Digital spaces help ease pain and distress

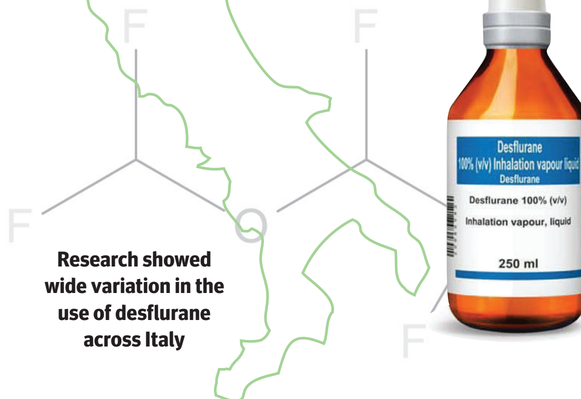
Immersive virtual reality seems to ease the pain and distress felt by patients with cancer, a pooled data analysis in *BMJ Supportive and Palliative Care* found. The technology may also help people with multiple sclerosis, kidney disease, and dementia. It might work by distracting and absorbing patients or altering their state of mind to reduce their experience of pain or boosting their ability to cope, said the researchers, and is especially promising in those at risk of polypharmacy.

MEDICINE

Anaesthetics

Europe-wide action is needed on desflurane

An analysis of the use of halogenated anaesthetics in Italy from 2009 to 2021 found a 25-fold difference across regions in the use of the highly carbon emitting agent desflurane, researchers reported in *Anaesthesia*. Study author Francesco Barone-Adesi is now trying to gather Europe-wide data on its use and called for more action nationally and across the EU for more rational use. Earlier this year Scotland became the world's first country to ban desflurane, and NHS England plans to stop using it by early 2024, except in exceptional circumstances.



Research showed wide variation in the use of desflurane across Italy

Prison health

Missed appointments are "storing up problems"

Young men in prison (under 25 years old) are missing around 45% of outpatient appointments, significantly more than young men of the same age in the general population (29%), found a Nuffield Trust report. Head injuries from violence and self-harm poisonings were much more common in young prisoners than the general population, as was ADHD. Nuffield Trust senior fellow Miranda Davies said missing medical appointments meant "storing up problems for the future, putting significant pressure on prison staff and NHS services, and putting prisoners at unnecessary risk."

Surgery

White men dominate top roles in US universities

Of 2165 faculty members at 154 surgical departments in 146 medical schools in the US and Puerto Rico, 1815 were men (84%), 350 were women (16%), and 75% were white, a study in *JAMA Surgery* found. Only 16% were Asian, 5% were African American, and 4% were of Hispanic, Latino, or Spanish origin. Most chairs were men (86%), as were vice chairs (68%). Melina Kibbe, dean of the University of Virginia School of Medicine, said in an editorial that diversifying the surgical workforce was crucial to improving patient outcomes.

Uyghurs

Call for Chinese association to acknowledge abuse

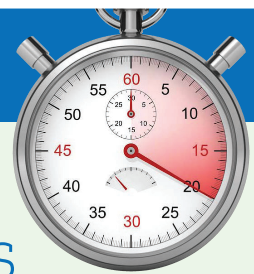
The World Medical Association's general assembly adopted a resolution to ask the Chinese Medical Association to acknowledge concerns set out in a report in 2020 by the Office of the UN High Commissioner for Human Rights and to comply with the WMA's 2020 resolution for members to "formally condemn the treatment of the Uyghurs in China's Xinjiang region." The UN report warned that large numbers of Uyghurs and people from other predominantly Muslim communities in Xinjiang had been detained and abused and that torture and ill treatment included forced medical treatment and sexual and gender based violence.

Cite this as: *BMJ* 2023;383:p2394

PENSIONS

More than **75000** NHS staff pulled out of the NHS pension scheme last year, a third of them aged under 30, making a rise of **67%** over the past four years

[The Times]



SIXTY SECONDS ON . . . HASH BROWNIES

THEY'RE SO GOOD—PASS ME ANOTHER

Are you sure? All things in moderation.

LIGHTEN UP, THEY'RE ONLY LITTLE

Yes, but they're "special" brownies, so it's not just the sugar and the butter expanding your waistline that you need to worry about.

BUT WE USUALLY HAVE AT LEAST TWO

You should know that the Food Standards Agency (FSA) has lowered its maximum recommended intake of cannabidiol (CBD) from 70 mg to 10 mg a day. I add 30 drops of 5% CBD oil to my chocolate brownie mix and make nine, so each brownie contains around 7.5 mg because FSA says that 10 mg of CBD is four or five drops of that strength oil.

AND MORE MAKES YOU PARANOID?

Apparently long term daily consumption of more than 10 mg a day can increase the risk of liver and thyroid problems and is linked to excessive tiredness.

WHY THE MASSIVE COMEDOWN?

FSA's 2023 recommendation that healthy adults have no more than 70 mg a day was based on limited evidence from studies of the use of CBD as a medicine—that dosage was determined by balancing the benefits against potential side effects. FSA is using a different regulation standard and treating all new CBD products as "novel food" when assessing their safety. This means companies have to submit specific data on CBD products if they want to market them in the UK. The daily limit was reduced after two FSA scientific committees reviewed these data.

BUT SOME RETAIL PRODUCTS CONTAIN MORE THAN THE NEW LIMIT

Yes, capsules, gummies, and drinks contain as much as 50 mg a serving, but they haven't been authorised by FSA as novel foods. There don't, however, seem to be any immediate plans to ban them. FSA says that there is "no acute risk" from exceeding 10 mg, but it will work with manufacturers to ensure consumers are not exposed to potentially harmful levels of CBD. The level of risk is related to how much is consumed in a lifetime, in the same way as for some other potentially harmful products, such as alcohol.

THEN PASS ME ANOTHER BROWNIE

None for you tomorrow, then.

Ingrid Torjesen, London

Cite this as: *BMJ* 2023;383:p2390

Confusion over covid vaccine in pregnancy is likely to have contributed to 27 deaths

Pregnant women are being urged to get the covid vaccine after an expert group found that "confused messaging and vaccine hesitancy" may have contributed to the deaths of 27 women during the pandemic in the UK.

The women, who died from covid-19 pneumonitis, had not been vaccinated, although they were eligible. Some declined, and in some cases there was no documentation that vaccination had been discussed. Only one of the women who died had received a single dose, and two other women who died from influenza had not received a flu vaccine during pregnancy.

The new analysis from the MBRRACE-UK collaboration looked at the circumstances of women who died during or up to a year after pregnancy, between 2019 and 2021.

Better care may have been able to change the outcome for 52% of the women who died
Marian Knight

Covid-19 was the leading cause of maternal deaths during this time. Of the 33 women who died from covid during pregnancy or up to six weeks after pregnancy, 14 were Asian and five were black.

The MBRRACE-UK coalition said the pandemic exposed gaps in the healthcare system and had brought to the fore the issue of vaccination in pregnancy. Its report said, "The confused messaging because of a lack of research evidence and consequent widespread vaccine hesitancy among clinicians and pregnant and postpartum women, notably among those from disadvantaged backgrounds and ethnic minority groups, has been well documented.

