We are hopefully entering the final straight of this pandemic, and we can begin to take stock of what it has meant to us all. If one word can describe our universal experience it is loss, which has become a daily event.

This might be the loss of a loved one, a colleague, or a friend, or prolonged separation from any of them. It could be the loss of routines, planned celebrations, or formal rites. And we have all experienced loss in our working lives: disrupted training or moving teams, jobs, even hospitals. Among these are less tangible, more ambiguous losses—such as the loss of status when having to move across work boundaries (for example, consultants, used to being in control, have become novices again as they take shifts in intensive care “pronation” teams). We have all experienced a loss of certainty, as none of us can be truly sure of what tomorrow will bring.

Grieving for these losses is difficult in a pandemic. Unlike normal grieving, we cannot easily take time out to recover and recuperate. Instead, almost without exception, we are just carrying on, creating a psychological barrier between how we “really” feel and what we tell others. The stock response, “I’m OK, thanks,” translates into, “I feel confused, tired—and, while you’re asking, quite distressed.”

Our survival techniques such as self-care, going to the gym, attending social events, or connecting with others are not the same when moved online. Those challenges we set for ourselves during the first lockdown—learning a new language, baking bread, or exploring the streets on long walks—have lost their sparkle and just add to our fatigue. Offering solace to patients when we too feel down and in need of comfort is hard, but as doctors we have to give more of ourselves, even when we feel empty.

It’s normal to feel sad during these changing times. It’s also normal to feel confused about conflicting emotions (also called cognitive dissonance). As doctors, we are in a privileged position. Most of us are still employed. We are still allowed to actually go to work rather than dial into it. Many of us are still engaging in real human contact, albeit often behind plastic visors. Yet we are also exhausted and overwhelmed by our cumulative experiences, and sometimes we just want to be cared for rather than care for others.

This pandemic creates isolation, but we are not alone in our experiences. We are all in this together, and we are all grieving, but it will subside, and some semblance of normality will resume. In the meantime, hang in there—and, if you need to, access the many supports now available to healthcare staff.

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Sometimes we doctors just want to be cared for rather than care for others
Interest is in mutations, not where the variants emerge

What do the virus mutations mean, and how should we track them?

In the past three months global attention has turned to the discovery and health risks of new variants of the SARS-CoV-2 virus. A new variant, B1.525, has very recently been identified in the UK. In December, the discovery of what has become known as the Kent variant, or B.1.1.7, saw the virus sweep across the UK and dominate infections because of an increase in transmissibility. This was followed by the South African variant B.1.351, which contains a mutation now being reported to reduce the efficacy of the ChAdOx vaccine to the extent that South Africa is removing it from its vaccination programme. The Brazil variant P.1 is also spreading to many countries with worries about its propensity for causing reinfections, as it emerged in a place that may have hit herd immunity in the first wave.

The world now seems obsessed with variants and designating them a place of origin. This is a stigma that should be avoided, as where a virus is first detected is not necessarily where it originated. Lest we forget, Spanish flu (the 1918 influenza pandemic) had no connection to Spain.

The fascination with variants is now almost as contagious as the virus, and it provokes similar knee-jerk reactions. The discovery of B.1.351 in the UK has led to a mass targeted testing and sequencing regimen in affected areas in an attempt to control its spread. This is because of a press release that stated the ChAdOx vaccine did not protect against mild and moderate covid-19 symptoms in a small South African study of young adults. While prudence and quick action should always be advised in matters of covid, it’s also worth remembering that none of the data are published and so a significant supposition is being made on the ability of the Oxford AstraZeneca vaccine to control B.1.351 cases.

Geographically unrestricted

What makes the variants a concern is not where they come from, but the mutations they contain. The B.1.1.7 virus is characterised by a deletion in the spike protein and a mutation at N501Y which enhances its transmissibility, as well as a potentially important mutation in the furin cleavage site. These mutations are found on a background of an unusually high number of other mutations, making B.1.1.7 distinct. In the case of B.1.351, what makes it a threat to vaccine efficacy is the E484K mutation in the spike protein, also seen in P.1. It is naive, however, to think that these mutations of concern are restricted to singular areas in an attempt to control its spread.

In recent weeks, the NHS has come under a degree of pressure it has never experienced before. Much commentary concentrates on how it will come out of this phase of the pandemic. There’s an understandable focus on staff support and recovery, tackling care backlogs, and meeting the increases in demand for mental health support.

There has been remarkably little comment on the profound consequences for the NHS for many years to come.

As covid-19 mutates we are likely to need an annual rolling vaccination campaign, with an annually tweaked vaccine. NHS staff are doing a brilliant job, but the current programme is using an unsustainable model. We are taking huge amounts of GP time. NHS trust staff, particularly in community trusts, are being redeployed. We are using volunteers who may not be available in future. A sustainable workforce model needs to be developed to deliver vaccines year in, year out, for some time yet. That is a huge undertaking.

If covid continues to circulate, it’s likely there will be significant numbers of covid positive patients in hospitals, so we will need to maintain strengthened infection control measures, which we have seen have a major impact on bed capacity. The NHS was already short of capacity before the pandemic and living with covid-19 will require us to invest in further capacity to cope, including with the increase in demand for mental health services.

