NHS diversity progress needs laws and fines

It’s that time of the year again—when the Workforce Race Equality Standard programme publishes its data. And, like clockwork, it’s also time for the annual soul searching, and pledges to improve. In due course we’ll have webinars or perhaps a dedicated hashtag campaign—someone may even throw in a TikTok video. And then we’ll move on, until next year.

If you want to convince yourself of improvement, let your confirmation bias take over and you’ll find some bits to help you: 10% of NHS trust board members are now from minority ethnic backgrounds, up from 7% in 2017. And 21% of staff in trusts and clinical commissioning groups in England are now from a minority ethnic background, up 2.9 percentage points since 2017. Surely cause to rejoice? I suspect it depends on your outlook—on whether you think continuing with the “Please sir, may I?” approach will deliver results. Or whether you recognise that, in 2021, after all the datasets and evidence about outcomes in the pandemic, we’re way past the time for soul searching: we need to recognise that the methods relied on to improve equality simply don’t work.

It’s worth noting that only about a third of CCGs submitted data—perhaps showing how important they find the datasets. White applicants were 1.61 times as likely to be appointed from shortlisting across all posts as ethnic minority applicants. This was worse than in 2019 (1.46), which itself was no improvement on the previous year. In fact, the past five years have seen fluctuation but no overall improvement in this measure. Let that sink in: no improvement in four years.

Just 40.7% of ethnic minority staff, compared with 88.3% of white staff, believe their organisation provides equal opportunities for career progression or promotion. The recent NHS staff survey shows even further evidence of the inequity, more pertinently during the pandemic. Ethnic minority staff bore the brunt, with 47% working in covid roles, compared with 31% of all staff. Those who reported facing discrimination rose from 16.5% to 19.4% in black ethnic groups and from 13.7% to 15.6% among Asian ethnicities. To add to the mixture, the few people from ethnic minorities who do make it to top positions in healthcare rarely speak publicly about systemic racism—that they see it daily but look away or feel powerless to intervene because of hesitancy, a need for career progression, or preferring to avoid controversy.

My tip to the NHS would be either to drop the charade—and use the money for something that may benefit lives—or to move beyond box ticking and bring in targets, regulation, accountability, financial penalties, and mandatory data collection. And, if progress is still incremental, hold people in leadership roles to account.

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Let that sink in: no improvement in four years
There are many questions still to answer in schools

Uncertainties over the risks of covid-19 in classrooms remain

Among the unknowns that have featured in the steep learning curve of our covid-19 year, the question of risks to (and from) children has been an ongoing area of uncertainty. At first, the conundrum that the young seemed so little affected by the virus prompted at least one world leader to pronounce they were “somehow immune.”

A year into the pandemic we have a much clearer perspective, especially from random testing surveys such as R, seroprevalence, and contact tracing studies. The overwhelming observation has been that children and adolescents are considerably less likely to be affected by severe disease or to be admitted to hospital. In transmission tracing studies, children are roughly half as likely as adults to become infected. While this is still the case, during the latest wave the age distribution of cases has shifted downwards.

In general, child and adolescent cases account for no more than a few per cent of reported, symptomatic cases and few severe or fatal cases. The difference may partly relate to the lower expression of angiotensin converting enzyme 2 in younger children. However, seroprevalence is similar between adolescents and adults, suggesting a high prevalence of asymptomatic spread in the former group. Since access to testing has mostly been predicated on the presence of case defining symptoms (and these have been defined in adults where they are likely to be more explicit), it is likely the caseload in children has been underestimated. This seems to be confirmed by comparison between unbiased population sampling (such as the React study) and symptom based surveys.

The presentation and immune profile in children who are admitted to hospital seems similar to the disease in adults. An exception is a small subset who develop multisystem inflammatory syndrome in children (MIS-C)—a disease of vascular involvement, shock, and strong T cell activation.

Potential hubs for super-spreaders?
Where does this leave us in terms of evaluating risks—both to and from children—around the return to school? The first point to consider is whether the high seroprevalence among adolescents offers potential hubs of super-spreaders for the community. Certainly, in those children who become sufficiently unwell for hospital admission, viral load reaches much higher levels than seen in adults, though it is unclear whether these are also seen in asymptomatic disease. While some contact tracing studies in schools identified relatively little spread, others show that teachers engaged in face-to-face teaching have roughly twice the infection risk of those teaching online. Also, the data indicate that jumps in the R value have followed term date restarts in countries where children have been at school during the pandemic. This scenario is reminiscent of the role played by children in transmission of winter flu—they are relatively unlikely to have severe disease, but can play a significant role in spread to the community.

Arguably the biggest unknown is the risk of developing long covid during asymptomatic spread in schools

Covid-19 has brought disruption, uncertainty, and pressure for doctors. In the first wave we were galvanised by feelings of community and pulling together. But it is different now.

The second wave has brought new challenges. As the caseload of sick patients accumulates, doctors are concerned about those whose care has been postponed as well as patients who don’t present at all.

In October, we concluded phase I of a Scotland-wide study on doctors' wellbeing. The doctors we studied experienced many changes at work, at home, and in their educational contexts, which have affected all aspects of their lives.

