An employment tribunal has ruled for the first time that the GMC discriminated against a doctor on the grounds of race.

Omer Karim, a consultant urologist referred to the GMC by his employers, was treated differently from a white doctor who was also under investigation, the Reading employment tribunal held, and there was no credible explanation for the difference. The way the GMC dealt with some of the allegations suggested that the regulator was “looking for material to support allegations . . . rather than fairly assessing matters presented,” the tribunal noted.

The tribunal said it was “concerned there was a level of complacency about the operation of discrimination in the work of GMC or that there might be discrimination infecting the referral process.” It noted “the failure of all the witnesses to express how, if at all, the awareness of the over-representation of [black and ethnic minority] doctors in complaints to the GMC was considered in the investigation process or whether discrimination may have been a factor consciously or unconsciously in the allegations faced by the claimant.”

The tribunal heard that Karim, a specialist in prostate cancer and robotic surgery, blew the whistle on poor practice, bullying, and discrimination at Heatherwood and Wexham Park Trust, now Frimley Health Trust. The trust accused him of bullying and threatening behaviour towards a colleague.

The trust referred him to the GMC in 2014. The next year interim conditions were placed on his practice, pending a full investigation. These were lifted later that year, but it took three more years for a hearing to clear him of any misconduct.

The tribunal heard that although black and other ethnic minority doctors made up 29% of UK doctors they were the subject of 42% of employers’ complaints. UK graduate doctors from ethnic minorities were 50% more likely to get a sanction or warning than their white peers.

Karim accused the GMC of a “callous disregard for the truth and honesty.” He added, “Right from the outset, the GMC saw me as a guilty black doctor. We doctors need to work to change the system.”

A GMC spokesperson said, “We are giving full consideration to the findings.”

Frimley trust said in a statement, “We want to be the best possible employer and we will continue doing everything we can to listen to staff and eliminate inequalities.”

Clare Dyer, The BMJ

Cite this as: BMJ 2021;373:n1595
SEVEN DAYS IN

Eight in 10 doctors experienced moral distress during pandemic, BMA survey finds

Four fifths of nearly 2000 doctors who responded to a BMA survey said the term “moral distress” resonated with their experiences of working during the pandemic, and over half said the same for “moral injury.”

The BMA defined moral distress as the “psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action.” Moral injury, the BMA said, can arise where sustained moral distress leads to impaired function or longer term psychological harm. “Moral injury can produce profound guilt and shame, and in some cases also a sense of betrayal, anger, and profound ‘moral disorientation,’” it explained.

Helen Fidler, deputy chair of the BMA’s Consultants Committee, said what was important was “being able to now name the struggles that many doctors are having and pinpoint exactly what needs to be done to alleviate them.”

The BMA has called for extra investment in the NHS, better staffing, and emotional and psychological support for healthcare workers.

Covid-19

Health secretary ordered to disclose documents

The UK information commissioner ordered England’s Department of Health and Social Care to disclose two briefing papers forming part of Exercise Cygnus, which Moosa Qureshi, an NHS consultant haematologist, has been campaigning for since the pandemic started. The papers cover how the NHS and social care would cope if a major pandemic overwhelmed resources. Qureshi said in a blog, “By refusing to provide a population triage protocol, both the Department of Health and NHS England have arguably transferred blame—and legal liability—from politicians and corporate executives to NHS healthcare workers who had already risked their lives on the front line.” The government has 28 days to respond to the request.

Mandatory vaccination could extend to NHS

Staff in England’s care homes will be required to be vaccinated against SARS-CoV-2 from October if legislation is approved by parliament, and the government is set to consult on whether to extend the requirement to NHS workers.

Chand Nagpaul, chair of BMA council, said that compulsory vaccination of healthcare staff raised new ethical and legal implications and that efforts should be focused on targeted engagement. Any policy must avoid discrimination, he said, given that uptake of the vaccine was lower in some ethnic minority groups.