"These women's deaths are evidence of the consequences. It is not clear, however, that plans are in place to prevent similar problems occurring in the future.

"This is not unique to covid—women are still dying of preventable diseases such as flu—and this highlights the need for consistent, clear messaging on vaccination in pregnancy."

The group's recommendations

OF THE 33 WOMEN who died from covid during pregnancy or up to six weeks after pregnancy, 14 were Asian and were 5 were black

Up to 2% of hospital patients caught covid after admission

Between 95 000 and 167 000 patients are estimated to have caught covid-19 in England's hospitals during the second wave of the pandemic while being treated for other problems.

A study reported in *Nature* used data from 356 English hospitals, representing almost all NHS general and acute care beds, to calculate the extent of transmission between June 2020 and March 2021. Using mathematical modelling it concluded that between 1% and 2% of all patients admitted during this period were likely to have been infected with SARS-CoV-2 in hospital. They then became the main source of transmission to other patients.

ALAMY

The highest rates of transmission were seen in the north west of England and the lowest in the south west and London. Hospitals with the fewest single rooms and the poorest ventilation were found to have higher rates of transmission.

"The findings reveal the previously unrecognised scale of hospital transmission, have direct implications for targeting of hospital control measures, and highlight the need to design hospitals better equipped to limit the transmission of future high consequence pathogens," said the research report, which was completed by an international team led by the Nuffield Department of Medicine at the University of Oxford.

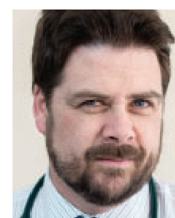
Acquiring covid in hospital can lead to poor outcomes for already sick patients, puts healthcare workers at risk, disrupts service delivery, and can play a major role in spreading infection to vulnerable groups in the community. The study recommended action on several fronts, including the early identification of infected patients and the adoption of control measures.

It said that transmission could be reduced by improving ventilation, use of face coverings by patients and staff, increasing distance between beds, minimising the movement of patients, and promoting hand hygiene. It also called for priority to be given to research into effective methods of reducing transmission in hospitals, including ward design and air filtration systems.

A report from the Health Services Safety Investigations Body in 2020 came to similar conclusions. However, David Oliver, a consultant physician and *BMJ* columnist who worked on covid wards throughout the pandemic, does not believe that change will be easy. "The lack of capacity is a problem that is not going to go away any time soon," he said.

Bryan Christie, Edinburgh

Cite this as: *BMJ* 2023;383:p2399



The lack of capacity is a problem that is not going to go away any time soon
David Oliver

include "the need to prepare a route for the rapid delivery of advice and data on new vaccines and treatments, alongside a sustained focus on the risks of flu, covid-19, and sepsis," and to ensure that pregnant and breastfeeding women are not excluded inappropriately from new vaccine and treatment research.

The MBRRACE-UK collaboration found that clinical staff were not always equipped to discuss with women the benefits and risks of taking drugs during pregnancy, which meant that women were often denied access to effective covid treatments, including tocilizumab and steroids, and heart-lung bypass support, "simply because they were pregnant."

Marian Knight, professor of maternal and child population health at Oxford Population Health, said, "Improvements in care may have been able to change the outcome for 52% of the women who died during or up to a year after pregnancy.

"This demonstrates an even greater need to focus on the implementation of the recommendations within this report to achieve a reduction in maternal deaths."

Matthew Limb, London

Cite this as: *BMJ* 2023;383:p2388

RCP to hold meeting to discuss concerns over physician associates

The Royal College of Physicians will meet later this month to discuss doctors' concerns about physician associates. The college has hosted the Faculty of Physician Associates, the professional membership body, since 2015.

The news of the meeting came after the Royal College of Anaesthetists said it would hold an extraordinary general meeting about anaesthesia associates on 17 October, after a call from its members. Physician associates and anaesthesia associates are among the roles identified for expansion by the 2023 *NHS Long Term Workforce Plan*, which set out ambitions for a workforce of 10 000 physician associates and 2000 anaesthesia associates by 2036-37.

RCP members and fellows David Nicholl, Trisha Greenhalgh, and Martin McKee have written to the college's council detailing concerns raised about the expansion of these roles. Their letter, which has been co-signed by more than 300 doctors, warns that the rapid expansion of physician associates and anaesthesia associates poses risks to public safety and to "professional jurisdiction."

An RCP spokesperson said, "It is becoming increasingly clear that the health and care workforce, patients, and the public need more clarity on the MAP [medical associate professional] role and scope of practice. The FPA is publishing a series of supportive guidance to help address this issue." This document states that physician associates should make their role clear to patients when they introduce themselves and explain that they are not a doctor.

It says, "PAs [physician associates] must correct patients and staff if they refer to them as a registered doctor, nurse, or other professionally protected role title. This includes verbal, written, and other forms of communication."

Abi Rimmer, *The BMJ* Cite this as: *BMJ* 2023;383:p2375

UK death rate is still higher than before covid pandemic

Overall mortality in the UK is still higher than it was before the pandemic, despite a downward trend, a new analysis shows. From the start of the pandemic through to 29 September this year around 204 700 more deaths from all causes were registered than expected, shows the analysis by the Institute and Faculty of Actuaries' continuous mortality investigation (CMI).

In the week ending 29 September there were 9935 expected registered deaths and 44 excess deaths in England and Wales, the analysis found, meaning that 0.4% more deaths were registered than would have been expected if age standardised death rates had been the same as in the corresponding week of 2019. In the previous week deaths were 5% higher than expected.

In the third quarter of 2023 a total of 2165 deaths were registered in the UK with covid-19 mentioned on the death certificate, nearly 50% of excess deaths. However, the overall effect of the pandemic on total deaths has varied over the course of the pandemic for several reasons, including the possibility that though some deaths may have been wholly or partly due to covid-19 this wasn't mentioned on the death certificate.

Cobus Daneel, chair of the CMI Mortality Projections Committee, said, "The third quarter of 2023 saw continuing excess mortality for the sixth quarter in a row but at a lower level than the previous five quarters."

Of 204 700 excess deaths, **75 600** were in 2020, **56 500** in 2021, **39 400** in 2022, and **33 200** in the first three quarters of 2023. The update covers week 39 (to 29 September) and the third quarter of 2023, a period with excess deaths but at a lower level than in the previous five quarters

Veena Raleigh (below), a senior fellow at the King's Fund, told *The BMJ* there had been large numbers of deaths related to flu and covid in December 2022 and this January, which was influencing the figures. "The 2023 figures do not compare well with 2019. Mortality to date is about 5.5% higher than it was for the same period in 2019," she said.

"With 2023 to date, we haven't had the bounce back that we might have expected once the worst of the pandemic was over. In the first three quarters of 2023 the mortality rate was higher than in many years in the pre-pandemic decade. If we have a good coming winter things could get back to 2019 levels relatively quickly, but it's unpredictable.