GPs as a group are usually reluctant to participate in this sort of study. A significant proportion, however, took part in ours. They reported finding new working practices and reduced patient contact highly challenging. Hospital doctors also highlighted notable changes to their working practices and patient pathways, as well as increased complexity of decision making. The cancellation of elective work and the effect this has on patients have exacerbated concerns.

Trainees also reported disruption to their education and training, while doctors across all career grades spoke of uncertainty about the future and told us they felt burnt out, stressed, and anxious. They also reported poor access to both formal and informal support, along with a perceived stigma around their use.

From our findings it appears that NHS employers have failed to demonstrate how
of around 10% and some research cohort studies that tend to put it considerably higher. The ONS data also indicate that around 79,000 of people in the UK with long covid are under the age of 19. Most of the symptoms described at www.longcovidkids.org are like those reported by adults: fatigue, shortness of breath, joint pain, rashes, and headaches.

Given the strong imperative to get children back into full time, face-to-face teaching, the key challenge is to maximally offset the risks of community transmission and paediatric cases of covid-19 and long covid. Analysis has shown that the protective impact of mitigation measures is cumulative as mask wearing, ventilation, regular testing, small class sizes, and spaced classrooms are added. The next few weeks will pose enormous logistical challenges. Luckily this is happening as we head into spring, with potential to make use of outdoor teaching and dining. After that, it will be time to start planning for the extension of vaccination programmes into schools.

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**ACUTE PERSPECTIVE David Oliver**

**Another chance to brief against the NHS**

On 9 February, with many patients still in hospital with covid-19 and hundreds of people dying daily, the Institute of Economic Affairs (IEA), a free market think tank, posted a report by its head of political economy, Kristian Niemietz. He argued that public respect and gratitude for the NHS’s pandemic response was irrational and that its performance both during and before the pandemic had been “nothing special.”

Niemietz criticised three common narratives: first, that austerity policies had left public services unable to cope; second, that the NHS had been the star performer in the pandemic and we should be more grateful than ever for having it; and, third, the idea that globalisation was partly to blame and that we needed a greater return to community parochialism.

Turning to international comparisons, Niemietz praised the “Asian Tigers”—Hong Kong, Singapore, South Korea, and Taiwan—for having low covid deaths and minimising economic fallout. By contrast, he argued, the UK, Belgium, Italy, and Spain had struggled the most among high income countries. He said the best performers had low levels of public health spending; open, globalised economies; and no health system similar to the NHS. The worst performers, conversely, had high public spending levels and state funded health systems.

One problem with all this is that the IEA has repeatedly denigrated the NHS model in reports, using selective performance data. It is open about its small state, pro-market ideology and repeatedly cites insurance based, multiple payer, multiple provider systems as exemplars while ignoring high performing systems much closer to the NHS model. It also relies on funding from tobacco, and it has in the past taken funding from gambling, sugar, soft drinks, and alcohol industries.

First, many countries with low covid mortality achieved this with considerable state intervention. They focused on non-pharmacological interventions including behaviour modification, lockdowns, and support for people in isolation—alongside well organised testing, tracing, quarantine, and travel restrictions. Second, Japan and South Korea had similarly successful pandemic responses, as did Australia, Canada, and New Zealand. The US did not—and yet it has a highly marketised system.

Japan’s public spending as a percentage of GDP is low by western European standards. But Australia, Canada, and New Zealand approach UK levels. High performing European countries such as Denmark, Finland, and Norway are also high state spenders. They all spend on healthcare in a similar range of GDP percentage or dollars per capita to the countries Niemietz criticised.

I suspect what really bothers the IEA is the British public’s persistently proud, emotional—and, to the IEA, illogical—support for the NHS. This is a big obstacle to the market models it is lobbying for.

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**Many countries with low covid mortality achieved this with considerable state intervention**
Protocols and plastic aprons

Having a particular, set way of doing things can be useful. Following a protocol means the whole team knows in advance what’s meant to happen. The steps will have been thought through, and if we adhere to them the likelihood of a safe outcome is increased.

This is the ideal. In general practice, however, protocols seem to have multiplied without any obvious commensurate rise in patient safety. Checking our shared drive this week, I discovered that we have (among others) an assistance dog protocol, a panic alarm protocol, and one about how to respond to sudden illness in the practice. No one would argue against having a well thought out strategy for any of those, but the problem with many written protocols is that they remain just words on a page. I’ve probably read all of my surgery’s protocols, but they clearly haven’t stuck in my brain. It’s also possible that they were created merely to satisfy the Care Quality Commission so that, if it asked us, we could say “yes.”

This isn’t an argument against protocols in themselves—more an objection to accumulating vast numbers that are written and forgotten. All staff may be required to tick a box to say that they’ve read them, but unless these procedures are rehearsed, discussed, and owned by everyone in the practice they serve little purpose. The vital ones must be revisited regularly so when you need the panic alarm, or a patient collapses, you don’t have to stop to look up the protocol.

When a protocol languishes in cyberspace it looks as if we’re just covering our backs: a fig leaf, contributing as little to patient safety in the surgery as the original ones added to modesty in the Garden of Eden. It always puzzles me when we, as doctors and people of science, continue to do things with no useful purpose. We now know that the SARS-CoV-2 virus is airborne, yet we persist in wearing flimsy plastic aprons over our scrubs. I’ve yet to meet a single primary care doctor who believes these provide any protection, yet we continue to don them obediently before each patient contact and add them to the toll of plastic waste each day.