Excited delirium

AMA opposes “excited delirium” diagnosis

The American Medical Association adopted a policy to oppose “excited delirium” as a medical diagnosis and to warn against using certain pharmacological interventions solely for a law enforcement purpose without a legitimate medical reason. It said that the new policy, adopted at the AMA’s special meeting of its House of Delegates, follows reports that showed a pattern of using the term “excited delirium” and pharmacological interventions such as ketamine as justification for excessive police force, which is disproportionately cited in cases where black men die in law enforcement custody.

Assisted dying

Hancock wants “holistic” and informed debate

England’s health secretary, Matt Hancock, acknowledged problems with the current law that prohibits assisted dying as well as the risks in changing it. He told the All Party Parliamentary Group for Dying Well, which opposes assisted suicide, that assisted dying was a matter for parliament to decide. “It is important that any debate that we have [on assisted dying] is nested in a wider debate about how we support people better towards the end of their lives,” said Hancock. He pledged to help improve the evidence base and accepted that palliative care services needed further investment.

Bill is introduced in Scottish parliament

Liam McArthur (right), MSP for Orkney, lodged proposals in the Scottish parliament for a new members’ bill that seeks to change the law on assisted dying in Scotland, paving the way for the first debate on prospective legislation in Holyrood for more than five years. Supported by Dignity in Dying, the bill would legalise assisted dying as a choice for terminally ill, mentally competent adults—a change supported by 87% of the public in Scotland.

Prevention

NHS will offer “health MOTs” at vaccination sites

The NHS in England plans to offer “health MOTs” at NHS vaccination services, pharmacies, clinics, and other sites. Announcing the plan, NHS England’s chief operating officer, Amanda Pritchard, said that the aim was to make “every contact count” by rolling out tests such as blood pressure, heart rhythm, and cholesterol checks when patients already have other appointments. Checks will be offered when patients attend for top-up covid vaccinations or flu vaccinations this autumn in locations such as village halls, churches, mosques, and local sports centres.
**Antibiotics**

**Use on UK pig farms has more than doubled**

Unpublished industry data show that the use of aminoglycosides on UK pig farms rose from 2.607 mg/PCU (mg per kg of body weight) to 5.957 mg/PCU from 2015 to 2019, raising concerns about the effect this could have on rise of antibiotic resistant infections. Agricultural leaders have suggested a recent jump in the use of aminoglycosides could be because of the push to reduce other antibiotic use, as well as the upcoming EU ban on the use of zinc oxide, which is commonly used to control scour (diarrhoea) in piglets.

**Childbirth**

**Caesarean sections continue to rise worldwide**

Research from WHO showed that caesarean section rates worldwide have risen from around 7% in 1990 to 21% today and are projected to continue increasing throughout this decade. Ian Askew, director of WHO’s Department of Sexual and Reproductive Health and Research, said caesareans were “absolutely critical to save lives in situations where vaginal deliveries would pose risks,” but he said that not all the procedures were needed for medical reasons and “can be harmful, both for a woman and her baby.”

**Primary care**

**GPs get extra funding for weight management**

NHS England announced a £50m package of changes to the general practice contract agreement for 2021-22, which it has identified as a priority in recovery from the pandemic. Practices will be able to voluntarily access £20m in extra funding for an enhanced service for weight management, to encourage GPs to engage with obese patients about their weight and refer people to weight management services, as well as a £30m enhanced service for GPs to treat patients with long covid.

**CPR**

**NHS offers training after footballer’s collapse**

The NHS and St John Ambulance have joined forces to encourage people to learn cardiopulmonary resuscitation and how to use a defibrillator (below). NHS England’s medical director, Stephen Powis, highlighted how the life of the Danish footballer Christian Eriksen, who required 13 minutes of CPR after collapsing during a Euro 2020 game, was saved by doctors. Powis said thousands more lives could be saved if more people were equipped with lifesaving skills. The charity will seek to train 60,000 people as part of the new programme.

**Suicide**

**WHO issues prevention guidance**

The World Health Organization launched guidance called LIVE LIFE to support countries in preventing suicide, as figures showed that more than 700,000 people worldwide took their own life in 2019—one in every 100 deaths. The guidance recommends limiting access to the means of suicide, responsible media reporting, fostering socioemotional life skills in adolescents, and early identification of people at risk.