The selection for random mutations that can confer a fitness advantage can happen anywhere, and at any time

geographically defined viral lineages.

What has driven the emergence of these phenotypically important mutations are significant selection pressures. In the case of B.1.1.7, random mutations conferring an increase in transmissibility led to an increase in virus fitness which was rapidly selected for and became dominant in the UK. In the case of B.1.351 it may be that selection is for a random mutation allowing some form of enhanced escape from immune pressure and onward transmission, generating a fitness advantage—although evidence remains weak.

The key point is that these selection pressures are not geographically specific. The virus is encountering similar selection pressures wherever it is transmitting and has relatively high prevalence, meaning the selection for random mutations that can confer a fitness advantage can happen anywhere, and at any time. This is now being seen with the emergence of the E484K mutation in the B.1.1.7 virus variant, meaning that the Kent variant now has the important South Africa mutation.

The key is to have sufficient surge, and super surge, capacity

In recent weeks, the NHS has come under a degree of pressure it has never experienced before. Much commentary concentrates on how it will come out of this phase of the pandemic. There’s an understandable focus on staff support and recovery, tackling care backlogs, and meeting the increases in demand for mental health support.

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Vilifying hospital doctors won’t help GPs

At the end of 2020, delegates at the local medical committee (LMC) conference of GPs backed a motion demanding “financial sanctions” against hospitals that failed to limit the “unfunded transfer of work to primary care.” They warned that the pandemic had led to a surge in tasks “dumped on GPs by hospitals.”

As a hospital doctor working in acute care, I have great sympathy for GPs’ concerns. Primary care (GPs and other practice staff—notably nurses) does around 90% of NHS patient contacts for about 10% of the budget and an annual budget of around £155 per patient on the practice list. A 2019 study in The BMJ compared 11 high income countries and found that UK GPs saw patients at twice the speed of those in the other nations. Surveys show an average of 41 patient contacts a day, and 10% of GPs see 60 or more.

The number of GPs barely grew during 2010-15, and the Nuffield Trust has reported nearly 2000 fewer permanent GPs in 2020 than in 2015 despite a growing population and demand. Community nurse numbers have also fallen, and social care and local government budgets have been cut. The UK has some of the lowest numbers of hospital beds per capita in the world, and ever increasing activity means ever faster patient transfers into the community and more pressure to keep patients at home.

No wonder the LMCs are unhappy and see hospital colleagues as part of the problem. The difficulty comes with the language of blame and hostility. We also have difficult jobs, and many specialties face growing workloads, rota gaps, recruitment and retention problems, and flagging morale compounded by a year of pandemic medicine.

Hospitals and their doctors are under tremendous daily pressure to organise the flow through acute beds and to discharge all medically stable patients to their homes. This is national policy, ramped up further by NHS England’s covid guidance. This pressure has come not least from GP led clinical commissioning groups, which want to take cost and activity out of hospitals through demand management, although the health white paper will disempower the CCGs. Commissioners discourage numerous costly referrals between consultants, pushing more referral decisions back to GPs. And hospitals are discouraged from bringing patients back for routine clinic appointments.

I completely understand GPs’ complaints that some hospital doctors seem not to understand their pressures or respect their equal value and expertise. I also understand the need to see some transfer of resource or staffing to accompany the workload—not least more hospital specialists working outside hospital walls in community and population health roles. And the national standard contract requires hospital doctors to follow up their own tests and requests.

I’m not sure, however, that fighting talk about fines—and a hostile stance that makes hospital doctors feel defensive and under-appreciated—will solve the problem.

Another lesson of the past year has been how the virus tends to surge in regionalised waves, creating peaks of demand that can potentially overwhelm services in affected areas. The key is to have sufficient surge, and super surge, capacity to cope with peaks of demand and ensure that mutual aid across trusts and regions works effectively. That has profound implications for NHS estates—how do we create community, hospital, general or acute, and intensive capacity that can be easily flexed up and down?

Reconfiguring the NHS to meet these challenges will require investment and leadership. These will need to be factored in alongside the bulging bag of other priorities. But it is a vital task we need to turn to quickly.

Chris Hopson, chief executive of NHS Providers
Debts of gratitude

Sometimes my day is brightened by someone’s gratitude. Even if I barely remember the consultation referred to in a card, clearly it was appreciated. If I’m thanked in person I often respond, truthfully, that I was just doing my job. Conversely, most GPs have experiences of patients for whom they’ve gone the extra mile—with hours spent on long consultations, referrals, and advocacy—and received not gratitude but dissatisfaction and sometimes complaints.

As a patient, I too have felt grateful to clinicians who have found the right words at the right time, who have been gentle and kind. But should I feel gratitude to the NHS as a whole? I’m certainly grateful to the post-war politicians who had the boldness to dream of a world where healthcare was a right and had the vision to create our NHS.

The problem with gratitude is that it can imply that we’ve received something that wasn’t ours by right. The NHS is funded by our taxes, explicitly to provide care and treatment for everyone in the UK. Those of us who earn enough to pay taxes should render up the money willingly; those who don’t should be secure in the knowledge they’ll get the care they need. How much tax we pay, especially in the upper earning brackets, is a matter for debate (leaving aside the issue of Modern Monetary Theory): how sensibly, carefully, and transparently our money is spent is a subject currently occupying the news media and the law courts.