Perhaps there’s little active harm in writing protocols that are immediately forgotten, or wearing pointless plastic pinnies, but there is an opportunity cost. Could the time spent writing the protocol have been better used? If we weren’t faffing about with plastic aprons, might we be more focused on opening the windows? We could also consider the deeper impact: what effect does repeatedly doing something that we know to be pointless have on our self-image as rational humans and scientists?

If we weren’t faffing about with pinnies, might we be more focused on opening the windows?

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Inside the Joint Committee on Vaccination and Immunisation
Anthony Harnden, GP, academic, and member of the UK’s Joint Committee on Vaccination and Immunisation, takes us inside the committee’s decision making in the latest Talk Evidence podcast. Harnden explains what evidence they look at, how they assess it, and what the next year of vaccination may look like:

“My personal view is that we are going to need a booster vaccine in the autumn and there are a number of reasons for that. One is that there are going to be new variants circulating. Without any doubt this virus is mutating, and we’re going to have to look very carefully at giving a booster vaccine to prevent the variant which is circulating at the time. The other thing is that we don’t know how long the duration of protection is going to last, and we certainly don’t want to see a winter like we’ve seen this winter. If we’ve got new variants circulating and we’ve got dropping off levels of immunity due to the vaccination, then that becomes an imperative to do a booster.”

Sharp Scratch: overcoming the shame of the F word
Why is academic failure surrounded by so much shame and guilt for medical students? This week the Sharp Scratch panel are joined by Rakesh Patel, a clinical associate professor in medical education, to unpick this question and find out what support is available for students:

“When you’re talking about failing at medical school, it’s bound up in your sense of where you’re going and what you’re going to become. So in the long term, you see yourself becoming a doctor and achieving a sometimes lifelong ambition. But in the moment, if you’re not quite getting through or you’re struggling on a task, that can be difficult to manage when you’ve got that ideal.”
A consistent lesson from the covid-19 pandemic is the importance of a functional test, trace, isolate, and support system. The ability of people to isolate is foundational to this multipronged strategy, as it breaks chains of transmission and reduces infection rates in a population. Even the most effective mass testing and intense contact tracing systems have only marginal value if people who test positive and their close contacts are unable or unwilling to self-isolate.

Given the global rise in cases of covid-19 and the emergence of new variants, effective isolation remains critical to controlling the pandemic. We examined the approaches to supporting and monitoring isolation in countries with available data to help understand what works. Data sources included government reports and websites, peer reviewed articles, preprints, and news media reports.

**KEY MESSAGES**

- Inadequate financial support is a commonly cited factor for not following self-isolation or quarantine rules
- Comprehensive support models are required to make self-isolation or quarantine feasible
- Alternative accommodation should be made available for people who cannot safely isolate at home
- Locally delivered solutions and community engagement are highly effective, particularly for vulnerable or low income populations

**Self-isolation rates**

The limited evidence available suggests adherence to self-isolation is generally low, and both financial and logistical factors determine an individual’s ability to isolate. A series of online surveys conducted in the UK with more than 30000 participants found that only 18% of those who had experienced symptoms in the past seven days had not left home since developing symptoms, and only 11% of close contacts quarantined. These figures are far from the stated public intention to self-isolate and quarantine, at around 70% and 65%, respectively. Commonly cited reasons for failure to isolate or quarantine include childcare responsibilities, experience of pandemic hardship, low awareness of covid-19 guidance, and working in a key sector.

Self-reported ability to isolate was lower among ethnic minority groups and those with annual household incomes below £20 000 or savings of less than £100. Interim evaluation from the Liverpool covid-19 community testing pilot concluded that a major barrier to testing uptake—mostly in deprived communities—was the fear of not having adequate support to isolate. Similarly in Iran, although the ability to adhere did not follow the social gradient, people who considered themselves of lower social class were less likely to comply with social isolation measures because of a perceived lack of social support.

The reason for the difference between intent and actual practice of self-isolation is relevant in predicting compliance. In particular, people who have symptoms or positive results are more likely to isolate than their contacts. In the Netherlands, public intention to isolate at home was around 95% if they were to receive a positive test result, reducing to 84% if a member of their household had tested positive, and 43% if a close contact had covid-19. A Norwegian study found that 65% of people required to self-isolate had not done so, but compliance was significantly higher among people with symptoms than among those who were asymptomatic.

Public adherence to protective behaviours in the pandemic has been high, and for behaviours where it is lower—as in self-isolation—the intention to adhere is high, suggesting adequate support could help enable these behaviours.

Public trust in institutions is a key determinant of compliance with public health guidelines, especially in times of crisis. The west African response to the 2014 Ebola epidemic showed that mobilising local leaders and promoting community engagement helped build trust and improved the success of public health measures. In the UK, longitudinal analysis confirmed a relation between trust in government and intention to follow covid-19 guidelines, although similar analyses on reported behaviours are currently lacking.
Support measures

We use “support” to refer to financial or other measures that enable people to follow self-isolation or quarantine guidance for the stipulated period. Most of the countries we studied have mandatory isolation periods for Covid-19 of 10 to 14 days, with France (7 days and voluntary) and Vietnam (21 days and mandatory) notable exceptions (table, see bmj.com). The support packages offered across countries can be divided into four types: financial support, employment benefits, practical support, and comprehensive services.

