We all have a narrative about why we became doctors. I was influenced by my father, who taught me from a young age to love medicine. His career started as a medical officer of health in Nigeria and ended, 45 years later, working as a volunteer with the blood transfusion service. In the time between he was a GP, with an initial list of 1500 patients in 1964, which expanded to what today would be considered a multipractice, with seven partners and 30 000 patients across three sites. When he died, I inherited two box files of his papers, which gave details of a complaint he’d received after the death of a patient, allegedly through my father’s negligence. The papers spanned a four year period, from the initial complaint to his appearance at the GMC’s headquarters in Hallam Street. The boxes contained legal letters, handwritten notes, and testimonials from colleagues, patients, and local dignitaries, describing my father’s care and the position of esteem he held as a family doctor in his community.

A letter from the GMC was short, just detailing the charges, telling him to attend on such and such date “to determine whether or not they should direct the registrar to erase your name from the register or to suspend your registration therein or to impose conditions on your registration” (so much for a presumption of innocence). Although I was a junior doctor by then, Dad didn’t confide in me about this complaint. I can only wonder what he must have felt. I suspect predominantly shame and anxiety.

His story resonates with doctors I’ve cared for at Practitioner Health—a free, confidential NHS mental health service with expertise in treating healthcare professionals. Many, like my father, trained overseas, work in underfunded areas with challenging communities, and face a higher risk of receiving complaints than doctors working in more affluent areas or trained in the UK. I’ve written before on how the GMC has improved its processes, and this is welcomed, but being involved in a disciplinary process is still painful and can understandably leave a doctor feeling depressed and even suicidal. Fortunately, unlike in my father’s day, help is at hand, from Practitioner Health, and through the BMA’s doctor support service.

My father retired from practice in January 1989—a month before his GMC hearing, which I imagine precipitated his decision. In his resignation letter to the family practitioner committee he talked of his long service, hard work, memories of patients he’d cared for, and the courage they gave him to work as a doctor. The box contained no concluding letter from the GMC, only a small cutting from the local paper, with my father’s face smiling at the camera and the headline: “Misconduct case—doctor is cleared.”

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Being involved in a disciplinary process can leave a doctor feeling depressed and even suicidal
The NHS has rightly been praised for its response to the pandemic but risks running into serious trouble unless the government faces up to the scale and depth of the challenges it now faces.

There has been much focus, understandably, on the growing number of people waiting for elective care, but rising use of urgent and emergency care and unprecedented demand for mental health services are just as important. General practices are also struggling to meet rising demand at a time when they are seeing more patients than ever and playing a major part in the vaccination programme.

The government’s response to these challenges has fallen well short of what is needed. The underlying financial pressures in the NHS have been masked by the time limited injection of extra resources to cover the costs of covid. Recent warnings by NHS England’s chief financial officer that the service should expect normal financial disciplines to return is a clear sign of the Treasury’s thinking. This will expose the reality of sustained underfunding during the past decade and the impossibility for many organisations of balancing budgets and improving patient care.

Only a multi-year funding settlement above historical annual increases of around 4% will come near providing the resources required. Priority claims include fair pay rises, adequate funding to expand education and training, continuing investment in elective care to reduce waiting lists, further progress...
We recommend NHS England publishes data on the respective costs of delivering vaccines through general practice sites compared with mass centres. The calculations must include set-up and running costs, and also explain where the clinical staff are coming from—knowing that staff shortages are already over 10% across the NHS. The work in dealing with queries from patients also needs to be factored into this evaluation. We also request a breakdown of the percentage of vaccines given in each setting thus far.

Investment in primary care led sites, supported by local pharmacies, is likely to be the most cost effective option, as well as being the option preferred by most patients. It is essential, therefore, for the government and NHS managers to work with primary care teams, giving them the resources needed to put in place a sustainable, long term infrastructure for vaccine delivery.

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in ensuring parity for mental health services, the expansion of services for people with long covid, renewed commitment to the health and wellbeing of children, and sustained investment in hard pressed primary care and community health services.

The government must also recognise the claims of social care and public health. This means restoring the public health grant to local authorities and investing in social care. An essential step would be to make permanent the extra funding made available to support discharge from hospitals in the pandemic as well as providing councils with resources to enhance preventive services.

Chris Ham is chair of the Coventry and Warwickshire integrated care system, non-executive director of the Royal Free London Hospitals NHS Foundation Trust, and co-chair of the NHS Assembly

ACUTE PERSPECTIVE David Oliver

Why shouldn’t GPs use social media?

On 6 June the Mail on Sunday published a piece by its health editor, Barney Calman: “All you GP face-to-face refuseniks take note: if I can read your Twitter rants, so can your patients.” This accompanied an article about a patient’s personal experience, whose burst appendix had been diagnosed only after an urgent trip to the emergency department when she was unable to secure a face-to-face GP appointment.

Calman has received dozens of stories from readers unable to get face-to-face GP access and claimed that, despite existing pressures in primary care, this had got worse since pandemic measures took effect. National patient surveys by Healthwatch England, the Health Foundation, and Ipsos Mori have flagged similar worries.