What purpose are these charities intended to serve?

Should there be a role for NHS charities? Are they needed as places through which patients can express their gratitude and “give something back”?

This has been a heated topic locally, including a community newsletter suggesting residents might wish to donate the “cost” of their vaccine to such charities. More widely, Captain Sir Tom Moore’s remarkable fundraising was inspirational. There are concerns that people without much cash may feel a moral obligation to contribute, perhaps even confusing these charities with the NHS itself. But, as our health service is state funded, a more fundamental question is at stake: what purpose are these charities intended to serve?

You might expect charitable funds to be earmarked for optional extras—artwork, treats. However, the website of the umbrella organisation for NHS charities states that in recent years they’ve funded “major capital projects, pioneering research, and medical equipment at our hospitals, helping patients access the best possible care when they need it most.” Isn’t this what core NHS funding is meant to do?

We must be careful not to let our gratitude to the people who work so hard in our NHS obscure the NHS’s founding principles. Above all, let’s celebrate the fact that, back in 1948, we moved beyond the need for charity.

Palliative care in the covid era

The latest Second Wave podcast focuses on palliative care during the pandemic, with this week’s special guest, Rachel Clarke, author and palliative care specialist, discussing how the specialty has changed:

“In a really profound sense, covid-19 has changed everything. We, as a specialty, try to deliver care that is in part hard medicine—it’s the right drugs for symptoms, it’s the right interventions. But it’s also partly a presence and a relationship at the bedside that helps a patient approaching the end of their life feel as though they’re supported, they matter, they’re not alone.

“And of course the one, perhaps the greatest, cruelty of covid-19 is the way in which it forces barriers between people at the one time when we need each other the most—when we’re frightened, vulnerable, and even at the end of life.”

Tackling hospital tech

This week the Sharp Scratch team talk about all the tech you might face working in the NHS—from bleeps and fax machines to slow computers. Chidera Ota, a junior clinical fellow in neurosurgery, talks about why IT can be frustrating.

“As much as I can, and likely will, complain about the tech in this episode, for my second foundation year, I worked at a hospital where we used paper notes for the most part, and I’ll tell you when it’s missing, you definitely feel it. It’s painful. But then even when it is there, and you’re able to prescribe and write patient notes online, it’s so clunky that you just think who made this and have they ever stepped foot into a hospital, have they ever worked with doctors before, because this just doesn’t make any sense.”
Will calorie labels for food and drink served outside the home improve public health?

Assessment of effectiveness of labelling policies needs to look beyond consumer behaviour, argue Eric Robinson and colleagues

The UK government first proposed mandatory calorie labelling of food and drink served outside the home in England in 2018. Although a consultation took place, no policy has yet been enacted. The increased risk of serious illness and death among overweight people with covid-19 led to the announcement of renewed plans for mandatory calorie labelling in July 2020, alongside other measures targeting the marketing of unhealthy food and a mass media weight loss campaign.

However, consumer behaviour studies suggest that calorie labelling may have at best a modest effect on calories ordered when eating out. Yet, here we argue that calorie labelling may affect diet and obesity through multiple other mechanisms. Only a global lens on potential mechanisms of effect, will allow us to judge its role in improving public health.

**KEY MESSAGES**

- UK government has proposed mandatory calorie labelling of food and drink served outside the home to help reduce obesity
- Evidence suggests calorie labelling may have little effect on what food people choose when eating out
- Calorie labelling may achieve public health effects through other mechanisms, such as stimulating product reformulation
- Researchers and policy makers should look beyond direct effects on consumer behaviour when judging the potential of mandatory calorie labelling policies on public health

Excessively calorific meals

Public Health England estimates that UK adults consume 200-300 calories a day more than they need to maintain a healthy body weight. Some of these excess calories come from sources outside the home—outlets such as takeaways, restaurants, and cafes, where food or drink is ready for immediate consumption.

Less than 20% of UK restaurant chains were voluntarily providing instore calorie labelling in any form in 2018. This lack of information may be particularly problematic given the energy content of food served out of the home. We recently found that 91% of main meals served in major UK restaurant chains contained more than 600 kcal—the energy content for a main meal recommended by Public Health England. Consistent evidence of easy availability of other food products (eg, beverages, desserts, side dishes) that are high in calories in the out-of-home sector has also been reported in the UK.

Evidence that consumers are unaware of the high energy content of the food they are purchasing and consuming outside the home has led to calls for mandatory calorie labelling. In the US, chains with more than 20 outlets nationwide are required to provide point-of-sale calorie labelling. Similar regulations have been implemented at a sub-national scale elsewhere. In 2018, the UK government proposed a mandatory calorie labelling policy for England, with a primary purpose to “ensure that consumers have the information they want in order to make informed and healthy choices.” Further details published in 2020 indicate that future legislation will make calorie labelling mandatory for businesses with over 250 employees on all items prepared and sold for immediate consumption. There will be a 12 month implementation period from the point of legislation, but the government has not stated the timing of the legislation.

Does calorie labelling change consumer behaviour?