Cite this as: BMJ 2021;373:n1604
Labour has called for the appointment process of the new chief executive of NHS England to be transparent, based on merit, and without undue political influence.

In a letter sent to cabinet secretary Simon Case on 19 June, Labour’s shadow health minister, Jon Ashworth, also called for the process to be “free from the cronyism that has existed over the past year.”

“This is a matter of the utmost importance for both patients and NHS staff, as the holder of this role will shape the future of the health service at arguably the most critical time in its history,” the letter said.

“I urge you to take action to make the recruitment and selection process public and subject to proper scrutiny to ensure that there is proper confidence in the next holder of this important role.”

Commenting on the letter, Ashworth said, “The NHS needs a chief executive with a proven track record of delivering quality care and who will never fail to champion a public universal NHS, stand up to Rishi Sunak, and secure crucial extra investment.

“This is one of the biggest healthcare jobs in the world. Patients expect the appointment to be made transparently and on the basis of merit.”

The news comes after one prospective candidate for the role, Dido Harding, faced criticism for comments she made about the NHS workforce. According to the Sunday NAGPAUL said nearly 87,000 NHS doctors are from overseas. The cost of replacing them with UK trained doctors will be £46bn regardless of the fact that the NHS is so enriched by diversity.

Regeneron’s antibody combination cuts deaths in seronegative covid patients, Recovery trial finds

Regeneron’s antibody combination treatment cut deaths in patients who had not mounted their own antibody response to SARS-CoV-2 by one fifth, the Recovery trial has found.

The researchers found that for every 100 seronegative patients treated with the combination of casirivimab and imdevimab there were six fewer deaths. They said patients admitted to hospital should now be tested for antibodies to determine whether they could benefit from the treatment.

The two virus neutralising antibodies work by binding non-competitively to the critical receptor binding domain of SARS-CoV-2’s spike protein, thereby stopping the virus from binding to and entering human cells.

As part of the trial, 9785 patients admitted to hospital with covid were randomised to receive either usual care plus the antibody combination or usual care alone between September 2020 and May 2021. Of these, about a third were seronegative at baseline, half were seropositive, and one sixth had unknown serostatus.

Among patients who received usual care alone, 28 day mortality was twice as high in those who were seronegative (30%) than in seropositive patients (15%) at study entry. Among those who were seronegative at baseline, however, the combination reduced deaths by a fifth: from 30% in the usual care group to 24% (rate ratio 0.80 (95% confidence interval 0.70 to 0.91)).

The treatment did not have an effect on people who were seropositive at baseline.

Belt and braces approach

In the study preprint the researchers said that, although they did not specifically look at variants, the major variants circulating in the UK throughout the trial, such as alpha, remained sensitive to the treatment. They added that although spike glycoprotein mutations in the beta and
**UK regulator extends lateral flow test authorisation despite US concerns**

The UK medicines regulator has extended the authorisation for lateral flow tests used as part of the mass covid testing programme, despite concerns raised by the US regulator over the main test—the Innova SARS-CoV-2 antigen rapid qualitative test.

**Binned**

The US Food and Drug Agency last week warned the public to stop using the Innova test and suggested that any unused tests should be destroyed, binned, or returned.

The agency issued a class 1 recall after an investigation uncovered “significant concerns that the performance of the test has not been adequately established, presenting a risk to health.”

However, the UK’s Medicines and Healthcare Products Regulatory Agency (MHRA) said its decision to extend the exceptional use authorisation (EUA) followed a “satisfactory outcome” of a review in response to US concerns. But, despite the apparently positive findings, the MHRA has extended the authorisation for only two months—until 28 August.

MHRA director of devices Graeme Tunbridge said, “We have now concluded our review of the risk assessment and are satisfied that no further action is necessary or advisable. This has allowed us to extend the EUA to allow an ongoing supply over the coming months. People can be assured of the MHRA’s work to continuously monitor the tests in use; as is our standard process.”

In the UK, the lateral flow tests are authorised for use in detecting positive cases of asymptomatic covid-19 and are used in schools and before larger events, such as Euro 2020 matches. The public can also order two tests a week for general use.