Calman also expressed concern that the number of posts on “medical Twitter” putting GPs’ side of the narrative—implying that, because the public could read them, these posts would damage trust and respect.

I realise many patients struggle with online or phone options and would prefer face-to-face appointments. But I’ll happily speak in defence of my GP colleagues.

First, throughout the pandemic GPs were instructed to shift to remote triage for infection control reasons, although they continued to offer a percentage of face-to-face consultations and operated “hot” covid hubs. General practice staff have since been at the vanguard of vaccine delivery. If GPs had ignored the edicts they would have risked serious infection control problems and the possibility of ruinous negligence litigation. They didn’t switch to remote triage and consulting for frivolous reasons any more than hospital based teams did.

Second, GPs and their royal college have argued there needs to be a rebalance back towards face-to-face appointments and that remote consulting has its limitations. They don’t need to be persuaded of the value of face-to-face appointments, despite a consensus that we could make more use of online and phone access in the future.

Third, independent policy analyses of GP activity in 2020 and 2021 show that, although numbers did drop off in 2020, GPs have carried out millions of consultations a month throughout the pandemic, with numbers of consultations at a record high.

Fourth, the serious workforce crisis in general practice is a matter of record. Full time equivalent GP numbers haven’t risen for a decade, during which time workload has increased year after year.

Calman’s piece implied that GPs tweeting about these stark statistics was somehow irresponsible, insensitive, or overly politicised, but it is surely legitimate for professionals, advocating for themselves and their patients, to highlight workforce gaps and their implications for patients.

The Mail on Sunday’s attempt to shame or silence medics who post about their own working lives is bizarre and, in my view, far more unseemly than the doctors’ tweets.

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It is surely legitimate for professionals to advocate for themselves and their patients.

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Cite this as: BMJ 2021;373:n1574
**PRIMARY COLOUR** Helen Salisbury

**Should I stay or should I go?**

Whenever two or three GPs of a certain age gather together, the subject of early retirement will arise. Last month a BMA survey reported that growing numbers were considering hanging up their stethoscopes for good because work had become too stressful to be worth the personal cost of continuing. I have no retirement plans at present, but these conversations inevitably make me think about what keeps me working.

After many years I still have the capacity to be surprised—even excited—by the challenge of diagnosis when some unusual constellation of symptoms and signs sets me scouring the internet for a half remembered condition I’ve never seen in the flesh. It’s also a delight to have colleagues with whom I can share moments of intellectual excitement. I’ve read so many personal statements from aspiring medical students about the joys of lifelong learning that the phrase can seem to lose all meaning, but these moments remind me that it’s true.

There’s also the satisfaction of being useful, often to dozens of patients a day. The democratisation of medical knowledge, now so easily accessible online, has increased the demand for our specialist skills: almost inevitably, typing even the most benign symptoms into a search engine can turn up terrifying results that need to be put into context. When it comes to relieving patients’ suffering, our ability to empathise and reassure is as important as our ability to refer or prescribe.

My city centre practice has a rapid turnover of patients, but I’ve nevertheless looked after some families on my list for nearly two decades. These long term relationships are one of the elements that keep me involved and engaged: each consultation builds on the last, and I’m always interested to know what will happen next. It’s not that these patients particularly need me; more that I have much to gain from being their doctor.

So, what would it take to make me throw in the towel? If the only way of seeing patients in future was through remote consulting, I wouldn’t last. Many doctors have adapted to this, but I’m not one of them. And if I lost continuity of care and was unable to look after my own list of patients, I’d struggle to enjoy the job.

Relationships within the practice are important too, along with the feeling of shared endeavour in doing the best we can for our community. Sometimes our ability to do the right thing for our patients feels threatened by micromanaging missives from above, but mostly we just carry on with what we think is sensible. Although some general practices have been subsumed into large conglomerates, most of us still guard our autonomy fiercely, and this is my final red line. If that goes, I really will be out of the door.

If I was unable to look after my own list of patients I’d struggle to enjoy the job.

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Medicalising the mind with Suzanne O’Sullivan

In the latest episode of Deep Breath In, the team discuss the mysterious phenomenon seen in Sweden of children seeking asylum who became completely inert, a condition now known as resignation syndrome. They are joined by Suzanne O’Sullivan, a consultant in clinical neurophysiology and neurology, who wrote *The Sleeping Beauties: And Other Stories of Mystery Illness*, which was sparked by these cases.

She talks about how these children started to challenge the way she thought about illness, diagnosis, and how we practise medicine.

“If slipping into resignation syndrome was something that was a response to psychological trauma, then we should be seeing this everywhere. But we only saw resignation syndrome in Sweden, and that really was the reminder I needed of how the sociocultural moulding of how we express our distress and interpret bodily symptoms seemed every bit as important as the psychological trauma these children had been through.”

As an expert in functional neurological disorders, O’Sullivan talks about how western medicine frames the people she sees in her practice, and the pros and cons of always seeking and applying medical labels to what they are experiencing.

“We can easily make people feel better by giving them labels that explain what’s happening to them, and that gives a sense of ultimate relief. However, it can create disability in the long run. So the minute I tell somebody that their lapses in concentration are due to dissociative seizures, I’m turning someone who perhaps could have something one could call normal into a medical problem, which labels that person as a patient. And as soon as I label someone a patient, that can lead to long term disability just through the way people treat them and how they view themselves.”