If calorie labelling policies reduce the number of calories consumers select when eating out, they could benefit public health. For this to occur consumers need to pay attention to calorie information, understand it, and then be sufficiently motivated to change from a higher to a lower calorie choice.

Unfortunately, evidence suggests that, at best, labelling has a modest impact on calories purchased. Most reviews conclude that out-of-home calorie labelling does not result in significant changes to consumer behaviour (table 1). However, a recent Cochrane review and meta-analysis concluded, on the basis of three low quality studies conducted in the US, that there is weak evidence of a modest effect, with calorie labelling resulting in a reduction of 47 (95% confidence interval 79 to 15) kcal purchased per meal. A recent observational study in a US fast food franchise found a reduction of 60 kcal (95% CI 72 to 48) per transaction immediately after implementation, but over the following year this fell to 23 kcal per transaction. Although these effects are not insubstantial, the small number of low quality studies available makes conclusions tentative at best.

Furthermore, most studies are from the US, and cultural differences may limit their generalisability. More recent studies in England found labelling had no significant effect on calories ordered. Nevertheless, a calorie labelling policy could still benefit public health through other important mechanisms.
Calorie labelling and industry behaviour

One of the most important alternative mechanisms of effect may be industry reformulation, including portion size reduction and new product development. The UK soft drinks industry levy provides a good example of how a public health policy can influence industry behaviour. This levy on manufacturers and importers of soft drinks has two tiers: a lower one for drinks with more than 5 g sugar/100 mL and a higher one for drinks containing more than 8 g/100 mL. The levy was announced two years before implementation to allow the soft drinks industry time to adjust.

Recent evidence indicates a substantial reduction in the sugar concentration of soft drinks in the months leading up to introduction of the levy, with the percentage of drinks with more than 5 g sugar/100 mL falling from 69% to 15%. There was some evidence of manufacturers reformulating “to target,” with new peaks in the distribution of drinks with a sugar concentration just below each levy threshold.

In the context of the out-of-home food sector, mandatory calorie labelling may lead to businesses being required to reveal information to their customers that they consider to be damaging to their reputation and profits. Potential responses to reduce these risks include reducing the number of calories in existing products, reducing portion sizes, and introducing new, lower calorie products. The most direct evidence in support of these effects is from a meta-analysis of predominantly US studies, where the introduction of out-of-home calorie labelling resulted in significantly fewer calories in the average dish (−15 kcal; confidence intervals not reported).

Importantly from a public health perspective, reducing the calories in available dishes bypasses the requirements for the conscious attention, understanding, and motivation required by individuals to change consumer behaviour. However, public health benefits depend on purchasing behaviour and consumption behaviour being aligned and people not compensating with increased calories elsewhere in their diets. Even a relatively small reduction in calories consumed per person through this mechanism could result in valuable benefits to population health when applied to the large proportion of the population who regularly eat outside the home.

Because many people are partly motivated by health and weight when making dietary decisions, other theoretical effects of mandatory out-of-home calorie labelling with the potential to benefit public health include raised awareness of calories consumed not just outside the home but also elsewhere, resulting in changes in purchasing and consumption across the diet; changes to the types of outlets visited (eg, avoiding outlets selling very high calorie meals); and reduced frequency of visits to out-of-home outlets. These speculative effects have received little, if any, research, and no attempt has been made to consider all of them in concert.

Table 1 | Summary of recent evidence reviews on calorie labelling

<table>
<thead>
<tr>
<th>Review</th>
<th>Analysis methods</th>
<th>Evidence summary</th>
<th>Main conclusions</th>
<th>Countries of included studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kiszlo et al (2014)</td>
<td>Systematic review and meta-analysis</td>
<td>Ineffective</td>
<td>“Overall the best designed studies show that calorie labels do not have the desired effect in reducing total calories ordered”</td>
<td>US, Canada</td>
</tr>
<tr>
<td>VanEpps et al (2016)</td>
<td>Narrative synthesis</td>
<td>Unclear</td>
<td>“Overall, the evidence regarding menu labelling is mixed, showing that labels may reduce the energy content of food purchased in some contexts, but have little effect in other contexts”</td>
<td>US</td>
</tr>
<tr>
<td>Bleich et al (2017)</td>
<td>Systematic review and meta-analysis</td>
<td>Unclear</td>
<td>“Because of a lack of well-powered studies with strong designs, the degree to which menu labelling encourages lower-calorie purchases and whether that translates to a healthier population are unclear”</td>
<td>US</td>
</tr>
<tr>
<td>Crockett et al (2018)</td>
<td>Systematic review and meta-analysis</td>
<td>Effective</td>
<td>“Findings from a small body of low-quality evidence suggest that nutritional labelling comprising energy information on menus may reduce energy purchased in restaurants”</td>
<td>US</td>
</tr>
</tbody>
</table>

Reviews summarising the effect of calorie labelling on calories ordered when eating out of the home, published from October 2014 onwards. Where reviews included both laboratory and real world data, conclusions quoted refer to real world data only. Most studies included in the reviews measure energy ordered and not consumed, so influence on energy consumed (eg, not consuming all of a high calorie meal) may differ.