"We need to remember that covid is still here and infections currently are picking up. Hopefully, we won't see the sort of death numbers we've seen before, but fewer people are getting vaccinated against covid."

Adrian O'Dowd, London

Cite this as: *BMJ* 2023;383:p2371

NEWS ANALYSIS

PROMISES, PROMISES: what to make of the Labour and Tory health pledges

On the close of conference season, **Gareth Iacobucci** assesses the health and social care policy pronouncements of Steve Barclay and Wes Streeting as they prepare for a general election campaign

Streeting's pledge on dentists is music to my ears
Rob Barnett

Barclay's pledge of £30m for IT in the NHS will not cut the mustard
Sally Warren

Waiting times

In his keynote speech to his party's conference in Liverpool on 10 October, the Labour leader, Keir Starmer, said that cutting waiting lists was the "biggest challenge" facing the NHS.

He pledged that a Labour government would commit an annual £1.1bn to provide two million more hospital appointments a year to tackle the backlog, which in England now stands at 7.8 million people waiting for treatment. This would be funded by ending the non-domicile tax status that allows some of the richest people in the UK to avoid paying tax.

It would rely on existing NHS staff, who would be paid overtime to work evening and weekend shifts. "We will get the NHS working round the clock. And we will pay staff properly to do it," Starmer said. But the BMA said that although the move could incentivise some doctors to do further overtime it could stall unless their calls for pay restoration were answered.

The prime minister made lowering NHS waiting times one of his five key priorities when he took office, but things have been moving in the wrong direction. In his speech to Conservative party delegates in Manchester on 4 October Rishi Sunak acknowledged that waiting lists were "patients' most pressing concern" but that efforts to tackle the backlog were being undermined by doctors' strikes.

Industrial action

The BMA hit back at Sunak for criticising striking doctors in his speech and for not acknowledging the association's offer of conciliatory talks facilitated by the Advisory, Conciliation and Arbitration Service (ACAS) to try to end the pay dispute with consultants in England.

In contrast, the shadow health secretary, Wes Streeting, said he would be "willing to negotiate" to end the doctors' strikes. In his keynote speech to the Labour conference Streeting spoke of a "window of opportunity for negotiations" before the next round of strikes took place. "A serious prime minister would take it," he said.

Speaking to *The BMJ*, the BMA's chair of council, Philip Banfield, said the association's offer of talks was still open. "It is very difficult because the underlying message from the government has been pretty consistent that they are not going to negotiate about pay in what is actually a pay dispute," he said. "That is not the position of Wes Streeting and the Labour party, who have said, 'Actually, we do need to talk about pay' . . . There is a recognition that it costs more [for the government and NHS] to stay in dispute."

Fixing the crumbling buildings in which these pieces of kit will be located should be a priority
Thea Stein

Diagnostic capacity

In his speech to the Conservatives' conference, the health and social care secretary, Steve Barclay, pledged £30m to accelerate the adoption of technology in the NHS. He promised "new tools to detect cancer sooner, help people receive treatment in their own home, or increase productivity to tackle waiting lists."

But Sally Warren, director of policy at the King's Fund, said £30m "will not cut the mustard" in terms of what the NHS needs for overall capital investment for buildings and equipment, pointing out that the cumulative maintenance backlog reached over £10bn in 2021-22.

Labour promised an extra £171m a year to double the number of computed tomography and magnetic resonance imaging scanners in the NHS over the course of a parliament. Streeting added the NHS would deploy the "power of artificial intelligence to spot disease quickly" under Labour.

Thea Stein, chief executive of the Nuffield Trust, said £171m was a sensible investment but only part of the solution. "Fixing the crumbling buildings in which many of these pieces of kit will be located should also be a priority," Stein said.

Rob Barnett, a GP in Liverpool who was representing the "Rebuild general practice" campaign at the Labour conference, backed the emphasis on more scanners for early identification of disease but added, "What he [Streeting] didn't necessarily talk about was the workforce that would be needed to not only interpret those scanners but then to help patients in the community when we've got those results."

Workforce

Barclay said that the government would make over 200 additional medical school places available at universities for next September, fulfilling commitments made in the *NHS Long Term Workforce Plan*.

Streeting promised the "biggest

expansion of NHS staff in history," referring to the Labour Party's 2022 pledge to double the number of medical school places, which was later included in the long term workforce plan.

Sarah Clarke, president of the Royal College of Physicians, said commitments to expand staffing were welcome but that improving working conditions was also important and that the "retention of existing staff must be a priority."

Banfield said that any increase in medical school training places was welcome but questioned whether the service would later be able to provide these doctors with sufficient numbers of postgraduate training places.

Labour's anti-GP rhetoric has changed to acknowledge general practice's essential nature Philip Banfield

Primary care

Labour has said that it will prioritise investment in the primary and community care workforce. Streeting said primary care "will be at the heart of Labour's plan for the NHS" and pledged to "bring back the family doctor." As well as training thousands more GPs, he said Labour would "cut the red tape that ties up their time" and put in place measures to "end the 8 am scramble for a GP appointment."

Barclay made little mention of GPs in his speech.

Banfield, who watched Streeting's speech at the conference, said he observed a change from last year in the tone towards GPs. "The anti-GP rhetoric has very much changed to acknowledging the essential nature of general practice," he said.

Barnett agreed, citing Labour's recent willingness to listen to the profession's concerns about the future of general practice and the importance of continuity of care. He added that Labour's pledge to deliver 700 000 extra NHS dental appointments each year and make sure that everyone who needed an NHS dentist could get one were "music to my ears," because "we've got patients coming to see us because they can't get to see a dentist."

Prevention and public health

In his speech Streeting outlined his intention to transform the NHS from a "sickness service" to "a neighbourhood health service as much as a National Health Service . . . preventing ill health, not just treating it." Barclay, in contrast, did not mention prevention in his speech.

Health experts said that Labour's aim was laudable but difficult to execute. "This refocusing towards community services has been a political ambition for decades, yet the rhetoric has not translated to reality," said Warren, adding that success would hinge on making careers in community services more attractive, improving outdated buildings, and shifting investment away from hospitals towards community services.

Banfield said that policies to tackle health inequalities had "to be a good thing" but warned, "By shifting the emphasis to prevention, we've still got people who have disease and illness. So there is a transitional cost, and I haven't heard any party say how it is going to fund or commit to that."

Sunak's big public health announcement was the plan to raise the legal age for buying cigarettes in England by one year every year until it applies to the whole population, to create a "smoke free generation." The government has since launched a public consultation on proposed legislation.

The policy has the backing of most doctors, medical bodies—and Labour. Streeting emphasised that it was his party that first proposed eliminating smoking earlier this year, and he said that Labour would back the legislation, contrasting with murmurs of opposition from some sections of the Conservative party.

DAVID OLIVER, p 110

Commitments to expand staffing are welcome but retention must be a priority Sarah Clarke

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;383:p2381

GPs can refer patients with low back pain to apps, says NICE

GPs can offer patients with non-specific low back pain access to digital apps to help them self-manage their condition and reduce pressure on NHS services, say draft recommendations from NICE. It concluded that evidence was lacking on the apps' clinical and cost-effectiveness and has proposed seven be made available to enable more evidence to be collected.