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Global covid-19 vaccine rollout and safety surveillance—how to keep pace

An agile, internationally harmonised monitoring system is essential to maintain favourable benefit-risk profiles and public trust in vaccination, argue Vincent Lo Re and colleagues

The first vaccines against the novel pathogen SARS-CoV-2 were deployed just nine months after the covid-19 outbreak was declared a global pandemic. Several types of covid-19 vaccines have been developed using different platforms and adjuvants, including messenger RNA based vaccines, adenovirus based vector vaccines, and inactivated vaccines.1 As of June 2021, 102 vaccines were under study in phase I-III trials, and 185 were under investigation in preclinical studies.2

Given the global impact of the pandemic, vaccine development received unprecedented public and political attention, resulting in accelerated regulatory review. However, there has been scepticism about the rigour of evidence supporting comprehensive benefit-risk assessments and concern that breakthroughs in vaccine development have not been accompanied by similar advances in systems to monitor adverse events or communicate safety signals among regulators, public health officials, and healthcare providers.3-5

The limited human exposure and follow-up within the pivotal covid-19 vaccine trials, optimised to allow formal conclusions about efficacy, did not permit detection of rare adverse events (occurring in fewer than 1 in 10000 people) after immunisation, particularly within subgroups under-represented in, or excluded from, those trials (such as pregnant women, children, and frail elderly or immunocompromised people).5,7

Public apprehension about the safety of covid-19 vaccines has contributed to hesitancy to receive a vaccine.8

These concerns were heightened in February 2021, when cases of unusual blood clotting occurring after immunisation with the Oxford-AstraZeneca vaccine (ChAdOx1-S) were reported to regulatory agencies (box).9 The timely detection of rare, serious events after covid-19 vaccination highlights the importance of robust safety surveillance systems. As countries roll out covid-19 vaccines to their populations, speed of safety assessments is crucial to ensure favourable benefit-risk profiles and preserve public trust. We highlight potential challenges in covid-19 vaccine global safety surveillance and suggest approaches to overcome them.

Current approaches to monitoring vaccine safety

Safety of vaccines after licensing should ideally be monitored by a combination of passive and active surveillance.10-12 Passive vaccine safety surveillance systems rely on spontaneous reporting of adverse events by vaccine manufacturers, healthcare providers, care givers, or patients. Reports are submitted to national regulatory authorities through systems such as the European Medicine Agency’s EudraVigilance and US’s Vaccine Adverse Event Reporting System. Regulators review their accuracy and completeness to evaluate them to detect safety signals. Spontaneous reports can inform hypotheses regarding causal associations between vaccines and adverse events.

The complementary active vaccine safety surveillance systems seek to determine as completely as possible the number of vaccine related events in a population. This information is critical during vaccine rollout, as is now exemplified in the realignment of target groups for the AstraZeneca vaccine.13 Traditionally, these systems have been based on reports from hospitals or clinics, but electronic healthcare databases provide population based data on a much larger scale.12 Such databases facilitate determination of the risk of particular adverse events in cohorts of vaccinated people and whether rates exceed those among unvaccinated comparator groups, at least until the majority of the population has received the vaccine.

Thus, they allow for the conduct of formal controlled studies (phase IV studies) that permit causal inferences about vaccine related adverse events and effectiveness to recalibrate benefit-risk assessments. Together, passive and active surveillance systems and their expansion into controlled observational studies represent the pillars of monitoring vaccine safety after deployment.

Challenges surrounding covid-19 vaccine safety surveillance

Global assessment of covid-19 vaccine safety faces several challenges. First, there is substantial heterogeneity in vaccine safety monitoring across countries.4 Many low and middle income countries...

KEY MESSAGES

- The development of rare, serious adverse events after covid-19 vaccination highlights the critical importance of robust vaccine safety surveillance systems
- The widespread rollout of covid-19 vaccines creates an opportunity for international harmonisation of pharmacoepidemiological designs, data, and safety endpoints
- Enhanced active vaccine safety surveillance systems could overcome existing barriers in ascertaining vaccine exposure and adverse events at a population level
- National regulatory authorities should establish formal collaborations across regions to promote sharing of safety data
Surveillance in action: thrombotic thrombocytopenia

Cases of moderate-to-severe thrombocytopenia and thrombotic complications at unusual sites (eg, cerebral venous thrombosis, splanchic vein thrombosis) occurring 5-24 days after initial immunisation with the Oxford-AstraZeneca vaccine (ChAdOx1-S) were first reported to regulatory agencies in February 2021.9 - 11 A population based cohort study from Denmark and Norway subsequently estimated an excess of 2.5 (95% confidence interval, 0.9 to 5.2) cases of cerebral venous thrombosis for every 100 000 people vaccinated.12

Analyses suggest that these events may be triggered by platelet activating antibodies and represent a rare vaccine related variant of spontaneous heparin induced thrombocytopenia. This is now referred to as vaccine induced immune thrombocytopenia.9 - 11

Europe briefly suspended use of the AstraZeneca vaccine until the European Medicines Agency concluded that the benefit of its use exceeded the risks. National regulatory agencies conducted independent benefit-risk reviews of the vaccine and made country specific recommendations.