Considering unintended consequences

Uncertainties concerning the likely effects of mandatory calorie labelling reinforce the need for a wider evaluative perspective than taken previously. This should include unintended consequences with the potential to undermine any benefits for public health.

For example, if calorie reduction is achieved by redesigning recipes, salt content may increase to maintain palatability. Likewise, if mandatory calorie labelling threatens profits (eg, because of the cost of implementation, as has been suggested by industry groups) then businesses may increase marketing to offset this. Even if labelling leads to reduced calories consumed from out-of-home food outlets, if these are substituted elsewhere in the diet then there may be little overall health benefit.

Another potential unintended consequence of mandatory calorie labelling is on health equity. People living in less affluent circumstances are less likely to report considering calories when making food choices. Thus, any positive effects of providing calorie information on consumer purchasing...
behaviour may be more exaggerated in more affluent groups and so widen existing socioeconomic inequalities in diet and obesity. However, if diners living in more affluent circumstances are already calorie conscious and avoiding higher calorie options, reformulation may have most benefit for those living in less affluent circumstances and so help to narrow inequalities.

Although it may not be practical to consider all of these effects in a single evaluation, the evidence to date has lacked a wider perspective on the possible effects of mandatory calorie labelling on, among other things, business behaviour, total diets, and inequalities. As evidence of some effects (eg, changes in consumer behaviour) becomes more consistent, researchers should be encouraged to focus on unanswered questions and integrating findings across contexts to determine which findings are and are not generalisable. Table 2 highlights research priorities for evaluations of the public health effects of mandatory calorie labelling in the out-of-home food sector.

### Table 2 | Unanswered questions about calorie labelling in the out-of-home food sector and how they could be answered

<table>
<thead>
<tr>
<th>Question</th>
<th>Research method</th>
</tr>
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<tbody>
<tr>
<td>Does calorie labelling have differential effects on calories purchased, based on type of business</td>
<td>Observational research examining purchases before and after implementation in a range of business types (eg, fast food outlets, full service restaurants, coffee shops, takeaway food) introducing calorie labelling (to examine change over time) and if possible in businesses not introducing calorie labelling (to examine change unrelated to introduction of labelling)</td>
</tr>
<tr>
<td>Does calorie labelling have differential effects on calories purchased, based on population subgroups, such as higher versus lower socioeconomic groups and people with healthy weight versus overweight and obesity</td>
<td>Field research using customer intercept questionnaires at food outlets (stratified by geographical region to ensure population representativeness) examining purchasing behaviour before and after implementation of calorie labelling</td>
</tr>
<tr>
<td>What effect does calorie labelling have on other behaviours when eating out?</td>
<td>Survey research examining consumer behaviour (eg, types of out-of-home food sector businesses visited, frequency of meals consumed in the out-of-home food sector) and analysis of market trend data before and after implementation of calorie labelling</td>
</tr>
<tr>
<td>What other effects does calorie labelling have on individuals, away from the out-of-home food sector?</td>
<td>Analysis of population level data (eg, National Diet and Nutrition Survey) characterising trends in daily energy intake and physical activity before and after implementation of calorie labelling</td>
</tr>
<tr>
<td>In what ways does calorie labelling affect industry behaviour (eg product reformulation, new products, and marketing)?</td>
<td>Surveillance work characterising nutritional content of products sold (through self-reported nutrition information from businesses or laboratory measurement) and marketing activities before and after implementation of calorie labelling</td>
</tr>
<tr>
<td>What are the wider effects of calorie labelling on industry?</td>
<td>Macro and micro economic evaluation of calorie labelling interventions</td>
</tr>
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### Obesity has been a slowly developing public health problem, and to date the UK has made no progress on reducing obesity

**Policy context**

Even if mandatory calorie labelling provides a small measurable public health benefit at the population level, it should only be one part of a multicomponent obesity strategy. Obesity has been a slowly developing public health problem, and to date the UK has made no progress on reducing obesity. This, alongside the complex and changing nature of the systems that contribute to obesity, means that quick fixes are unlikely. Instead, a wide ranging portfolio of policies and interventions that evolve over time will be required to bring about reductions in obesity.

The mechanisms we have outlined are not the only ways that mandatory calorie labelling could contribute to national and global obesity control efforts. Although information provision interventions like food labelling have been criticised by some as being weak public health strategies, they could support further policy action. By highlighting the problem of the energy content of food sold in the out-of-home sector, calorie labelling may prompt further action simply by raising awareness. Furthermore, in a few years, if it is thought that mandatory labelling has led to insufficient gains to public health, this failure itself could prompt further action.

Globally, only the US has introduced nationwide mandatory calorie labelling in the out-of-home food sector. Its introduction in England will provide a further case study to enable the generalisability of US findings to be explored. If findings are consistent, the policy could be extended to smaller business in England and inspire other jurisdictions to follow suit, leading to global as well as national benefits. However, if evaluations of calorie labelling focus on consumer responses alone and do not consider wider effects, enthusiasm for wider adoption of mandatory calorie labelling policies may be prematurely cut short. The public health research and policy communities should be supported and encouraged to move on from asking what effect calorie labelling has on consumer behaviour to ask wider questions about its overall effects on population health through other mechanisms.
**Patient access to electronic health records**

New ruling mandates full and free access for US patients

On 5 April a new federal rule will require US healthcare providers to give patients access to all the health information in their electronic medical records without charge.\(^1\) This new information sharing rule from the 21st Century Cures Act of 2016\(^2\) mandates rapid, full access to test results, medication lists, referral information, and clinical notes in electronic formats, on request.