The draft guidance says GPs and other health professionals would be able to refer patients aged 16 years or over to seven apps that provide support for new non-specific back pain or back pain that has lasted more than three months. Patients would also be able to self-refer, through their GP surgery, to some apps that provide initial triage and symptom assessment.

The app providers would be expected to collect performance data, which NICE would review after three years to determine whether they should be made routinely available on the NHS.

The apps offer advice from a multidisciplinary team through video or email messages, guided exercise with video demonstrations, and reminders to do exercises or complete forms. Some also offer psychological treatment, pain specialists, video tutorials on managing pain, and mindfulness sessions.

NICE's draft guidance says the apps could also reduce demand for GP and physiotherapy appointments, use of drugs, and need for surgery.

Around 9.1 million people in England have long term back pain, with musculoskeletal conditions accounting for 30% of GP consultations, and these apps could provide extra capacity, said Mark Chapman, NICE interim director of medical technology and digital evaluation. "We believe these technologies have the potential to offer value for money, while offering people with low back pain quicker access to the care they need at a time and place of their choosing," he said.

NICE said the apps could also help reduce inequalities in access to musculoskeletal services caused by variations in waiting lists but acknowledged that their use might be more difficult for people with disabilities, lack of access to the internet, or difficulties understanding written English. Consultation on the draft guidance is open until 25 October.

Ingrid Torjesen, London Cite this as: *BMJ* 2023;383:p2380

IN ENGLAND around 9.1 m people have long term back pain, and musculoskeletal conditions account for 30% of GP consultations

Right: A special terrain ambulance delivers patients to the Ichilov hospital, Tel Aviv, after the strikes by Hamas on Israeli towns

A Palestinian civil defence officer injured in Israeli attacks is treated on the street outside Al-Shifa Hospital, Gaza, on Monday 16 October

MATAN GOLAN/SOPA/ZUMA/ALAMY

ALI JADALLAH/ANADOLU/GETTY

THE BIG PICTURE

Israel's hospital order is "death sentence for the sick," says WHO

The World Health Organization has condemned Israel's orders to evacuate 22 hospitals in Gaza that are treating more than 2000 inpatients, including babies in incubators and patients on life support.

WHO labelled the call a "death sentence for the sick and injured" and said Israel must immediately reverse the order and ensure that health facilities, health workers, patients, and civilians weren't targeted, as required by international law.

Israel has dropped thousands of bombs on Gaza, in what the UN and humanitarian organisations have labelled "collective punishment." Gaza has a population of 2.3 million, half of whom are children. The seige follows an attack in Israel by the Palestinian militant group Hamas on 7 October in which more than 1400 people were killed, at least 3715 were injured, and at least 150 civilians were taken hostage, an illegal act under international law.

After the attacks by Hamas, Israel's government also cut off supplies of food, water, and electricity to Gaza. So far, more than 2670 Palestinians have been killed and 9600 injured, and more than one million people displaced.

On 13 October Israel ordered hospitals and civilians in northern Gaza to evacuate and travel south, before a "ground invasion." This left doctors and hospital staff "facing an agonising choice," WHO said, "abandon critically ill patients amid a bombing campaign, risk their own lives to continue providing care, or endanger patients' lives while attempting to transport them."

Gazan hospitals are struggling to cope with the huge influx of patients, amid blackouts, shortages, and airstrikes. WHO also repeated its call for Israel to allow "medical supplies, fuel, clean water, food, and other humanitarian aid into Gaza."

Elisabeth Mahase, *The BMJ* **Cite this as:** ***BMJ*** **2023;383:p2397**

EDITORIAL

New tobacco control measures for England

Bold proposals will prohibit sale of cigarettes to anyone born in or after 2009

On 4 October 2023 the UK prime minister, Rishi Sunak, announced his intention to introduce legislation ensuring that from 1 January 2027, and on the same day every year thereafter, the minimum age of sale for tobacco would rise by one year. If enacted, people aged 14 and under today will never be able legally to purchase cigarettes, making England only the second country (after New Zealand) to introduce this measure.

Current adult smokers will be unaffected by the new law. But Sunak also announced new funding for media campaigns to encourage current smokers to stop smoking (£15m) and for trading standards offices to reduce underage sales and counter illicit tobacco and vape markets (£30m); a doubling of the budget for local government stop smoking services (£130m); and a review of packaging, disposable vapes, point of sale displays, and other levers to limit the uptake of vaping products in children and young people.[1] The devolved nations of the UK have indicated they may adopt similar measures.

The new funding is a welcome reversal to progressive budget reductions that have occurred since 2010, although it won't fully restore funding for media campaigns, cessation services, or policing of illicit sales to pre-austerity levels.

The extra funding for existing evidence based tobacco interventions will reduce premature mortality, disability, and the annual £17bn cost of smoking to the NHS and social care and also help to narrow health inequalities caused by tobacco. Media campaigns in the UK such as

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The age of sale proposal is a step change in UK tobacco control policy

"Stoptober" are recognised as low cost, high impact tobacco control interventions.[3,4] Local government stop smoking services are highly cost effective and have helped over five million people stop smoking since their inception over 20 years ago, but the numbers using them have fallen steeply in recent years.[5]

The age of sale proposal is, however, a step change in UK tobacco control policy and arguably the largest public health intervention in a generation, aside from the covid response.

The measure won't end smoking among young people because cigarettes can be accessed in many ways other than legal over-the-counter purchase. What it will do over several years, however, is encourage new societal norms among young people that do not, for the most part, include tobacco smoking. Concerns about prohibition fuelling illicit trade seem unfounded, as buying tobacco will remain legal for adults born after 2009, and other nicotine products will still be available.

Smoking among children and adults has been falling steadily for years in the UK[9] in response to control measures such as tax rises, advertising bans, prohibition of smoking in enclosed spaces, standardised packaging, and promotion of harm reduction (for adults) through vaping. Their individual effects in isolation are modest, but together these measures have contributed to some of the lowest smoking rates in the rich world. Similarly, the proposed legislation may have a modest effect on its own but will add to an already effective public health response to one of society's most hazardous addictions.

Implementation hurdles

What could threaten the new measures? First, and most critically, the tobacco industry is likely to seek to halt, obstruct, delay, and dilute the legislation, as it has before (by challenging plain packaging mandates, for example[10]). The tobacco industry will also likely raise concerns about a nanny state, inflating the risks of illicit supply, and over-regulation.[11] Health charities, public sector bodies, academia, and the public must work together to prevent industry interference in accordance with article 5.3 of the Framework Convention on Tobacco Control.[12]

Second, pressure on the public purse may tempt future governments to reduce some of the newly allocated funds, and this temptation must be resisted.[13] Third, the new legislation will require retailers to verify the age of increasingly older adults purchasing tobacco. Managing this may be challenging for retailers, and compliance will need careful monitoring by trading standards services. That burden could be mitigated by a licensing scheme for retailers, limiting the number and location of licensed tobacco retailers.