Financial support—Some countries offer one-off payments to people who test positive for Covid-19 and their contacts to self-isolate. Among the most generous are Australia which offers up to A$1500 (£840), UK (£500 for those receiving government income support), and South Korea (£270). Taiwan offers £25 for each day spent in isolation to cases and their caregivers. The UK restricts payments to those who receive government benefits, whereas Singapore, South Korea, and Taiwan extend financial support to everyone required to isolate.

Employment benefits—These are commonly paid to those having to isolate, often alongside nominal allowances. Generally, these benefits can only be obtained by people who are employed or earn above a specified income level. In the UK, around two million low paid workers are not entitled to statutory sick pay of £95.85 a week.

Practical support can take the form of home visits or help with food, medication, and alternative accommodation. The French government mobilised health teams to conduct home visits for confirmed cases, advising them to self-isolate, offering antigen (rapid) tests for household members, and providing extra practical support. In the Netherlands, those isolating can contact local municipalities and the Red Cross for practical help.

Providing accommodation is particularly important given the heightened risk of household transmission and difficulties of isolating when living in large, crowded, and multigenerational households. In Denmark and Norway, local governments offer accommodation to anyone unable to isolate at home. In the US state of Vermont, housing policies enabling people to safely isolate from household members were considered central to its response. This involved strengthening existing infrastructure to provide comprehensive housing protection for vulnerable communities.

Comprehensive support—Local authorities in South Korea, Taiwan, New York (box 1), and San Francisco (box 2) offer comprehensive support for self-isolation. In South Korea, as well as one-off payments, people in quarantine are provided with daily necessities and sanitary kits worth around £40 and quarantine facilities if they cannot isolate at home. In Taiwan, local government centres offer transport arrangements, food delivery, medical care and household services, including accommodation for people without a residence. San Francisco’s “right to recover” programme provides eligible workers with two weeks of salary reimbursement at the minimum wage ($1285; £930; €1000), practical support, and alternative accommodation if required.

Monitoring self-isolation

Broadly, two mechanisms for monitoring isolation have been used with varying degrees of stringency: regular or random checks conducted in person or by telephone, and digital surveillance technologies. Checks are coordinated by local public health authorities or private sector staff and supported by the police.

To be allowed to isolate at home in Slovakia, people must install a mobile phone app that carries out random facial recognition checks and provides tracking information. Australia, Singapore, South Korea, and Taiwan also conduct digital surveillance of people who are quarantined through mobile phone apps, location based software, drones, video calls, and close circuit television as well as daily monitoring calls by local health teams. Violation can result in heavy fines and even prosecution. Other countries may find it harder to use digital surveillance measures. Countries in the Asia-Pacific region have a strong culture of surveillance combined with increased public trust in the government, whereas privacy laws in European countries and public attitudes towards governance and liberty may not support such measures.

Most countries fine people who are found violating isolation guidelines, and flouting the rules can result in imprisonment in Australia, Germany, Italy, Finland,
and Norway. In the absence of support, penalties alone are unlikely to encourage desirable behaviours during the pandemic. Given the material threat that covid-19 poses to individuals’ health, social support with a firm belief in collective responsibility is more likely to achieve constructive actions across communities.

A key feature of monitoring compliance in countries that have been comparatively successful in controlling transmission is that their systems are driven by local public health authorities with linked testing, contact tracing, and supported isolation efforts. In the UK, contact tracing under the Test and Trace service is divided between outsourced private companies and local health protection teams, while financial support for isolation is managed by local councils. Since the launch of Test and Trace, 98% of all contacts allocated to local health protection teams have been successfully reached, compared with 68% of those coordinated by the national call centre.

Without locally delivered solutions, individuals are only loosely instructed to self-isolate without support or monitoring. Improved coordination between local health protection teams, councils, and community organisations for test-trace-isolate efforts could lead to improved public trust, reporting of contacts, and adherence.

Do support interventions work?

Despite the scarce data on the effectiveness of isolation support measures, financial and comprehensive support seems beneficial. The Families First Coronavirus Response Act allowed some US employees (subject to eligibility criteria) to receive 14 days of emergency sick leave at full pay (limited by an upper threshold). This measure is estimated to have reduced the number of confirmed daily cases by 400 per state, or 1 case for every 1300 workers. In Israel, 94% of adults said they would comply with self-quarantine if they got financial compensation, dropping to below 57% in the absence of financial support.

While financial resources are important to enable self-isolation, wider support models are necessary to elicit high rates of adherence. Places that offer comprehensive support packages had high rates of adherence to self-isolation guidelines and few violations. In South Korea, the median number of people who quarantined was 36,561 a day, with around six violations recorded each day—a rate of 1.6 violations/10,000 self-quarantined people. Since the Asia-Pacific countries usually manage isolation through designated quarantine facilities, stringently monitored by healthcare workers, compliance is likely to be high. However, preliminary data from New York City showing high levels of isolation (box 1) indicate the effectiveness of comprehensive support.