Several countries recommended that the vaccine be administered only to people above a particular age (range, 30-65 years).13 Regulatory authorities in France and Sweden recommended that people younger than 55 years and 65 years, respectively, who had received a first dose of AstraZeneca vaccine receive a different vaccine for their second dose.13 The UK announced that it would offer an alternative vaccine to people under 40 years of age.14 Cameroon, Denmark, and Norway stopped using the vaccine altogether.13

Shortly after, cases of thrombotic thrombocytopenia were reported in people who had received the Ad26.COV2.S vaccine made by Janssen (Johnson and Johnson),15 prompting a formal benefit-risk review by the US Food and Drug Administration and EMA. Both agencies concluded that the benefits outweighed the risks, and immunisation with this vaccine resumed. Denmark decided to exclude the Janssen vaccine from its immunisation programme.

These events interrupted covid-19 vaccine access, and publicity surrounding their investigation may have damaged the public’s trust in these vaccines.

have had challenges in establishing and maintaining passive and active vaccine safety surveillance systems.19 These include low participation in spontaneous reporting and limited resources for investigation and communication of safety signals.20

Follow-up with patients who experience adverse events after covid-19 vaccination (or their care givers or healthcare providers) to collect clinical information has been uncommon, even in high income countries.21 Moreover, in many countries, limited collaboration between national regulatory authorities and immunisation programmes prevents assessment of vaccine related events by regulators.

Low and middle income countries often lack electronic healthcare data or the pharmacoepidemiological expertise to permit active vaccine surveillance using large, validated data sources. Data from surveillance programmes in high income countries may not be able to detect adverse events that affect particular ethnic subgroups or have specific genetic, environmental, or socioeconomic patterns that occur in lower income countries.

Second, passive surveillance systems globally will find it difficult to use traditional approaches to the analysis of spontaneously reported adverse events because of the unprecedented rapid rollout of different covid-19 vaccines and intense scrutiny of their safety. While this scrutiny may have qualitative value, quantitative assessments will be challenging because signal identification in these systems relies on comparisons against “expected” rates (eg, for other vaccines). Reports may not include details about vaccine type or immunisation date,22 which may further impede safety monitoring.

Third, even for countries with well established infrastructure for real world data, such as access to electronic health record or administrative databases, the rapid and simultaneous release of multiple covid-19 vaccines poses challenges to population based ascertainment of vaccine exposure and adverse events. Since some people are being vaccinated outside of healthcare settings and without reimbursement by health plans, documentation may not be available within electronic healthcare databases.23 This will lead to incomplete digital tracking of vaccine administration, missed opportunities to capture important vaccine safety outcomes, and misclassification when establishing exposure groups for controlled comparisons.

International travellers may present for urgent care after pre-travel vaccination, requiring clinical understanding of vaccine safety at the global level

International travellers may present for urgent care after pre-travel vaccination, requiring clinical understanding of vaccine safety at the global level.

Different vaccines will have different event profiles, requiring careful tracking of product detail and lot numbers.24 Vaccine registries, which may provide such information locally, may not be linked to healthcare databases. The possibility that individuals will receive different vaccines for the two doses (eg, AstraZeneca for first dose and Pfizer for second dose) will make it more difficult to identify which vaccine may have caused an adverse event. Any lags in availability of analysable data because systems are not set up for data linkage and extraction will delay assessment of rates of vaccine related adverse events.

A final, but extremely important, challenge to covid-19 vaccine safety is the need for global coordination of monitoring, evaluation, and communication of adverse events.25 This includes not only coordination of passive surveillance efforts but also standardised data collection of safety and effectiveness endpoints for phase IV studies. Country specific usage patterns and population specific adverse events will require identification and broad communication. As a practical example, international travellers may present for urgent care after pre-travel covid-19 vaccination, requiring clinical understanding of vaccine safety at the global level.
Making vaccine safety surveillance work

The global deployment of covid-19 vaccines affords an unprecedented opportunity for innovation in post-licensing vaccine safety assessment. National regulatory authorities could collaborate on the development of “master protocols” that detail approaches to capture vaccine administration within healthcare databases or vaccine registries with linkage to electronic health records; ascertain events of interest after vaccination using prespecified algorithms; and identify subgroups that were under-represented in trials.46

Such protocols would help overcome challenges related to the heterogeneity in vaccine safety monitoring across countries by promoting harmonisation of pharmacoepidemiological designs, data, and safety endpoints across countries. They would also allow assessment of the heterogeneity of safety signals across different settings and subgroups. Protocols to harmonise safety evaluations of covid-19 vaccines have been developed by the US Food and Drug Administration’s Center for Biologics Evaluation and Research,46 the Safety Platform for Emergency Vaccines46 funded by the Coalition for Epidemic Preparedness Innovations,47 the Vaccine Covid-19 Monitoring Readiness (ACCESS) programme funded by the EMA (which uses the list of adverse events provided by the Safety Platform for Emergency Vaccines),48 and the Japanese Society for Pharmacoepidemiology,49 but broader collaboration between national regulatory authorities is needed.