Overall, Sunak's proposed new legislation is a bold move that sends a strong signal globally that despite the siren voices of the tobacco industry and many in his own party he intends the UK to meet its target of a smoke-free society.

Cite this as: *BMJ* 2023;383:p2358

Find the full version with references at http://dx.doi.org/10.1136/bmj.p2358

EDITORIAL

The BMJ's commitment to achieving net zero

Journals and publishers are part of the problem and must lead on the solutions

The 2023 synthesis report from the Intergovernmental Panel on Climate Change leaves no doubt about the impact of human behaviour on planetary health and the urgent need to reduce greenhouse gas emissions.[1] *The BMJ* has long raised awareness about the climate emergency, highlighting the effects on people's physical and mental health and the consequences for biodiversity, wildlife, habitats, and the health of the planet.[2]

The BMJ has long raised awareness about the climate emergency

Publishing and campaigning on climate action are important but not enough. As a company with both print and digital products, BMJ is part of the problem. Journals and publishers regularly call on readers and other health professionals to show sustainability in their clinical practice—we must also be at the forefront of the solution.

Reaching net zero will be complex given the number of supply chains involved in publishing, but other industries have done this and we cannot use complexity as an excuse. The collective power of the publishing industry can put pressure on supply chains and companies to decarbonise. We can also learn from measures taken by the UK's NHS.

In January 2023, University College London Hospitals NHS Foundation Trust published a strategic plan for reaching net zero.[3] The plan includes a programme for reducing the carbon footprint of the hospital estate—for example, by looking at buildings' energy, waste, and water supplies; moving to more sustainable medical practices

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such as reducing the use of certain anaesthetic gases and switching to more sustainable inhaler options; and considering indirect effects on the hospital's carbon footprint from external suppliers, staff commuting, and medicines and medical devices. The plan recognises the importance of engaging staff, patients, and external suppliers in the strategy to achieve net zero. It is also clear on the barriers to success, such as funding, the scale of the project, and cultural barriers to change.

First steps

The publishing industry faces similar challenges. Print products have a higher carbon footprint than digital products.[4] However, online publication is not impact free, and reaching net zero in publishing is not just about moving away from print but considering the environmental impact of all activities, estates, equipment, travel, and supply chains.[5] Many of the larger publishing houses, including Springer Nature, Oxford University Press, and Conde Nast, are working towards net zero by switching to renewable energy, using Forest Stewardship Council (FSC) paper, and reducing paper weight.[5-7]

The BMJ is also working to reduce its environmental impact. The paper in the print edition is all traceable to a sustainably managed forest. All three UK print editions are wrapped in FSC paper and have on-pack recycling labelling. International copies are wrapped in a recyclable and carbon neutral polywrap.

BMJ is working with a climate and sustainability consultant to calculate a baseline for its carbon footprint and to build a reduction plan towards carbon neutrality by 2040. We are appointing a sustainability taskforce to ensure that all parts of the business are included. We are committed to communicating our sustainability efforts internally and externally, and to working with editorial teams across all BMJ journals. We plan a full environmental assessment of BMJ and its external supply chains.

The BMJ recently signed the UK Health Alliance on Climate Change's commitment to help organisations "take steps to mitigate and adapt to climate change."[8] One key commitment is to publish a plan to achieve net zero. By signing this commitment, we pledge to identify and measure our carbon footprint, establish ways to reduce our carbon emissions, set a target for when we will reach net zero, establish intermediate targets, create an implementation plan, and report progress annually.

Journals cannot do this alone; they require backing and commitment from publishers and owners. BMJ, as an organisation, is also a signatory of the UN SDG publishers compact—a commitment to uphold progress towards the sustainable development goals (SDGs), work towards sustainable practices, and champion the SDGs to protect people and the planet.[9] We call on all publishers to join us in prioritising achieving net zero across medical and scientific publishing.

Cite this as: *BMJ* 2023;382:p2135

Find the full version with references at http://dx.doi.org/10.1136/bmj.p2135

DECOLONISING MEDICINE AND HEALTHCARE

The uncomfortable identity of London's renowned school of tropical medicine

One of Britain's most renowned medical institutions is grappling with its colonial history and the effects of racism and inequality on its culture today. **Mun-Keat Looi** asks whether its efforts are enough

In 2019 the London School of Hygiene and Tropical Medicine (LSHTM) put itself under interrogation. The school, at the forefront of global health with a leading role in treatments for Ebola, malaria, and HIV, commissioned a two year independent review of structural racism at its heart.

Completed in 2021, the review found that the university's culture and practices "still too often disadvantage people of colour" and that its curriculum remained "Eurocentric." Staff and students from minority groups felt "unsupported" when experiencing or trying to tackle racist behaviours, and they were found not to have "equitable experiences or opportunities to progress at LSHTM." Discriminatory behaviour by senior staff went unchecked because of their influence at the institution, the review concluded.

"While the conclusions of the review are difficult to confront, facing up to them is an essential step towards creating an environment where everyone's contributions and perspectives are valued," says Liam Smeeth, professor of clinical epidemiology at LSHTM who, since the review was first commissioned, has been appointed as the school's director. But what an institution is—and always has been—is not easily changed.

The structural racism review included a separate historical review of the school's foundations in colonialism. It described in detail how LSHTM owed its existence and development to funding, teaching, and research created to support colonialism—and how patterns of racial discrimination and exploitation were established by this.

The review was commissioned under the watch of a previous LSHTM director, Peter Piot, at the tail end of his time in charge. Piot, known as the scientist who first identified the Ebola virus, has himself faced criticism, with some claiming that his memoirs play up his role in Ebola's discovery at the expense of Jean-Jacques Muyembe of the Democratic Republic of Congo and other researchers who contributed to the discovery.

This debate is indicative of the way global and public health and medicine—and perhaps science as a whole—have been seen for centuries, with the credit falling to white male researchers from powers such as the UK for discoveries made in its colonies.

The questions now are to what extent history means identity, what should be done in response, and what this says about the wider issue of colonial attitudes at British institutions.

Colonial foundations

LSHTM was founded in 1899 by Patrick Manson, chief medical officer to the Colonial Office, and its training was mandatory for anyone attempting to treat colonial officers working in the British empire. (The British empire spans 400 years, but for the purposes of this article British colonialism is regarded as 1800-1960, during which time Britain

Patrick Manson, chief medical officer to the Colonial Office, founded LSHTM (right) in 1899

took control of India and parts of Africa, among other places, until the nations gained independence. "Decolonisation," in the sense of dismantling the empire into independent countries, is regarded in this article as firstly the postwar period 1945-55 mostly in the Middle East and Asia and secondly after 1955 mainly in northern and sub-Saharan Africa.)

"In comparison to other British universities established around the same time period, almost all of which are entangled with or have benefitted from British colonialism, LSHTM was established specifically to support the expansion and administration of the British Empire," wrote Lioba Hirsch, lecturer in social anthropology at the University of Edinburgh and author of the LSHTM report, in an LSHTM blog post in 2021. "The foundation and maintenance of [LSHTM] were made possible through the forced labour and financial exploitation of colonised subjects."