Mutual aid groups—rapidly and widely developed to support vulnerable and shielded people to isolate—have helped protect community health and wellbeing. Requests to and activities of these groups show the needs of those in self-isolation and could be built to support isolation efforts, particularly through collaboration between local government bodies and community organisations.

Policies around self-isolation should be supportive and compassionate in acknowledging the challenges that people face. Although strategies centred around strict monitoring and penalties for violations have not been thoroughly evaluated, they may even be counter-productive, compromising testing uptake and honest reporting during contact tracing and eroding public trust. Regular reporting of self-isolation behaviours is also needed to monitor the effectiveness of test-trace-isolate systems.

Local government driven efforts are central to successful crisis management but remain a largely ignored tool. Being led by local health protection teams is an important, perhaps defining feature, of effective test-trace-isolate systems. The covid-19 pandemic presents many opportunities to improve links between local public bodies and community based organisations and to empower and mobilise community stakeholders to contribute to multiple aspects of the covid-19 response, including supportive strategies to encourage and facilitate self-isolation and quarantine.

Policies around self-isolation should be supportive and compassionate in acknowledging the challenges that people face. Although strategies centred around strict monitoring and penalties for violations have not been thoroughly evaluated, they may even be counter-productive, compromising testing uptake and honest reporting during contact tracing and eroding public trust. Regular reporting of self-isolation behaviours is also needed to monitor the effectiveness of test-trace-isolate systems.

The test-to-care model involves engaging with community members and local public health leaders in a densely populated and predominantly Latin American neighbourhood of San Francisco, California. This model, designed to support vulnerable, low income populations, has three support strands: information services, practical services (such as groceries, medication, hygiene products, and other necessities) and ongoing medical, social, and emotional support. Support is delivered by healthcare providers and community health workers.

Although its evaluation did not directly assess rates of isolation and quarantine, 65% of participants received support for the duration of the self-isolation period. In addition, around 1 in 10 participants disclosed more contacts than at the initial contact tracing interview.

The take care initiative aims to provide any resources an individual requires to safely observe their full self-isolation period either in a hotel or at home. This initiative is coordinated locally, with “resource navigators” from community organisations delivering a wide range of services, including financial help, food delivery, health insurance, medical kits, pet care, and mental health support across every neighbourhood. The support package has high acceptance, with only 2% refusing assistance.

Preliminary findings showed that local contact tracers were able to locate 82-87% of people at home during random monitoring visits (personal communication). Even among those who left their homes multiple times a day before symptom onset or a positive test result, around 90% reported not leaving their home during the self-isolation period. This figure is increasing as the initiative continues to strengthen, and adherence may be as high as 95%.

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LETTER OF THE WEEK

Fatal anaphylaxis: counting all cases

Baseggio Conrado and colleagues note that, although hospital admissions for food induced anaphylaxis rose between 1998 and 2018, the case fatality rate decreased over this period, from 0.7% to 0.19% (Research, 20 February).

Improved survival might result from better management, but misclassification of deaths should also be considered. Having evaluated deaths for the UK Fatal Anaphylaxis Registry (UKFAR), we raise these points:

Deaths from anaphylaxis might be mislabelled as asthma or as sudden and unexpected deaths and require systematic scrutiny. Mislabelling can occur when the trigger of the anaphylactic reaction is different from the known food allergens for that person. Patients with food allergies often restrict diets to reduce risk of exposure, which might increase the possibility of coexistent, undiagnosed food allergies. The cause of fatal anaphylaxis might not be accurately ascertained when the allergen is not on the mandated list of declared allergens. Variations in coroners’ practices might lead to allergy focused investigation being neglected. Late collection of gastric aspirate samples, for example, is unlikely to confirm the relevant allergen.

Optimising data collection is key. Timely specialist evaluations, relevant sample collection, and expert analysis are required. The importance of UKFAR has been emphasised at recent inquests. Founded in 1994, it is evolving into a collaboration between the British Society for Allergy and Clinical Immunology and Manchester University NHS Foundation Trust. It seeks support from multidisciplinary teams, including sudden unexpected death in childhood investigation panels, coroners, and the UK register of anaphylactic reactions.

Thorough investigations of fatal anaphylactic reactions will reflect UK trends more accurately and build on lessons from previous registry findings.

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Cite this as: BMJ 2021;372:n691

NSAIDS FOR MUSCULOSKELETAL PAIN

NSAIDs interact with lithium and antidepressants

Machado and colleagues review non-steroidal anti-inflammatory drugs (NSAIDs) for musculoskeletal pain (Therapeutics, 13 February). Some documented evidence shows a link between chronic pain and mental disorders, and patients who have a mental health diagnosis might be more likely to take drugs such as NSAIDs for pain relief.

Some evidence also indicates that NSAIDs can reduce the therapeutic index and precipitate the toxicity of drugs like lithium. NSAIDs can also act synergistically to precipitate bleeding with antidepressants; patients on lithium or antidepressants who are taking or about to start taking NSAIDs must inform their doctors for proper monitoring and dosing.