Scientists have previously warned the tests may miss as many as half of cases, depending on who is using them, and provide false reassurance to people who receive a negative result.

Sheila Bird, former programme leader at the MRC Biostatistics Unit, Cambridge University, said that the MHRA’s transparency failures, including that it had not provided details on how the recent review was carried out or its findings, must be immediately redressed.

**Delta cases rise by 79%, but rate slows**

Almost all new UK cases of covid are the delta variant, but new data indicate that, while case numbers are increasing, the rate of growth is slower than a week ago.

Public Health England’s weekly data on variant cases show that numbers of delta in the UK have risen by 33 630 since last week to 75 953, a 79% increase. The most recent data show 99% of sequenced and genotyped cases across the country are the delta variant.

The data also show that 58 830 positive test results were recorded between 11 and 17 June, an increase of 33.7% on the previous week.

PHE said the data showed the risk of hospital admission and the delta variant is now dominant. The increase is primarily in younger age groups, a large proportion of whom were unvaccinated but are now being invited to receive the vaccine. It is encouraging to see hospital admissions and deaths are not rising at the same rate, but we will continue to monitor it closely.”

Paul Hunter, professor in medicine at the University of East Anglia, said, “Cases are still rising but apparently not as rapidly as they were a week ago. On balance, it does appear the epidemic in the UK may no longer be increasing exponentially.”

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Trust is fined £733 000 for unsafe care of mother and son

A hospital trust that admitted failing to provide safe care and treatment for a newborn baby and his mother has been fined £733 000.

East Kent Hospitals University Trust pleaded guilty last April to providing unsafe care resulting in avoidable harm to Harry Richford and his mother, Sarah, in the first such criminal prosecution of an acute care NHS trust. At a sentencing hearing on 18 June at Folkestone magistrates court the trust was also ordered to pay a £170 victim surcharge and costs of £28 000.

Harry died a week after his emergency delivery in 2017 at Queen Elizabeth the Queen Mother Hospital in Margate. The prosecution by the Care Quality Commission came after his parents, Sarah and Tom Richford (above), spent years searching for answers as to why their baby died.

Initially the trust described his death as “expected,” and it was only in 2020 that a coroner’s inquest was held. The coroner found his death was “wholly avoidable” and contributed to by neglect at the hospital. He found more than a dozen areas of concern, including the delivery by an inexperienced locum doctor and delays in resuscitation.

An independent inquiry, commissioned by NHS England and headed by Bill Kirkup, is carrying out an urgent review of maternity and neonatal services at the trust, which is due to report in late 2022.

Cite this as: BMJ 2021;373:n1589

BMJ INVESTIGATION

Number of doctors retiring early has trebled since 2008

The number of doctors taking early retirement from the NHS has more than trebled over the past 13 years, official figures show. In England and Wales 1358 GPs and hospital doctors took voluntary early retirement or retired because of ill health in 2020-21, up from 401 in 2007-08.

Overall, the total number of doctors retiring rose by 21% over this period, from 2431 in 2007-08 to 2952 in 2020-21. The total number of doctors employed by the NHS in England and Wales rose by 25% over this period, from 141 000 to 176 000.

The figures were provided to The BMJ by the NHS Business Services Authority in response to a freedom of information request. They relate to doctors who claimed their NHS pension in a specific pension year, some of whom may have returned to work in the NHS in other roles after claiming their pensions.

As the number of doctors retiring early has risen, the number retiring on the basis of age has fallen: from 2030 in 2007-08 to 1594 in 2020-21. The average age at which doctors are retiring has also fallen over this period, from 61 years in 2007-08 to 59 in 2020-21.

Changes to pension tax regulations since 2010 have left many senior doctors facing large tax bills. The BMA said that changes to tax regulation were one of the main reasons prompting doctors to retire, a situation confirmed last week by the financial watchdog the National Audit Committee. The fluctuations in the number of doctors taking early retirement also reflect this, showing sharp increases in some years. For instance, in 2013-14 2069 doctors took early retirement ahead of the changes to the NHS pension scheme in 2015.