The massive rollout of covid-19 vaccines also offers an opportunity to enhance active vaccine safety surveillance systems. This could help overcome existing barriers in ascertaining vaccine exposure and adverse events on a population level. Ideally, these systems should use databases that can be accessed in near real time to identify large numbers of individuals who have been vaccinated, ascertain the vaccine and lot number administered, and detect adverse events using validated coding algorithms, such as those developed by the Brighton Collaboration.50 These systems could address concerns regarding cases of Bell’s palsy observed in phase III trials of the messenger RNA based vaccines developed by Pfizer-BioNTech (BNT162b2) and Moderna (mRNA-1273)51 by comparing incidence of this outcome against background rates in the general population and matched non-vaccinated comparison groups.

Settings that have not yet established such systems could invest in infrastructure to record covid-19 vaccinations and diagnoses of relevant events electronically. This has been done in Vietnam to monitor events after measles vaccination52 and in Guatemala to assess the safety of the DTP-HepB-Hib vaccine.53

Moreover, the creation of databases across regions and countries could increase sample size and diversity, enhance detection of rare acute and delayed onset events, allow adequately powered comparative vaccine safety studies, and promote collaborations and communication. This will enable regulators to determine the causes of adverse events more quickly and definitively. As mRNA based vaccines are a new technology, such databases will be especially important for evaluating their long term safety.

The Vaccine Safety Datalink in the US and European Accelerated Development of Vaccine Benefit-Risk Collaboration are two examples of collaborations that successfully established distributed systems based on electronic medical records for rapid monitoring of vaccine safety.54

In Europe, the ACCESS programme recently published background incidence of events of interest to allow comparisons between those who have and have not had covid-19 vaccines.55

Since many countries are initially vaccinating healthcare and other essential workers, registries of these workers could be developed and linked to electronic health data to assess rates of vaccine related events. In addition, use of novel data collection methods, such as smartphone based surveys like V-safe in the US,56 V-Watch in Taiwan,57 and WEB-RADR in Europe,58 could enhance capture of covid-19 vaccination and related adverse events, although these systems have not identified any adverse events related to covid-19 vaccines so far.

Finally, national regulatory authorities should foster close collaborations with their regional and national immunisation programmes to ensure timely dissemination of information about safety signals and changes to vaccine recommendations. They should also establish collaborations across regions to promote sharing of vaccine safety data, including potential signals for which causality cannot be established.

Failure to keep pace with vaccine rollout and overcome the challenges to global surveillance of vaccine safety could lead to delays in determining important alterations in the benefit-risk profiles of covid-19 vaccines. This could erode public confidence in vaccination programmes and have grave public health consequences.

Cite this as: BMJ 2021;373:n1416
LETTER OF THE WEEK

Vaccinate vulnerable people before children

Lavine and colleagues call for a much needed reconsideration of the push to vaccinate children against SARS-CoV-2 (Editorial, 22 May). In my (highly privileged) social circle in Toronto, most 12 year olds have already had their first vaccine. Meanwhile, the number of fully vaccinated Canadian adults, including those at risk, remains low.

To spell out the concerns with vaccinating children against SARS-CoV-2:
- The risk of severe sequelae from covid-19 to children is very low, making it hard to justify exposing them to any vaccine related risks.
- The risk of transmission from children is also low. Even if we were to assume that vaccines prevent transmission from children to adults, we cannot rely on children being vaccinated instead of putting the onus on adults to get vaccinated.
- In Canada, most at-risk adults have only received their first dose of vaccine, with their second dose being scheduled four months later because of limited supply. It would make more sense to give vulnerable adults their second doses rather than vaccinating children.
- Globally, it is hard to accept what is happening in India—a major vaccine exporter sending their vaccines to privileged 12 year olds while they experience a calamity.

There may be circumstances where vaccinating children would be desirable—for example, those with medical conditions that put them at particular risk from severe covid-19.

In our eagerness to emerge from this pandemic, it is imperative that we remain level headed. Children have already paid a high price during lockdown, including school closures. Vaccinating them against SARS-CoV-2 is a strategy with questionable benefits and unnecessary risks; rather, the focus should be on maximising vaccine uptake among adults, while prioritising the most vulnerable.

Finally, we need to think beyond political borders to tackle this pandemic effectively and ethically.

Elia Abi-Jaoude, psychiatrist, Toronto

Cite this as: BMJ 2021;373:n1533

DIGITAL ACCESS AND PATIENT DEMAND

Reshaping online consultations

Widespread adoption of online consultations during the pandemic has allowed them to be tested extensively in live settings (Rammya Mathew, 22 May). What problems do they solve?

By priming a telephone encounter with information from an online template we can achieve shared understanding much earlier in the conversation and build empathy.

Online consultations can be submitted 24 hours a day and multiple consultation templates can reach a practice simultaneously. This leads to temporal stretching (extended hours) and widening (multiple templates simultaneously) of a novel channel into the practice.

Triage is essential to ensure safe care for everyone. But without a shared understanding of its purpose and benefits, it might be seen as blocking access. Online consultations allow us to work flexibly, which can improve our control over workload.