Praneeth Dara, specialty doctor, psychiatry; Olufemi Talabi, core trainee, psychiatry; Mounika Iderapalli, core trainee, psychiatry, Basildon

Cite this as: BMJ 2021;372:n679

BACKLOG OF PLANNED SURGERY

What efficiency do we want for the NHS?

Carr and colleagues discuss the growing backlog of planned surgery caused by covid-19 (Editorial, 20 February). Cataract surgery is the most common operation done in the NHS, usually provided by one of the smallest units in hospitals. The ophthalmology waiting list is likely to be longer than the ones mentioned.

The authors call for a leaner, more cost effective, and more flexible NHS, but it was the current leanest of the lean NHS that stopped surgery happening, as trained nurses were pulled to intensive treatment units and emergency trauma theatres.

Compared with the NHS, which runs at capacity (around 95%) for long periods, the German health system is designed to consistently run at a capacity of around 80%. This allows for maintenance and development in good times and capacity for emergencies during bad.

What efficiency do we want for the NHS, which covid-19 has shown us was dangerously lean to begin with?

Charles Diaper, consultant ophthalmologist, Glasgow

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COVID MUTATIONS AND PANDEMIC CONTROL

Honesty from politicians and scientists needed

The government is compelled to be optimistic about getting control over the pandemic in order to maintain the nation’s morale and help adherence to restrictions. On the other hand, scientists, by their very nature, are cautious. There is, however, a need to be honest. The coronavirus is mutating fast (News Analysis, 13 February) and it is likely that a strain will emerge that will ultimately render current vaccines ineffective.

There will be a cycle of mutation and vaccine development which will keep deaths down to an “acceptable” level. Vaccinations should not, however, be viewed as a magic bullet. No single intervention will get us out of this. If we are truthful then, perhaps for the next two years or so, social distancing, masks, and temporary restrictions will become the norm. If the public is told this more often and unambiguously, it will be better informed and more likely to adhere.

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Cite this as: BMJ 2021;372:n656
RECRUITMENT TO COVID-19 TRIALS

Fund nursing research studies
Darzi and colleagues call for better recruitment to SARS-COV-2 trials (Editorial, 6 February). Sadly, no mention is made of trials for nursing care.

No specific pandemic nursing care guidelines exist, and nurses remain unsure of the best way to care for SARS-COV-2 patients. In the absence of effective treatments, nursing care is the primary intervention patients receive. The only UK funded trial of a nursing care intervention for non-invasively ventilated patients has struggled to recruit sites and patient participants.

It is frustrating for the nursing profession when externally funded and well designed attempts to gather evidence are so far down the pecking order when research infrastructure support is allocated that desperately needed knowledge is delayed.

Most would agree that nurses are critical to patient recovery. Would they also agree that this care should be underpinned by best evidence and that these data are prioritised and collected as urgently as possible?

David A Richards, professor of mental health services research and head of nursing, Exeter
Cite this as: BMJ 2021;372:n601

Allow recruitment by those not previously involved in research
Before the pandemic, research activity had fallen in most specialties in England (Editorial, 6 February). The Principle study, with its full online consent and follow-up, has allowed recruitment by everyone in healthcare, including those not previously involved in research.

Primary care covers every medical condition and almost every patient in the UK. A trusted GP often knows the patient over many years, and they hold comprehensive healthcare records. This leads to higher rates of recruitment from direct GP contact. However, it is who undertakes the research, rather than who recruits, which determines funding. Both should be considered by the Clinical Research Network.

More support from staff embedded in primary care is needed, but the financial risk to GPs is significant. Improved models include funds to offset costs and risk.

We need more research emerging from primary care. Enhanced support is required to get primary care questions converted into research questions.

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Cite this as: BMJ 2021;372:n599

SELF-ISOLATION SUPPORTING TEST AND TRACE

Lessons from San Francisco
I was pleased to see mention of San Francisco’s effort to help people isolate with the Right to Recover Act (Feature, 13 February). Even before this, the city recognised that the hardest hit people were those already living in poorer communities and who were medically underserved.

The case investigation and contact tracing team provided support to those being asked to isolate in the form of food, cleaning supplies, medication delivery, crisis counselling, and information about rent relief. A team of clinicians answered the questions of those anxious about their situation and their contacts. The city dedicated many of its hotels to people who needed to isolate, who could receive meals for their entire quarantine period, at no cost to the individual.

Although not spared from disease or deaths, San Francisco has had one of the lowest test positivity rates and currently has the lowest covid-19 mortality of any city in the US.

Ellen Weber, physician, San Francisco
Cite this as: BMJ 2021;372:n652

LOSING ONE’S FAITH IN LEADERS

Keep the faith in the NHS workforce
I read Kar’s article on losing faith in leaders with sadness (Partha Kar, 20 February). At the beginning of this tragic situation, those of us in the NHS stood together. We had everyone’s backing—all that applause and so many rainbows.

To say we are all tired is an understatement. We stand to do the right thing, so it’s hard when we feel let down by those who represent us. No one could have known how bad things would get, no human would have wished it, and those at the helm are just that, human.

But what we can be proud of, and continue to have faith in, is the people who make up the NHS workforce. We came together when needed, and we continue to deliver care at all costs, because that is what we trained to do. Keep the faith in the workforce, Dr Kar. We have each other’s backs.