The BMA has also warned that successive

“Artificial pancreas” trial for type 1 diabetes

This technology has the potential to make a remarkable difference to millions of people’s lives

Simon Stevens

Up to 1000 patients with type 1 diabetes will be fitted with an “artificial pancreas” in a landmark NHS trial.

The “closed loop” technology automatically balances blood sugar levels by constantly measuring glucose concentrations and delivering insulin directly to the bloodstream, when needed, through a pump. It is designed to offer better glucose control, reduce the risk of hypoglycaemia, and remove the need for finger prick tests.

Announcing the trial at the NHS Confederation’s virtual conference on 15 June, NHS England’s chief executive, Simon Stevens, said the technology marked a new phase of innovation in diabetes care. “Living with diabetes is a daily challenge for millions of people across England, and this technology has the potential to make a remarkable difference to their lives,” he said.

“In a year that marks a century since insulin was discovered, this innovation is a prime example of the NHS’s continued progress in modern medicine and technology.”

Up to 1000 hybrid closed loop systems will be offered to adults and children at specialist centres in England, which will submit data through the NHS’s National Diabetes Audit. Results will be fed into the evidence assessment undertaken by NICE.
Patients who are offered the technology will ordinarily already be using pump therapy and flash glucose monitors or continuous glucose monitors and will not be achieving an HbA1c of less than 8.5%. The Diabetes Technology Network, a subgroup of the Association of British Clinical Diabetologists, has developed clinical eligibility criteria that are based on “a pragmatic consideration of those most likely to benefit from the new technology from a clinical perspective based on current technology use and glucose control,” NHS England said.

The trial follows the increasing availability on the NHS of non-invasive glucose devices like the Freestyle Libre, which is worn under the skin and continuously monitors glucose levels, allowing patients to scan a sensor to get a reading. NHS England said over 40% of people with type 1 diabetes benefit from flash glucose monitoring.

Partha Kar, NHS specialty adviser for diabetes, said the trial signalled a “quantum leap” for type 1 diabetes technology. He added, “This technology is an extension of the fantastic work achieved by the NHS, third sector, and industry partners working together to improve the lives of patients.”

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2021;373:n1538

A BMA SURVEY found that 72% of doctors would consider retiring earlier as a result of the tax changes

Commenting on the new figures, Vishal Sharma, chair of the BMA’s pensions committee, said that repeated surveys from the BMA had shown that more than half of doctors planned to retire before the age of 60, with most citing pension taxation as their primary reason. He said that the current pension taxation system was “punitive” and left “senior doctors with little option but to consider early retirement.”

The strain of working through the pandemic has left many doctors exhausted and battling stress and burnout, Sharma added. “Many have had their annual leave cancelled, and they have not had adequate time to rest and recover from the tumultuous year they have had, with no sign of let up as they now face the biggest backlog and waiting lists since records began.”

Sharma said the situation had been exacerbated by the government’s decision to freeze the lifetime allowance for pensions taxation for the next five years, which will increase the amount of tax many doctors have to pay on their pensions. “A BMA survey demonstrated that 72% of doctors would consider retiring even earlier as a result of these changes,” he said. “The combination of an exhausted workforce coupled with the freezing of the lifetime allowance being imposed at the same time will potentially result in a mass exodus of highly experienced doctors, at a time when patients need them the most.”

He said a “simple but effective” change the government could make would be to implement a tax-unregistered pension scheme in the NHS. “The government has already implemented such a scheme for the judiciary to address similar recruitment and retention issues,” he said. “A comparable solution within the NHS will allow our most experienced doctors to remain working in the NHS and avert this workforce crisis.”

Tom Moberly, The BMJ
Cite this as: BMJ 2021;373:n1594

“I, as a medical doctor, hope to bring to the office of president over the next two years.”

The pandemic has been unprecedented in terms of the challenges it has presented. For the first time in our history visits had to be suspended from March to July last year, and although we’ve been able to undertake all the planned visits this year it hasn’t been without difficulty.

“When we talk about public health we must consider prisons.”

More information about the work of the committee can be found at www.coe.int/en/web/cpt/home
THE BIG PICTURE

Caring in wards without water

As covid-19 continues to hit Malawi, more than half its health facilities lack handwashing facilities, almost two thirds have no decent toilets, and almost a fifth do not have clean water on site.