Among the worst known atrocities of British colonisation are the concentration camps used in the second Boer War (1899-1902) and the Kenyan Mau Mau uprising of 1951-60, the latter of which saw prisoners tortured, with some castrated and sexually assaulted.

"Really terrible things happened in the colonial efforts," Smeeth tells *The BMJ*. "That colonial effort had power imbalances, discrimination, and racism baked into it by its very nature. It's not to be hidden, it's not to be pretended that it didn't happen, the fact that many projects and much of LSHTM were founded as part of the effort to colonise parts of the world."

NGADI SMART

"People say, that's not enough. We need, if not reparations, institutional change. We need changes in institutional culture. We demand something"

LSHTM was established specifically to support the expansion of the British Empire Lioba Hirsch

Funding from colonial governments and companies with colonial interests continued to support LSHTM until the 1960s, the school's influence being further strengthened by its governance committees, which had representatives from government offices, international health bodies, and private industry, all with British colonial links.

This financial reliance on the Colonial Office—and later on colonial companies and industry—meant that research and teaching objectives were inevitably aligned with colonial interests and that racism and white supremacy influenced its research, teaching, public speeches, and academic writing. For instance, in the 1930s the school "taught and employed several members of staff dedicated to eugenics and its potential to govern British and colonial public health," wrote Hirsch in her 2022 LHSTM report. "During both World Wars, the School was instrumental in protecting British troops against tropical diseases and ensuring the protection of its imperial possessions."

Things changed as the British empire broke up, but the fact that many British experts in "tropical medicine" and public health were required to have studied at LSHTM (or the Liverpool School of Tropical Medicine), not to mention its world leading position in research on these subjects, meant that it retained authority in the new world.

Hirsch wrote in her LSHTM report that "while the School recruited widely from amidst its student body, a student-to-staff pipeline predominantly existed for white male students, most of them British. The

The Tate group of museums and galleries is one of many British institutions that is confronting its colonialist past

Critics say the work of Jean-Jacques Muyembe of the Democratic Republic of Congo on Ebola was underplayed in the memoirs of Peter Piot (right)

latter travelled and conducted research on colonised populations across the Empire. Resultant knowledge was consolidated at the LSHTM in London, further cementing the School's future position as a leader in global public health research and amplifying the epistemic disconnect between the metropolis and its colonies."

Defensive move

LSHTM is just one of many British institutions whose histories are steeped in enslavement and colonialism—from art galleries such as the Tate to charities and landowners such as the National Trust, financial companies including Lloyds, and publishers such as the *Guardian*—all of which began and grew their operations during colonial or early postcolonial eras and are now finding themselves needing to confront their pasts.

The identities of institutions that were born from this have come under increasing scrutiny in the past decade. Universities worldwide have felt scrutiny tighten under a civil movement that challenges them to acknowledge rather than gloss over the uncomfortable truths of slavery and colonialism. The covid pandemic and the murder of George Floyd further exposed systemic racial inequities. "Racism nowadays does a lot of damage in its violent forms when people are verbally or physically abused," says Hirsch. "But it does just as much damage when it is very quiet and polite and barely visible to the mainstream white eye."

Commissioning Hirsch's report was LSHTM's move to confront these "barely visible" forms of racism. Of course, it was partly defensive. "Institutions still prefer to have a hold on how these histories play out," Hirsch says, adding that there was a "fear" at the institution that a newspaper would publish something or would dig deep and submit freedom of information requests, such that LSHTM would no longer be in charge of those histories.

Another major driver is staff. "The LSHTM report was not commissioned out of the goodness of their heart," says Seye Abimbola, associate professor of health systems at the University of Sydney and editor in chief of *BMJ Global Health*. "It was commissioned because black and brown people at the school were agitating for it. It was something that LSHTM was forced to do because of the people who were there."

Smeeth tells *The BMJ*, "As director of LSHTM I do what I think is the wise and compassionate thing to do—for the world as a whole, as well as for LSHTM. I guess people can believe me or not."

Hirsch agrees with Abimbola. "There is a genuine curiosity—predominantly staff of colour—pushing for it," she says, adding that staff are not satisfied with merely finding out who had influence over an institution's development and to what extent. "People say, that's not enough. We need, if not reparations, institutional change. We need changes in institutional culture. We demand something."

"Decolonising the curriculum"

LSHTM is working to improve diversity and inclusion, make partnerships more equitable, and "decolonise the curriculum." Smeeth says that this covers all teaching materials, many of which use colonial examples, as well as who does the teaching. For instance, in a practical module on mpox, an example outbreak at a village in a fictional African country has been relocated to a shelter for homeless people in London.

After a lecture on the aetiology of infections, students met a Zika expert (and LSHTM alumna) who led the research response to the microcephaly epidemic in Brazil, teaching the value of knowledge from both research and direct experience. Similarly, before a lecture on eradication LSHTM's students met a polio expert involved in the elimination campaign in India and clinical trials of novel vaccines.

Smeeth tells *The BMJ* that students are now involved in creating teaching content. The school added a lecture on colonial dimensions of infectious diseases and introduced the concept of "decolonising the curriculum" to students in their course descriptions and introductory lectures, while also adding readings on decolonising global public health to the taught materials.

Related to that, says Smeeth, is thinking "again and again and again about what we can do in terms of access, overcoming barriers to the highest performing courses, and ensuring, as much as we can, not just equity but really overcoming barriers for bright people who are from either disadvantaged groups or groups with less resources."

LSHTM isn't alone. In 2019 the University of Glasgow vowed to raise and spend £20m towards reparative justice, decolonisation of its curriculum, measures to improve staff and student diversity, renaming of buildings, and scholarships. It also signed an agreement with the University of the West Indies to fund a joint centre for development research. But is that enough?

Peter Piot, former LSHTM director who commissioned the 2021 review

I do what I think is the wise and compassionate thing to do for the world, as well as for LSHTM Liam Smeeth

"Past" is still present

What irks Abimbola is the idea that colonisation is history. "It is not past. It continues," he says. "You can say, 'My ancestors messed up'; it's much more difficult to say, 'I'm continuing their legacy.' I don't think anyone with power is willing to do that just yet."

Covid vaccines are a classic example. South Africa is among the countries that have contributed to our understanding of covid and the development of vaccines at an unprecedented pace, says Zulfiqar Bhutta, a professor of child health at the Aga Khan University in Pakistan. Yet the imbalance in access to the vaccines is well known, and continues. Most countries outside those that are classified as higher income still struggle for access to vaccines or the knowledge and technology to help them make their own.

Bhutta explains, "MRNA vaccines came in during the pandemic, but it has taken time and a lot of international effort to get the technology shared with [the vaccines hub in] South Africa. I would like to see a lot more research and development happening in other low and middle income countries and, to some extent, some reverse osmosis of learning and gains which also derive from experiences in those very geographies who struggle to access the fruits of research."