A V Wake, general practice partner, Towcester
Cite this as: BMJ 2021;372:n661

TRUST IN FAMILY DOCTORS

Primary healthcare is heart of vaccination strategy
Organising covid-19 vaccination programmes puts pressure on healthcare systems. Two challenges must be tackled for a long term, sustainable strategy.

First, we need to account for vaccination hesitancy. Secondly, the strategy must be tailored to the healthcare system.

In many countries, authorities organise mass vaccinations in improvised centres. In the short term this is necessary for rapid deployment. In countries with a dense network of primary healthcare providers, however, this could be counterproductive in the long term.

The public rate physicians, pharmacists, and nurses highly for trustworthiness (Helen Salisbury, 6 February). Therefore, we should place primary healthcare providers at the heart of vaccination strategy. Being vaccinated in places you know, such as a GP surgery or local pharmacy, by healthcare providers you know, fosters trust.

Given that covid-19 may remain endemic, optimal use of existing healthcare resources should be favoured to achieve sustainable population health benefits.

Arnaud Chioloro, epidemiologist and professor of public health; Stéphane Cullati, senior lecturer in epidemiology, Fribourg; Valérie Santschi, professor of health services research, Lausanne
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OBITUARIES

Donald John Macleod

General practitioner  
(b 1918; q Glasgow 1941), died from a urinary tract infection on 12 May 2020

Donald John Macleod (“John”) was called up to the army in 1942 and spent time in Northern Ireland, Persia (now Iran), and India, and was a prisoner of war in Thailand and Palestine. He was demobbed in mid-1946 and returned to Glasgow. After a brief spell at Glasgow Royal Infirmary, he joined a family practice in Carluke as an assistant. In 1947—the year before the inception of the NHS—he set up a family practice in the Yoker area of Glasgow and worked there until his retirement in 1983. Despite his considerable workload John enjoyed time with his growing family and had many interests. His wife, Catherine, died in 2015, shortly after they had celebrated their 70th wedding anniversary. John leaves four children, six grandchildren, and six great grandchildren.

Ian Alexander Macleod

Cite this as: BMJ 2021;372:n202

Henry Hugh Gebbie

General practitioner  
(b 1930; q Glasgow 1953; FRCGP, FRCP Edin), died from Parkinson’s disease on 16 September 2020

Henry Hugh Gebbie did national service in Germany before becoming a GP partner in the seaside town of Nairn on the Moray Firth. He greatly enjoyed practice there, undertaking home deliveries and visiting the local aristocracy in rambling castles. A move to Edinburgh led to partnership in the now West End Medical Practice, where he was the longstanding senior partner and trainer. He was appointed Apothecary to the Queen at Holyrood Palace in the city and hugely enjoyed this role, caring for the royal family and all royal household staff when they were in residence. In retirement, he moved to France and enjoyed many long summers in the Languedoc region. Dorothy, his wife of over 60 years, predeceased him, and he leaves four children, 14 grandchildren, and one great grandchild.

Ailsa Gebbie

Cite this as: BMJ 2021;372:n199

Philip Morrison Brown

Psychiatrist (b 1963; q Aberdeen 1986; FRCPsych), died suddenly from complications of diabetes on 19 October 2020

Philip Morrison Brown (“Phil”) did his early training in Glasgow, which he very much enjoyed. He married and started a family with his wife, Rachel. He moved to Manchester to specialise in psychodynamic psychotherapy and then took up a consultant post to lead the Preston psychotherapy department. He ran Balint groups for trainees, and was active in the Balint Society, where his workshops were highly regarded. Phil managed to do all this while dealing with the complications of diabetes, which he had since age 11. He kept working till his planned retirement. He and Rachel then relocated back to Scotland—Dumfries, where they planned to spend their retirement. Sadly, Phil died suddenly. He leaves Rachel, two children, friends, and colleagues. He had only just become a grandfather.

James Mackie

Cite this as: BMJ 2021;372:n198

Elizabeth Maughan

Consultant haematologist  
Alexandra Hospital, Redditch, Worcestershire;Consultant haematologist, Worcestershire Acute Hospitals NHS Trust; FRCPath, FRCP (now Birmingham), died from metastatic carcinoma sarcoma of the fallopian tube on 23 October 2020

Elizabeth Maughan (“Liz”) was brought up near Audlem in Cheshire. She trained at the University of Oxford Medical School. After qualifying she trained in general medicine at the Royal United Hospital Bath and spent a year in general practice in Bradford on Avon. Subsequently she embarked on a career in haematology in Birmingham. She was briefly, therefore, a member or fellow of three royal colleges, having taken their exams. Although Liz did general haematology at Redditch, she subspecialised in coagulation and obstetric liaison. She was widely respected by her colleagues and patients. Outside medicine she was a keen gardener, lover of wildlife, and fond of international travel. She leaves her husband and twin children.