The US is not alone in providing patients with full online access to their electronic health records. In Sweden, patients gained access to their records between 2012 and 2018.\(^3\) Estonian citizens have had full access since 2005.\(^4\) The sharing of personal health information isn’t without precedent in the US: around 55 million people already have access to their online clinical notes,\(^5\) and many more have access to laboratory results and other parts of their records. But for some US clinicians, the new rule may feel like a shock.\(^6\)

To patient groups, however, it is the culmination of 25 years of advocacy and relationship building with clinicians, researchers, and policy makers. Back in 1996, the Health Insurance Portability and Accountability Act gave patients the legal right to request and receive copies of their records,\(^7\) but this takes time, effort, and money.\(^8\) The new information sharing rule will enable anyone receiving free healthcare in the US timely access to both ambulatory and inpatient care records through secure online portals. The new legislation also stipulates that people should be able to download their data to third party digital applications (apps) and aggregate all their health records into their digital platform of choice by October 2022, allowing people to share health information with anyone involved in their care.

Studies show that patients who read what is written about them by clinicians feel more involved in and knowledgeable about their care, feel better prepared for visits, and report being more likely to follow their clinicians’ advice.\(^9\) These results are consistent across ethnic groups, gender, socioeconomic status, and education, and the same benefits accrue to family caregivers.\(^10\)

As with all innovations, some concerns have been raised. The rule requires all test results—including imaging and pathology reports—to be released without delay. Some people may therefore learn of a cancer diagnosis, for example, from an online health record alert rather than during a conversation with a clinician.\(^11\)

As the US moves to a more transparent health record ecosystem, there will be an opportunity to elicit patients’ views and experiences of the benefits and risks of receiving test results in real time. In the future, it should be possible to ensure patients have a choice over how and when they receive health information.

**Benefits and risks**

Patients have much to gain from the new rule on information sharing. Around 80% of internet users search for health information online\(^12\); combining these searches with personal health information from the medical record is likely to result in more accurate, relevant, and useful information. On the other hand, legitimate concerns include a greater infringement of online vulnerability associated with search engines collating and selling medical data that people now provide freely without fully comprehending the long term consequences.\(^13\)\(^14\)

A further concern is that the new US rule allows clinicians to block information. Recognising that this discretionary right may be misused, the US Department of Health and Human Services has established an online reporting system for “information blocking”—that is, hiding information from patients.

Finally, the new rule still does not change who owns health records outright. Records remain the property of hospitals or doctors in half of all US states. Laws in the remaining states view records as having shared ownership with patients.

US healthcare organisations may choose to comply with the rule, or they may simply keep quiet about it and hope patients don’t notice their new rights. Choosing to keep quiet would be a mistake. Full sharing and transparency of personal health information should strengthen patient-clinician communication, raise health literacy, promote self-management, enhance teamwork, and increase trust.

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LETTERS

Self-isolation is the weakest link

At last the weakest link in the chain of covid-19 transmission—self-isolation—is getting the attention it deserves (Editorial, 30 January). Cevik and colleagues say that “risk of household transmission within crowded and otherwise inadequate housing intersects with financial barriers to isolation and inability to work from home.” In other words, given the practical difficulties associated with self-isolation in a confined space with shared facilities and several household members, the net effect of self-isolation across the population might be increased transmission. The new variant will have amplified that possibility. We know that at least 60-70% of transmission is within households, 10 times more than any other single route. This was also true outside lockdown periods.

At current rates of community transmission, “managed isolation” (providing alternative accommodation for all cases) looks unfeasible. An alternative, which is no more than an extension of existing policy, is to make the unit of self-isolation not the individual but the household, so that all those living under the same roof as the case self-isolate for 10 days or until the last household member has a negative test result, whichever is later. Financial compensation should be related to household size. A one-off early payment might be an incentive to all to maintain social distancing in the house. There could be a threshold for supplementary compensation in cases of extreme serial household infection. Other support, material and psychological, will be needed, especially when self-isolation stretches beyond the minimum 10 days.

At the very least, SAGE should commission modelling of the current approach to estimate the size of the effect of different rates of self-isolation on overall transmission. We should do all we can to exclude the possibility that this key covid-19 control intervention has any unintended, or even regressive, effects.

Michael Gill, former regional director of public health, London
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FEELING SAFE WORKING ON FRONT LINE

Doctors faced with impossible rationing decisions

We do not share the optimistic view of the barrister quoted about the potential for pandemic related complaints (This Week, 30 January).

Although state indemnified and not financially responsible for claims relating to covid-19 treatment, doctors would still have to give evidence and face the anxiety of having their clinical work criticised and decisions questioned, even though they are treating patients in extraordinary circumstances. This is one reason the Medical Defence Union thinks that the NHS and NHS healthcare professionals should be exempt from covid-19 related clinical negligence claims.