We risk online consultations being the blunt knife in our toolbox. But we can reshape them to align with both patient and clinician needs.

Richard Pratt, GP, Truro

Cite this as: BMJ 2021;373:n1515

FACE-TO-FACE APPOINTMENTS AGAIN

Total triage is the future

Rather than increasing face-to-face appointments, as the NHS has suggested (This Week, 22 May), our focus should be on increasing access and offering consultation options to our patients. The "total triage" model is the future if we are to sustain workforce.

Online consultations are quick, convenient, and secure, enabling patients to choose how they interact with clinicians. Patient queries can be prioritised and directed appropriately and efficiently. Remote consultations reduce consultation length, improve accessibility, and provide flexibility. They enable doctors to have more consultations in a day or longer face-to-face consultations for complex cases. Patients who prefer face-to-face consultations can still access the practice.

The experience of personal communication matters more to patients than the consultation modality. Being prepared to switch between different modes of consultation depending on technical, patient, or clinical factors will ensure safety of the consultation as well as satisfaction for patient and clinician.

Vasumathy Sivarajasingam, GP partner, Greenford

Cite this as: BMJ 2021;373:n1532

Digital exclusion of marginalised groups

The rapid shift to physical closure of surgeries, digital appointments, and online triage presented challenges for marginalised patient groups, who already face major barriers to accessing primary care. Our national study found that virtual consultations and online forms exacerbated existing language barriers, posed challenges building rapport and identifying safeguarding cues, and risked technological exclusion.

Increased digitalisation is where to stay yet risks amplifying existing inequalities in access to primary care. Practices need to ensure that the systems they introduce do not widen inequity in the context of stretched capacity. We need a flexible and patient centred approach, underpinned by effective clinical decision making about choice of modality, supported by Royal College of General Practitioners’ guidance, and combined with harnessing the opportunities of digitalisation—through, for example, virtual group consultations, YouTube based health advice, and engagement through multiple modalities to provide targeted, translated advice, as identified in our study.

Felicity A E Knights, GP academic clinical fellow; Jessica Carter, GP and NIHR in-practice fellow; Anna Deal, doctoral student; Sally Hargreaves, associate professor, London

Cite this as: BMJ 2021;373:n1542
COVID-19 VACCINATION HESITANCY

Resisting the “righting reflex”

Razai and colleagues discuss covid-19 vaccine hesitancy (Practice Pointer, 22 May). We think that the motivational interviewing approach has potential value—in particular, the importance of resisting the “righting reflex.”

The biggest challenge for many health professionals in these conversations is shifting from a “directive” approach to a more “guiding” one. This includes letting go of the so-called righting reflex—the urge to identify a problem and solve it for the patient. Getting the facts straight is important, of course, but there’s much more to patient decision making, including trust, previous experiences, and health beliefs. The risk of this directive approach is the loss of patient trust, resistance, and inauthentic dialogue. Rollnick and colleagues suggest guiding the patient to do this work for themselves—identifying their own “problem” and any possible solutions.

This central change in attitude can transform confrontational and ineffective consultations into much more constructive and effective ones.

Graham P Easton, GP and professor of clinical communication skills, London
Cite this as: BMJ 2021;373:n1566

DRUG EFFECTS ON GUMS

Under-reported and under-diagnosed

Ramakumar and Deepthi present a case of gingival hyperplasia associated with diltiazem (Minerva, 22 May). This condition, known as drug induced gingival enlargement, is a common side effect of all calcium channel antagonists, including the dihydropyridines, such as amlodipine, and the non-dihydropyridines, such as diltiazem. The prevalence of this condition varies between studies but might be as high as 20%. There is more evidence of its prevalence in patients taking dihydropyridines than non-dihydropyridines, given the relative infrequency of prescription of the latter.

Although most dentists are aware of drug induced gingival enlargement, its general lack of recognition seems to result from under-reporting by dentists and under-diagnosis by doctors. Dihydropyridines are the sixth most common class of drug prescribed in the UK, so doctors are encouraged to be aware of this problem. Drug substitution, when medically appropriate, seems to be highly effective, although appropriate periodontal treatment is also indicated.

Francis J Hughes, emeritus professor of periodontology, London
Cite this as: BMJ 2021;373:n1571

DELAYED ANTIBIOTIC PRESCRIBING FOR RESPIRATORY TRACT INFECTIONS

Dilemma for primary care doctors

Stuart and colleagues conclude that “delayed antibiotic prescribing is a safe and effective strategy for most patients” with respiratory tract infections (Research, 1 May).

But antibiotic treatment within the first hour of presumptive diagnosis is thought to reduce mortality in patients with infections complicated by sepsis—although this is increasingly being questioned, as none of the few prospective or randomised trials have shown a benefit. The problem, particularly in primary care, is that pneumonia is largely impossible to diagnose clinically. And, sepsis is difficult to identify even in an intensive care setting.

This creates a dilemma, particularly for the primary care physician. If a patient presents with respiratory symptoms, does not receive antibiotics, and subsequently dies from pneumonia and sepsis, then the physician could be deemed negligent. This is despite uncertainty that optimum treatment would have altered the outcome and that most deaths occur in older people with frailty and comorbidities.