David Thickett

Cite this as: BMJ 2021;372:n204

Kirsty Annabel Gillgrass

General practitioner  
(b 1980; q Sheffield 2004; FRCGP, PGCertMedEd, DFSRHI), died suddenly on 16 November 2020

From a young age, Kirsty Annabel Gillgrass (née Smith) excelled in everything she did. Her dynamism and energy were pivotal in her fulfilling roles in teaching and management. She became an academic teaching fellow at Sheffield University in 2012, GP partner in 2013, and GP trainer in 2016. She worked for Sheffield Clinical Commissioning Group for several years, most recently as a clinical director and covid-19 lead. At the time of her death she was studying for an executive masters in medical leadership. Kirsty was an active member of Sheffield Women in Medicine and a mentor to many. Kirsty was a remarkably intelligent, caring, and industrious doctor with a can-do attitude, who was open about her struggles with her own mental health. She leaves her husband, Jon, and two sons.

Sarah Costen and George Scott Davison

Cite this as: BMJ 2021;372:n200

Andrew Robinson

Consultant haematologist  
Alder Hey Children’s Hospital, Liverpool; Consultant haematologist, Aintree University Hospitals NHS Foundation Trust, died from a ruptured abdominal aortic aneurysm on 16 December 2020

Andrew Robinson was a remarkable specialist and teacher widely respected by his trainees and all his colleagues. After qualifying in Edinburgh, he trained in haematology at St George’s Hospital, London, and then took up a consultant post in Liverpool. He returned to Edinburgh in 1988, where he trained in haematology. Andrew was a highly intelligent man with an encyclopaedic general knowledge, especially of classical music and literature, which never ceased to amaze us all. He leaves Cathie, his wife of 49 years; two children; three grandchildren; and one great grandchild.

Cite this as: BMJ 2021;372:n206
Archibald Johnston Malcolm (b 1950; q Glasgow 1974; FRCPath), died from haemochromatosis on 23 November 2020

The correct diagnosis of a suspected bone tumour is a prerequisite for optimum management. Bone tumours are rare, so a pathologist cannot be expected to come to the right diagnosis immediately. In every generation one or two people emerge as national and international experts.

When Archie Malcolm qualified in Glasgow he decided on a career in pathology and came under the tutelage and influence of Mary Catto, the outstanding bone pathologist of her generation. It did not take long for Malcolm to become fascinated by the complexities of the subject but also by its simplicity. Looking at a microscope slide is all about pattern recognition—birdwatchers call this the “jizz.” It is a combination of size, shape, colour, and—in the case of birds—posture, flight, sound, and habitat. Even after a brief glimpse it lets the observer recognise what it is, or what it can’t be.

There are many additional tests that can be done, but almost invariably these would confirm what his first impression had been. Malcolm had a natural ability, which he rapidly honed to become the go-to UK expert for difficult cases. Within 10 years he was receiving a dozen or more specimens a week from all around the world.

He moved to Newcastle in 1981 and quietly set about developing a reputation for excellence and establishing the first regional bone tumour registry in the UK, a prerequisite for planning and evaluation of service, teaching, and research. He became an integral part of an international cadre of experts.

In addition to his tumour work he was involved in research into joint replacement surgery. John Charnley from Wrightington, the pioneer of hip replacements in the UK, amassed a collection of prosthetic hips removed from patients after they had died and bequeathed the collection to Malcolm for research.

Malcolm, along with Henry Mankin at the Massachusetts General Hospital in Boston, played a major part in the US’s dramatic change in practice from using cement to fix the implant to uncemented—as in the UK, where the incidence of loosening of the implant was much lower. He subsequently received the prestigious John Charnley award.

**Career**

Malcolm arrived for his first consultant post in Newcastle in 1981, set up an excellent clinical service, and was heavily involved in teaching and research. He was an inspirational teacher, spending countless hours on his double headed teaching microscope. He also facilitated many research projects especially in the area of children’s cancer.

Always approachable and caring, he acted as his department’s “agony aunt.” In more recent years he was a recognised expert in the diagnosis of bone fractures in possibly abused children.

Occasionally it is difficult for someone even with Malcolm’s skills to come to a definitive diagnosis and, particularly when dealing with relatives, this causes great distress and anxiety. He was never afraid to come to the ward and sit with distressed parents and explain the problems. He was a very caring man.

A superb lecturer, he was in huge demand and eventually limited himself to six major international trips a year. He acted both as secretary and president of the UK Association of Clinical Pathologists. He was recognised as a wise man and on two occasions was asked to head inquiries into poor performance in major hospitals in England.

He married Alison Strain, a fellow Campbeltonian, in 1972 and after their divorce he married Pat Mitford in 1988. Between them they had five children, all of whom got on very well as a composite family.

**Later career**

In 2000 Malcolm moved to a new post in Shrewsbury, where he spent the rest of his career. He was especially good at explaining the intricacies of postmortem findings, and coroners valued his ability and willingness to talk to bereaved relatives.

His health for the past few years was plagued by haemochromatosis, a genetic condition that leads to the deposition of iron in most organs of the body. He bore this with his usual fortitude and remained cheerful.

Outside medicine he enjoyed cricket and following the Scottish rugby team. He was an expert on malt whisky, but in later years he switched to port. He loved walking and revelled in the jizz of birdwatching.

He leaves his wife of 32 years, five children, and six grandchildren.

Alan Craft, emeritus professor of child health, Newcastle University

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