Nchisi, a rural district of 300 000 people, has one hospital and three health centres. None have adequate water, sanitation, or hygiene facilities.

As part of a campaign ahead of next year’s World Health Assembly, researchers from WaterAid, which is working with the Wimbledon Foundation to bring clean water and effective sanitation to the district, spoke to health workers, patients, and families about conditions before, during, and after childbirth.

The researchers heard that an assistant at one centre has to collect water four times a day from community boreholes, 300 m away; that at another unit, which delivers up to 60 babies a month, the labour ward has one working toilet, which is often blocked; and that across all the sites water supply is intermittent, which means that doctors and nurses cannot always wash their hands.

Helen Hamilton, a senior policy analyst at WaterAid, said, “Globally, 1.8 billion people are at greater risk of contracting covid-19 and other diseases simply because they use or work in a health facility that lacks basic water services. Two years ago, at the World Health Assembly, global leaders resolved to prioritise water, sanitation, and hygiene in all healthcare facilities. Now is the time for them to make good on those promises.

“It would take just 30 US cents a year [per head of population] to make sure every health centre and hospital in the 47 poorest countries had a reliable water supply and working toilets, saving the lives of one million new mothers and babies every year.”

Alison Shepherd, The BMJ  Cite this as: BMJ 2021;373:n1602
1. Khuwi health centre
2. Steria, a community midwife assistant, with a new mother at Kangolwa health centre
3. Loveness Saulosi, preparing food for her daughter, a patient in Mkunzi health centre
Persistent pulmonary disease after covid-19

Lingering pathology contributes to a wider picture of poor health after hospital discharge

It has been over a year since the first patients were discharged from UK hospitals following treatment for covid-19. Hospital admission was largely dictated by the requirement for supplementary oxygen and additional respiratory support. Acute imaging commonly showed multifocal airspace opacification, and venous thromboembolism was recorded in around a quarter of adults admitted to critical care. This led to concern about the long term respiratory consequences of covid-19, particularly interstitial lung disease and pulmonary vascular disease.

Fifteen months later, our understanding of the complications after hospital treatment for covid-19 is improving. A UK study of 47 780 discharged patients reported all cause mortality of 12% and readmissions in one third after 140 days of follow-up. Interestingly, although respiratory disease was diagnosed in 29.6% after discharge, rates of extrapulmonary complications, including diabetes, adverse cardiovascular events, and liver and kidney dysfunction were also increased compared with those in population matched controls, indicating that the effect of covid-19 extends far beyond the lungs. Outcome data from single centre cohorts have shown that the lungs are often physiologically and radiologically impaired 3-6 months after hospital discharge.

Concordance among these studies suggests the findings are likely to be applicable to hospital treated patients more generally. Indeed, lung abnormalities persisting a few months after other viral pneumonias are recognised. Interestingly, however, while most patients in these studies had persisting symptoms (particularly fatigue, memory problems, and psychological sequelae), only a minority reported dyspnoea.

Data on longer term post-covid sequelae remain sparse, although a small prospective study from Wuhan (n=83) looked at respiratory outcomes over the course of a year after hospital discharge. The percentage of patients with radiological abnormalities fell from 78% at 3 months to 27% (22/83) by 9 months and remained unchanged at 12 months. Only four patients reported dyspnoea one year after discharge and functionally, patients recovered well with normalisation of six minute walk distance. These findings are reassuring, but wide extrapolation should be avoided: participants had a median age of 60 but had no pulmonary and cardiac comorbidities, had never smoked, and 46% did not require respiratory support during the acute infection.

Ground glass opacification

The follow-up studies use various radiological descriptions, but “ground glass opacification” is often reported. In the absence of dilated bronchi, this can indicate a potentially reversible cellular (inflammatory) infiltrate. However, in the year long Wuhan study, ground glass opacification noted at nine months was still present at 12 months, raising the possibility it may in part represent fine fibrosis. This distinction is important as it could influence use of immunomodulatory therapy in patients with persisting ground glass opacification (which will have no effect if fibrosis is the underlying cause). Currently, the benefit of such treatment remains unclear. A single study from the UK reported improvement in dyspnoea scores, lung function, and imaging with a tapering course of corticosteroids starting six weeks after discharge for patients with persistent inflammatory change on CT.