Doctors faced with impossible rationing decisions can contact the Medical Defence Union or their own medical defence organisation for advice, 24 hours a day. Doctors should not withdraw treatment from a patient who needs it, with the aim of providing it to benefit another. If faced with this dreadful dilemma, which we hope won’t arise, they must seek legal advice.

Christine Tomkins, chief executive, Medical Defence Union
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Reciprocal understanding among decision makers

When rationing care in a pandemic, individual clinicians might decide to provide or withhold care from individual patients. This might be based on clinical judgment, but people under pressure tend to show their unconscious biases.

Public health experience across patient populations can shape guidelines and decision aids. My favourite approach, across hospital and community settings, was having a health benefit group to plan a range of linked services and share out resources. But clinicians in acute settings were reluctant to accept epidemiological approaches that included groups of patients that they, personally, never saw. That lack of trust might have been related to the different ethics of caring for individual patients and planning for populations.

The more difficult the choices that need to be made, the more important it will be to have reciprocal understanding among the decision makers: in healthcare management, in clinical teams, and in population health.

Woody Caan, retired professor of public health, Duxford
Cite this as: BMJ 2021;372:n462

COVID-19 REINFECTION: THE STORY SO FAR

Defer vaccination of people who have had covid-19

Vaccine is in short supply, and trial evidence is being overlooked to deliver one dose instead of the recommended two. Why not save millions of doses by deferring the vaccination of people who have already been infected and have greater immunity than is delivered by a single dose (Briefing, 30 January)?

About 3.7 million people in the UK have had confirmed infection. They are unlikely to get it again this season. Of the 80 million people with proven infection globally, 31 have been confirmed as reinfected, showing that immunity is remarkably strong for at least six months. People who have recovered from covid-19 could deliver essential services, given their reduced risk.

Is vaccinating people who already have partial immunity a priority in this critical period? If not, we can save vaccine, money, and person power and focus on those who have no immunity from either previous infection or vaccination.

Raj Bhopal, emeritus professor of public health, Edinburgh
Cite this as: BMJ 2021;372:n465
OBITUARIES

Raymond Lambert Hurt
Consultant cardiothoracic surgeon (b 1922; q St Bartholomew’s Hospital, London, 1944; FRCS (Eng), DHMSA), died from old age on 13 November 2020
Raymond Lambert Hurt was appointed senior registrar at Barts and was awarded an Evarts Graham scholarship to work for a year at Stanford Hospital, San Francisco. In 1958 he organised open heart surgery at Barts, which became established in 1960. He was appointed a consultant thoracic surgeon at the North Middlesex Hospital in 1959 and later moved to Barts. He was Hunterian professor at the Royal College of Surgeons in 1981. He retired in 1987 but embarked on a second career as a medical historian and completed an acclaimed History of Cardiothoracic Surgery in 1996, and a biography of George Guthrie in 2008. Predeceased by his wife in 2001, whom he had married in 1963, he leaves two children and a devoted partner, Carmen Beal.
Raymond Lambert Hurt
Cite this as: BMJ 2020;371:m4792

Abiola Olamide Aiyenigba
Postdoctoral researcher (b 1977, q Ago-Iwoye, Nigeria, 2004; PhD), died from acute gastrointestinal haemorrhage on 21 July 2020
Abiola Olamide Aiyenigba (née Adelowo) initially studied food science before medicine at Obalisi Onabanjo University. After a spell in general practice in Edinburgh, she joined the University of Liverpool’s Sanyu Research Unit in 2013 to undertake a part time PhD about psychological support for infertile Nigerian couples. The detailed manual for FELICIA (the Fertility Life Counselling Aid), named after her beloved mother, is now published. Abiola was an integral part of the unit for over six years and was quick to extend her generous support to colleagues. She had recently moved to the Liverpool School of Tropical Medicine. Abiola was a bright and warm researcher, wife, and mother, and we will miss her greatly. The legacy of her work will live on. She leaves her husband, Tola, and son, Levi.
Abiola Olamide Aiyenigba
Cite this as: BMJ 2020;371:m4807

Kenneth Kaye
General practitioner (b 1928; q Sheffield 1958), died from frailty and old age on 21 November 2020
Kenneth Kaye (“Ken”) joined the Royal Air Force from school to train in electronics. He was stationed near Eastbourne, where he was seriously injured in a motorcycling accident. He spent two and a half years in Eastbourne Hospital, where his legs were saved from amputation. This inspired him to train in medicine. In 1956, Ken married Brenda, and they had two sons. In 1960 he founded the Goldthorpe Group Medical Practice, where he was the senior partner until he retired from general practice at the age of 60. Ken was involved in motor racing, played golf, enjoyed salmon fishing and amateur photography, in addition to owning a successful racehorse. Ken was a supporter of several charities, the most notable of which was the Leukaemia Research Fund. He leaves his family.
Kenneth Kaye
Cite this as: BMJ 2020;371:m4793