Patrick J Bradley, retired GP, Wollongong
Cite this as: BMJ 2021;373:n1502

Authors’ reply

As Bradley says, there is no evidence that early treatment of suspected sepsis in primary care improves outcomes. The key challenge is the timely identification of early sepsis, which can be indistinguishable from common infections. Observational data indicate that risk of sepsis in respiratory tract infections is lower than in other conditions and the number needed to treat is large.

Nevertheless, fear is prevalent among clinicians that if a patient develops a serious illness there might be actual or perceived blame, and this is an important driver of immediate antibiotic prescribing.

Approaches to managing this problem must acknowledge uncertainty, and primary care clinicians should support each other in recognising that not all sepsis, or other adverse outcomes, can be “detected early” or prevented. Prescribing immediate antibiotics to all patients with respiratory tract infections would result in overtreatment and an increase in antibiotic resistance. This would harm more people than it benefits.

Beth Stuart, associate professor of medical statistics; Paul Little, professor; Michael Moore, professor; Nick Francis, professor, Southampton
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ACCURACY OF DEPRESSION SCORE

High HADS score is the tip of the iceberg

Wu and colleagues’ study on the HADS score is a reminder of the importance of screening for depression and the limitations of screening tools (Research, 15 May).

There are many reasons for a high HADS score. Limitations of HADS are noticeable in the context of co-occurring psychiatric disorders in the adult “neurodiverse” population. Attention deficit hyperactivity disorder (ADHD), for example, is under-recognised despite being one of the most treatable psychiatric conditions. Up to 90% of adults with ADHD experience mood instability that can resemble mood disorders.

There is emerging evidence of associations of neurodevelopmental and co-occurrent psychiatric disorders with disease patterns more commonly attributed to medical “organic” or “functional neurological” conditions, including chronic migraine, fibromyalgia, and obstructive sleep apnoea. A more considered longitudinal approach is required.

A truly holistic integrated approach focused on patient empowerment, access to resources, and coordination of care would benefit patients, reduce economic burden, and increase system capacity.

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Jessica A Eccles, clinical senior lecturer in liaison psychiatry, Brighton
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Martin Mansell
Consultant nephrologist (b 1948; q Guy’s Hospital, London, 1971; MD, FRCP), died from covid-19 after three weeks in intensive care on 24 April 2020
Martin Mansell was appointed consultant nephrologist and senior lecturer at St Peter’s Hospitals in 1983. He moved to the Middlesex in 1992, and to the Royal Free in 2005. His specialist interest was in renal stone disease, and he was a noted authority on oxalate stones and oxalosis. With surgical colleagues he built the transplant unit at the Cromwell Hospital, and his opinion was sought worldwide. He fell into medicolegal work by chance but quickly became renowned as the premier UK expert in nephrology. He met Cathy, to whom he was completely devoted, his childhood sweetheart; three sons; and an array of grandchildren, dogs, and tortoises.
Sophie Mansell, Simon Carter
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Kshiti Ranjan De
Consultant general surgeon Jersey Hospital, Channel Islands (b 1930; q Kolkata Medical College, India, 1952; FRCS Edin, FRCS Eng, FRCoG), died from a heart attack on 23 September 2020
Kshiti Ranjan De (“Kit”) did his house jobs before he came to the UK from his native Punjab, India, in 1958. He completed surgical training and training in gynaecology in Leeds before moving to Jersey in 1972. In 1982 he was appointed consultant with a special interest in breast and bowel cancer. Although he was already 50 when appointed he built up a substantial private practice, which he continued into retirement. Kit enjoyed a game of golf on Sunday morning and latterly had a house in France, also on a golf course. He was a warm, quiet person and was able to quickly build up a local following. A better colleague would be hard to find.
John Day
Cite this as: BMJ 2021;373:n918

Kris Miloszewski
Senior lecturer in medicine and consultant gastroenterologist St James’s University Hospital, Leeds (b 1937; q Leeds 1963; MD, FRCP), died in his sleep on 11 March 2021
Kris Miloszewski came to the UK in 1950 with his family as a war displaced person. He did all his training jobs in Leeds and was appointed consultant in 1975. Interested in acute gastrointestinal bleeding, he was the first to recognise prognostic significance for re-bleeding of stigmata of recent haemorrhage. Research into inherited Factor XIII deficiency was his life’s passion. He personally supervised six patients from five Yorkshire families for 30 years, and the therapy he devised transformed the patients’ lives. A great enthusiast of teaching bedside clinical medicine, he continued teaching for seven years in retirement. Kris loved walking in the Dales. He leaves his wife, Krystyna (his childhood sweetheart); three sons; and six grandchildren.
Adam Miloszewski
Cite this as: BMJ 2021;373:n906