He adds, "There are many things globally which are happening, cutting edge and advanced—you know, diagnostics methodologies where we would like the fruits of some of those technologies to be available to low and middle income countries as well, and they will not be available on the same kind of parameters in terms of equal sharing of IP [intellectual property], just because of the 'nature of things.' So, we need to work in parallel to ensure that the benefits of technology advances can also pass to those living in geographies with greatest need."

Squaring a colonial past with the "nature of things" today is therefore key. The questions, says Hirsch, are, "Where are we in relation to this past? What has changed? How does the past still have a hold on where we are in the present?"

Hirsch's commission was to cover the 20th century only up to the 1960s, so the report doesn't link the past to the present directly. LSHTM says that this was always the intention—that the first stage covered the period up to the independence era, as this was seen as the vital colonial time. It hopes to complete a second phase covering the 1960s onwards but, although some ongoing research is continuing, there's no current timeline for completion of a new report.

As such, it's difficult to say whether the current actions in response to increasing calls for decolonisation match up to the wrongs of the past. "We are still describing things too much, in my view," says Abimbola. "When people with power ask, 'How are we doing?' we just describe their power rather than challenge its legitimacy."

Bhutta asks, "Decolonisation, yes—but decolonisation for what? To absolve yourselves of the responsibility for global health and centuries of neglect? No. We need more engagement from high income countries into the health, wealth, and wellbeing of countries that are suffering right now in Africa and Asia, and not less. And that does require that we find a middle ground, so that decolonisation does not equate to disengagement."

He adds, "I see such key collaborations and partnerships in other disciplines [such as climate change or the CERN physics research institute in Switzerland]. Sadly, I don't see it in global health yet."

Smeeth says, "The important thing is how we want to do things from now on. The world faces many challenges, many impacting on health in increasingly complex ways."

Certainly, people in former colonies are now wise to this. In the 16 December 2020 issue of LSHTM's monthly newsletter *Decolonising Global Health*, one academic told of inviting a colleague in South Africa to collaborate. "She wanted to know—and was testing me, in effect—to see whether I was one of those Northern academics who might claim interest in working 'horizontally' but would later show up to the table expecting to dictate the terms of collaboration, an experience she has had many times before," they wrote. "She asked me, and this is what sticks with me most, to think in terms of my own position vis-à-vis the politics of global health: 'Are you putting the food on the table, sharing the meal, or are you the meal itself?'

"This metaphor was meant as a cautionary tale—don't get eaten up by the very institutions whose power affords you a place at the table but, similarly, don't be dictating the terms of what is served."

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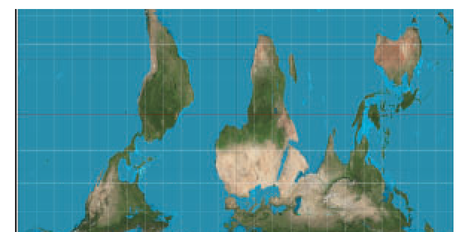
Cite this as: *BMJ* 2023;383:p2232



This article is part of a collection and podcast series on decolonising health and medicine
www.bmj.com/decolonising-health

DECOLONISING MEDICINE AND HEALTHCARE

What should genuine decolonisation in medical institutions look like?

A spotlight on race and inequality has highlighted the colonial nature of historic medical institutions. But decolonisation means far more than diversification, finds **Mun-Keat Looi**

"I feel like everything's being decolonised these days," says Lioba Hirsch, a social anthropologist at the University of Edinburgh and author of a study into the colonial foundations of the London School of Hygiene and Tropical Medicine (LSHTM).

"On one hand, that's encouraging because people think it's something worth engaging in or thinking about. On the other hand, 'decolonisation' increasingly means diversifying staff, diversifying students, and trying to close the awarding gap between white students and other students—rather than tackling the root problems it has caused."

So, what else should decolonisation mean?

Ending international outposts

University College Hospital in Ibadan, Nigeria, describes itself as the "flagship tertiary healthcare institution in Nigeria" offering "world class" training, research, and services. Opened in 1957, it fulfilled the long term aim of a commission set up in the wake of independence from the British empire of west African countries.

Today it is indeed one of the leading hospitals in west Africa—but the standard it holds itself to is that of its former coloniser.

From the very beginning, even before the Ibadan hospital had been built, the new faculty of medicine founded to deliver the country's workforce of medics was "linked to the academic unit of the University of London to enable Ibadan graduates to obtain the bachelor of medicine and bachelor of surgery degree of the University of London."

"UCH in London was the goal of UCH in Ibadan in Nigeria," says Seye Abimbola, associate professor of health systems at the University of Sydney, "and that logic still underpins how medicine is thought of and practised."

There remains, he says, a trend of setting up local offices of British institutions as a method of internationalisation. "The BBC, for example, can never do for Nigeria what it does for Britain," says Abimbola, "That is very colonial, in my view. It's one thing to be in London. It's another thing to pretend to be local. And by so doing it destabilises local spaces."

Funding is largely tied to European and US bodies, which make decisions based on interests made from abroad

There's nothing normal in me conducting a study in Nigeria and wanting to publish it in London Seye Abimbola

University College Hospital in Ibadan, Nigeria, was established in 1957 yet still holds itself to the standards of its namesake in London, says Abimbola

Medical students test a computer controlled ventilator they designed at Kenyatta University, Nairobi

JOHN MUCHUCHA/AP/ALAMY

THE COLONIAL LEGACY OF BRAIN DRAIN

The haemorrhaging of talent is a problem in all countries, but the generational effects on LMIC settings can be catastrophic, particularly for health systems.

A senior doctor in east Africa, speaking under condition of anonymity, says, "I'm training doctors. I'm spending a lot of my time and money training these doctors to be the best in the world. And they are wanted by the UK, for example. But when the UK takes my doctor, they pay me nothing. If they wanted a footballer to come and play for an English football club, they would have to pay millions.

"Decolonisation needs to look at that because our doctors are being stolen. Our nurses are being stolen. The investment in education and health in the UK has dramatically gone down. So now, the higher income countries are turning to LMICs and stealing our doctors, and they're not paying us a penny.

This is stealing and must be part of decolonisation.

"When we allow people to migrate from Uganda to the US, France, the UK, it's part of colonialism. How come they don't prevent doctors from entering, but they are preventing migrants from Vietnam, from Burkina Faso, from Niger from crossing? They are interested in educated people. And those who are not educated must be exported to Rwanda."

More conferences and events should be hosted and planned by the countries affected, not higher income states

Levelling the research playing field

In a 2021 *Lancet Global Health* paper, Muneera Rasheed, a psychologist and global early childhood development researcher in Karachi, Pakistan, wrote about how critical decisions about a study involving investigators from low and middle income countries (LMICs) were often made by researchers in high income countries, who may also undermine the in-country principal investigator by travelling to the site of the study without prior communication; publishing papers or deciding authorship without the knowledge of local experts; or directly communicating with field staff without in-country investigators' knowledge.

She also cited cases when "unsubstantiated allegations against the principal investigator" were communicated to the lower income country's university leadership "as a means of coercive influence."