John Barter
General practitioner (b 1954; q Cambridge 1980; MRCGP, DRCOG, DCH), died from cholangiocarcinoma on 16 August 2020
John Barter was admitted to St John’s College, Cambridge, aged 17 to study veterinary medicine. After a tour to the Lofoten Islands to study the connection between avian and human influenza, he went to University College London to do a conversion course to human medicine before training at St Thomas’ Hospital. He married Judith in 1982, and he joined the Rowden Medical Practice in Chippenham in 1985. He developed an interest in geriatric medicine, and later became an integral part of the stroke unit at St Andrew’s Hospital, which received national recognition. John continued to travel, walk, ski, and row competitively during his terminal illness. He and Judith had three children, one of whom died in infancy. He leaves Judith, two children, and grandchildren.
John Barter
Cite this as: BMJ 2020;371:m4791

Edward Robert Williams
Consultant physician Nuneaton and Coventry (b 1935; q Peterhouse College, Cambridge, 1960; MA, MD, FRCP), died from metastatic carcinoma on 27 March 2020
Edward Robert Williams (“Ted”) was appointed as a general physician and neurologist, one of the last, at the newly built Walsgrave Hospital in Coventry and George Eliot Hospital in Nuneaton. After more than a decade juggling acute medicine at separate sites, he moved to Nuneaton full time and combined acute medicine with setting up a multidisciplinary diabetes service. He worked hard for patients with chronic illnesses. He was involved in management throughout his career. Ted had a fine strong bass voice and played the trombone. He became an enthusiastic bell ringer in retirement and played with the village swing band. He enjoyed travelling and quizzing, took up Scuba diving in his 50s, and loved rugby. He leaves his second wife, Angela, and his four children.
Edward Robert Williams
Cite this as: BMJ 2020;371:m4794

John Thomas Anderson
Chief of service James Cook University Hospital, Middlesbrough (b 1941; q University College London 1965; CBE, FRCS Ed), died from a stroke on 6 August 2020
After finishing his studies in London John Thomas Anderson returned to his native Teesside and married Elfrieda. He noticed a poster recruiting medical doctors for the Royal Air Force and saw this as a way of combining two of his passions. Early postings as a medical doctor included stints in Aden and Bahrain. Around 1975 he returned home and worked as consultant orthopaedic surgeon at Middlesbrough General Hospital and then moved to the new site, the James Cook University Hospital. In 2004 he was appointed a CBE for services to medicine. Serving the people of his hometown was an honour. John explained complicated procedures and patients valued his approachability and his reassuring nature. He leaves his wife, Elfrieda, and five children.
John Thomas Anderson
Cite this as: BMJ 2020;371:m4790

Nicholas Whyatt, Ian Grandison
Cite this as: BMJ 2020;371:m4791

Angela, and his four children.

Angela Williams, Jessica Butcher
Cite this as: BMJ 2020;371:m4794

Andrew Weeks
Cite this as: BMJ 2020;371:m4807

Rachael Martin
Cite this as: BMJ 2020;371:m4790

Tim Kaye
Cite this as: BMJ 2020;371:m4793

Theobald Barter was admitted

BMJ | 27 February 2021

335
Tony Gershlick
Pioneering cardiologist

In 2017 Gershlick received the inaugural lifetime achievement award of the British Cardiovascular Intervention Society. He carried on working until he became fatally ill and died in the Leicester hospital he had worked in for 30 years—only a fortnight earlier he had been out running.

Posted only three days before his death, his last tweet reflected a lifelong commitment to robust data. He implored a fellow tweeter: “It can only be hypothesis generating. Don’t over-interpret.” His passion for figures was seen, wrongly, to be at odds with his talent and love of painting people pictures.

His impish sense of humour shone out of his Twitter biography: “A jazz interventionist specialising in coronary reconstruction.” Taking time out from clinical and lecturing commitments, he played the alto saxophone all over the world—from Washington, DC, to Johannesburg.

His many visits to South Africa included a three month professorship, where he was acclaimed—as all over the world—for his generosity and as an outstanding mentor and teacher. His initial learning difficulties may have made him a more empathetic teacher. He taught generations of interventionists.

Early life and career
Young Tony was one of three siblings whose parents—his father was a bakery delivery driver and his mother did multiple jobs—worked long hours to enable them to go to university.

His many visits to South Africa included a three month professorship, where he was acclaimed—as all over the world—for his generosity and as an outstanding mentor and teacher. His initial learning difficulties may have made him a more empathetic teacher. He taught generations of interventionists.

Interventional cardiology
His many achievements included practice changing studies into ways of delivering drugs on to stents to cut unwanted tissue response and a ground breaking publication in 1996, showing the efficacy of drugs given locally in this way.

He was especially proud of the React trial, published in 2005 in the New England Journal of Medicine. This answered the critical unresolved question of what to do with patients who had failed thrombolysis. Part of what made it special for Gershlick was that it was the first trial where UK interventionists had worked together in such a way. His fellow collaborators included Nick Curzen from Southampton and Adrian Banning from Oxford.

Curzen explained: “It was the React trial that first inspired a generation of academically minded interventionists to believe that the UK could produce high quality trials of this type. Tony was an ambassador for interventional cardiology both in the UK and abroad, and paved the way for many others.”

Gershlick’s angioplasty training continued at the London Chest Hospital under two of the specialty’s most innovative men, Raphael Balcon and Martin Rothman. In 1989 Gershlick moved to Leicester, where he became a consultant at Glenfield Hospital. In 2009 he became professor of interventional cardiology at the University of Leicester and an honorary hospital consultant.