Kenneth Raymond Gough
Consultant physician (b 1927; q Bristol, 1954; MD, FRCP), died from a cerebral tumour on 11 July 2020
Kenneth Raymond Gough (“Ken”) trained at Bristol University, where he played cricket and football and met his future wife. After house jobs, an MD, a year at Duke University in the USA, and posts at Queen Square and the National Heart Hospital, Ken was appointed a consultant in Bristol. He moved to Bath in 1965. He introduced a flexible Japanese endoscope and developed this service widely. He researched acid suppressant and anti-inflammatory drugs. Ken had a university honorary chair and also taught. Gardening, golf, and cricket remained his loves, but a passion became flying his four seater plane to Provence. He lived life to the full, and during his short illness he still enjoyed his Merlot through a straw. He leaves his wife, Pauline, a GP; three children; and eight grandchildren.
John Reckless, Peter Bennett
Cite this as: BMJ 2021;373:n924

Richard Keith Levick
Consultant radiologist (b 1930; q Welsh National School of Medicine, Cardiff, 1954; FRCP, FRCR, FRCPCH, DL, CStJ), died from covid-19 after a long period of failing health on 4 January 2021
In 1964 Richard Keith Levick (“Keith”) was appointed as the first full time radiologist at the Sheffield Children’s Hospital. Along with an initially very small number of colleagues, he provided an expert radiology service; he pioneered the use of ultrasound diagnosis in pregnancy and the management of hydrocephalus and developed renal isotope scanning. Sheffield became a major centre for the training of radiologists in paediatric practice under his guidance, with an international reputation in the specialty. After retiring from clinical medicine, he took on the new role of chief executive of the newly formed Children’s Hospital Trust and ensured the vital continuing independence of the trust. Keith leaves his wife, Beti, a GP; and three daughters.
Peter Bull, Alan Sprigg
Cite this as: BMJ 2021;373:n904

Carlos Michael Azurdia
GP (b 1938; q Liverpool 1963; MRCGP, DOBst RCOG), died from covid-19 and pulmonary fibrosis on 26 January 2021
Carlos Michael Azurdia (“Michael”) trained at the Liverpool Royal Infirmary in surgery and medicine. He gained a wide variety of surgical experience as a senior house officer and was an anatomy demonstrator for 12 months. It was on the wards that he met his future wife, Gillian Patricia Crosthwaite, who was a state registered nurse; they married in 1966. He worked as a GP in Bebington, Wirral, from 1969 to 2001 and became senior partner in 1990. He was interested in sports medicine and was medical officer for Tranmere Rovers for 18 years (1986-2004). Michael also had many charitable roles and acted as divisional surgeon of St John Ambulance Brigade in 1972-92. His wife, Gill, predeceased him by four days, and he leaves four children and eight grandchildren.
Richard Azurdia
Cite this as: BMJ 2021;373:n915
Peter Dunn

Coined the term “perinatal medicine”

b 1929; q University College London Hospital, 1953; MRCGP, MFPHM, died from acute renal failure due to colitis induced by immunotherapy for metastatic renal cell carcinoma on 29 December 2020

Dunn brought together obstetricians, midwives, and paediatricians and ensured they worked for the benefit of the baby. Scholarship helped cement his scientific training, and he was appointed as a senior lecturer in Bristol in 1968. His questioning mind and energy are shown by the range of his 20 publications as a trainee, which included haemolytic disease, phocomelia, timing of cord ligation, diabetic pregnancy, neonatal polycythaemia, and ventilatory response to CO₂. He took a special interest in congenital dislocation of the hip, the subject of his doctoral thesis. He established neonatal intensive care in Bristol in 1970, publishing on continuous positive airway pressure in 1971. From then on Dunn put a lot of his energy into better organisation of perinatal care in the UK and internationally. After the founding of BAPM in 1976, he galvanised the British Paediatric Association, the Royal College of Obstetricians and Gynaecologists, and the House of Commons Social Services Committee into recognising and supporting perinatal medicine in the UK.

He believed that accurate data were vital for monitoring and improving clinical care and was on countless committees to achieve this. He never became a confident user of Microsoft Office. Every day he conducted extensive correspondence with perinatal colleagues all over the world, walking around loudly dictating letters to his secretary at her desk.

As an archivist, Dunn’s capacity was enormous. He kept a copy of all correspondence he ever sent and received. Each was filed, indexed, and then put into bound volumes year by year. Doctors, and even students, who had spent time in the neonatal unit at Southmead many years before, could ask Dunn a question or request a reference and promptly received a detailed reply. His more than 100 articles on the history of perinatal medicine are a unique demonstration of his ability to collect, recognise, and disseminate important advances.

In 2005, when Dunn was 75, the University of Bristol administrators politely suggested that he retire and vacate his university office as he had no research projects registered with the ethics committees nor any research grants. Dunn replied, “Have you not looked at my publications? I have published 40 articles in international journals since 1999, 38 in Archives of Disease in Childhood, including five in the past year. How many paediatric academics in Bristol have published more than I have?”

He kept his university office until 2009 when he was 80 and continued to publish several papers a year. He donated his extensive historical library to BAPM. In 2001 he was awarded the James Spence medal of the Royal College of Paediatrics and Child Health, its highest honour.

Dunn married Judy Lunt, a nurse from Great Ormond Street Hospital, in 1961, and they had three children.

Andrew White, emeritus professor of neonatal medicine, University of Bristol

Alan Craft, paediatric oncologist, emeritus professor of child health, Newcastle University

Cite this as: BMJ 2021;372:n769