Funding is also largely tied to European and US bodies, which hold the purse strings and make decisions based on interests—however well intended—made from abroad and from an identity that is historically colonial.

Speaking at a roundtable discussion on equitable research partnerships held at BMA House in December 2022, Eneyi Kpokiri, clinical pharmacist and assistant professor in social innovation at LSHTM, pointed out that there can be systematic and structural barriers to receiving funding in LMICs. For example, it is currently impossible for researchers in some countries in the global south to be principal investigators because of the organisational requirements of some funders or financial regulatory requirements. This makes it difficult to use funding models devised with high income settings in mind.

"Funders need to be aware of national policies or legislation that can create barriers to participation in some countries, and work to accommodate or help change them," she said. "Funders need to be more flexible and look to increase the inclusion of LMIC participants in research operations as well as researchers."

"There are structural problems around money," says Liam Smeeth, director of LSHTM, "And then there's the more subtle, deeper problems, partly historical, around patterns of behaviour and power relationships that are important to acknowledge. This is why it's important to have these things front and centre. Because this is on the back of decades or centuries of people from the imperial nations being in charge."

Equal collaboration

Greater involvement, particularly collaboration between LMICs themselves (often called south-south collaborations), means that those affected most by initiatives to fight infectious disease, the effects of climate change, and poor sanitation, among other things, will be at the forefront of decisions affecting them—including committing their own funding and choosing which research questions to prioritise. This would reduce the "saviour" model, where aid agencies and high income countries swoop in and impose solutions they deem right.

"I would like to see leaders in low and middle income countries stand up and be counted," says Zulfiqar Bhutta, a professor of child health at Aga Khan University in Pakistan, "just like they did several decades ago when setting the UN Millennium Development Goals, when they spoke up on the rights and wellbeing of poorer populations in low and middle income countries around justice, education, access to services, and equity."

That's not to say working with higher income countries should be off the table. Instead, Bhutta is at pains to emphasise how it's about truly equal collaboration with equal reason and reward.

"It's only a few decades since we had the unbelievable debate over the ethics of placebo controlled trials in HIV populations [in which to comply with double blinded randomised trial protocols, half the study participants would have received placebo drugs]," he says. "Academia and some people on the ground in LMICs stood their ground, saying, 'You cannot do a placebo controlled trial if you're doing a trial for drug development and testing in my population, just because you believe that treatment would never be accessible to those countries anyway and therefore placebo controlled studies are justified.'

"One of the fundamental principles of decolonisation is that you give equal weight to the quality of life and to the rights of all populations, to the rights of the researchers and the institutions. And, therefore, you create a level playing field around which things can be built.

"If you look at research over the past 50 or 60 years, it's only relatively recently that we see institutions in LMICs drawing a line and saying, 'We're not doing this clinical trial because [the company or country is] doing it for themselves, not for the benefit of populations that we serve or work in.'"

A related point is for more conferences and events to be hosted and planned by the countries affected, rather than higher income countries where visa restrictions have accentuated the problems of access.

There has to be a lot more clarity about what former colony institutions want to achieve Muneera Rasheed

You give equal weight to the quality of life and to the rights of all populations Zulfiqar Bhutta

Tackling journal influence

The editorial choices of journals in high income countries impact what research people choose to undertake. "There's nothing normal in me conducting a study in Nigeria and wanting to publish it in London," says Abimbola, "It is not normal. It is colonial by definition. Yet somehow we've come to accept that. And it has consequences for the kinds of study that I want to conduct in Nigeria. It's all to impress a guy in London. And the guy in London is completely inconsequential as far as improving anything in Nigeria is concerned."

Abimbola says, "There is a responsibility that the likes of LSHTM, *The BMJ*, or the *Lancet* have—to say, 'Please do not see us as the be all and end all. We are not the arbiter.' They have to say these things because colonised people listen to them."

Alex,* a Ugandan doctor, says that while working in Zimbabwe he submitted a paper to a UK journal which was rejected. Shortly after he moved to the UK he resubmitted the paper to the same journal with his new address. The paper was accepted with minimal changes.

Giving up power

One step would be visible changes at the top. Would the likes of Smeeth—a white British man—step aside if a suitable candidate from an LMIC emerged? Smeeth agrees that, ideally, the next director of LSHTM would be from an LMIC—if they truly are the best person for the job.

"It'd be a great reflection on the state of world science. Someone from a lower income setting stepping up—as long as there's not a hint of tokenism. For me, anti-discrimination and equity are about fully recognising what someone can bring. And there's no doubt that somebody from a lower income setting, from different backgrounds, can bring a great deal. I would love to see that experience and that depth of knowledge fully appreciated and valued.

"The aim is clear: it's not to pretend that the past didn't exist, but to overcome those patterns. So that people feel and are able to step up and express their expertise, and that competence, and take that responsibility and lead without any sense of inferiority and enter into equal partnerships. I'm not going to pretend that's easy."

It's not about having a particular skin colour, says Hirsch, "Just putting a black or brown person at the top of any of these institutions might not change anything.

"It's about the ways in which we were educated. How we were all taught to comport ourselves in public, what we value, how we can approach things, how we can engage in conflict or disagreements."

Rasheed acknowledges that giving up power "is not easy for anyone, anywhere. Even for people who are not white [but are from the UK or US], for them to give up that power. I don't think it's going to happen."

Hirsch says, "We need honesty and humility to recognise that sometimes we're not the right person to lead a debate or to occupy a position or to lead a campaign. To say, 'I'm going to step aside and I don't need to be involved in everything. I can support the people who should lead this, and I will by making spaces for them, by stepping aside and empowering someone.'"

Such leadership, she says, is especially needed in academia, which is built on the idea of objective knowledge and truth, and confers much value and esteem to historic names as the arbiter of these values.

Says Abimbola, "You have a responsibility to undo that influence because no matter how much I preach to Nigerians, they still look at me like, 'Guy, relax.' But if the *Lancet* says what I'm saying, if [*Lancet* editor Richard] Horton says what I'm saying or if Liam Smeeth says what I'm saying, then it means more. Because the arbiter who may have told them that their work is worth nothing, is instead saying to them, 'Look, we got it wrong.'"

What do the formerly colonised want decolonisation to look like?

There is a bigger question, however. "It's not adequately understood how [people in former colonial countries] want to tackle the power asymmetries between the north and the south," says Rasheed.

"There has to be a lot more clarity about what former colony institutions want to achieve by decolonising, what they're asking for. Are they talking about the challenges that we in the global south have and about giving or distributing power to the people who work here or live here, or who they partner with or collaborate with for global health research? Or is it just about themselves?"

Rasheed emphasises that decolonisation efforts themselves have a colonial face. "It has to come from people who actually live in the global south, they have to be the face of decolonisation. Decolonisation efforts also have to be decolonised."

Abimbola agrees. "I feel that decolonisation is limited to inclusion and diversity: let's have more women, more black and brown people. But the colonial logic that underpins this organisation and institution remains."

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Cite this as: *BMJ* 2023;383:p2257