However, this was an uncontrolled observational study of just 30 patients, and since outcome studies have shown improvement in these measures over time without use of corticosteroids, it is difficult to draw conclusions.

Pulmonary emboli are common in patients in hospital with covid-19. Analysis of healthcare claims in the US also found an increased incidence of venous thromboembolism 200 days after the acute illness, although little is known about the burden of chronic thromboembolic disease. Interestingly, a small pilot study from the UK (n=9) using hyperpolarised xenon magnetic resonance imaging of the lungs found regional diffusion abnormalities persisting for three months after hospital discharge, even in those with near normal appearances on computed tomography. These findings may indicate enduring pulmonary vascular abnormalities after acute covid-19, but further investigation is required. The clinical significance of these abnormalities remains unknown.

Many studies highlight the extent of non-respiratory physical and psychological symptoms after acute covid-19, and follow-up studies report all-cause mortality exceeding 10% in the six months after discharge. Thus, while persisting lung damage may be substantial for some, for many, morbidity and mortality after covid-19 are influenced most by pre-existing conditions, infection severity, and the extra-pulmonary complications of SARS-CoV-2.

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Find the full version with references at http://dx.doi.org/10.1136/bmj.n1565
**The NHS needs a comprehensive recovery plan**

This system-wide challenge demands a system-wide response

Even before covid-19, the NHS was in need of some emergency treatment. In the 2019 general election the UK government promised 50 000 more nurses, 6000 more general practitioners, and another 6000 other primary care professionals in addition to the 20 000 already promised. The reason for these commitments was easy to see: widespread staff shortages and a slow but steady decline in many key markers of performance, whether in elective or accident and emergency care (where data are good) or in general practice, mental health, and community services (where they aren’t).

Covid-19 then intervened, causing a massive disruption to services. At their lowest point, GP referrals to hospital fell by around 75% from the previous year, diagnostic tests by 70%, emergency admissions by just under 40%, and GP appointments by about a third. Elective activity is back to around 90% of pre-covid levels, although in any normal year a 10% fall in activity would still be shocking.

The size of the hospital waiting list first dropped sharply as referrals dried up, before rising by 1.3 million as activity picked up again. By June 2021, even as covid-19 admissions to hospital once again begin to rise, signs of returning demand are appearing across the NHS. Attendances at major emergency departments hit their second highest level ever in May, and the volume of appointments with GPs has risen above pre-pandemic levels even without fully accounting for covid vaccinations.

Confronting these challenges will need a long term solution made up of four key elements. Firstly, although the visibility of the waiting list draws attention to the acute sector, solutions need to be about more than acute care. In general practice, despite the increases in activity, the number of GPs and practice nurses is not rising (measured by whole time equivalents) even if some progress is being made on the recruitment of other professions into primary care. Anecdotal reports of rising demand for mental health services are consistent with the effect of prolonged lockdowns and interruptions in care. This is a system-wide challenge and needs a system-wide response.

**Long term planning**

Secondly, we need long term planning. Some of the key resources—such as operating theatres and medical imaging scanners—don’t get built overnight. Most critically of all, workforce shortages are so deep that they cannot be overcome quickly, and the service desperately needs a workforce plan that provides some relief to staff already exhausted by the past year while also setting out longer term staffing commitments and how they will be met.

Thirdly, the plans will need funding. The government had set out spending totals for the NHS through this parliament, but these were all agreed before the pandemic and excluded essential budgets such as training, public health, and capital spending. To the pre-existing priorities from the NHS long term plan—many of which remain valid—we must now add dealing with growing backlogs of care, long covid, and an ongoing pandemic. Leaked estimates suggest that between £2bn and £10bn (€2bn–€12bn; $3bn–$14bn) a year will be required to reduce elective waiting lists back to acceptable levels—the wide range underlines uncertainties over future trends in demand, not least from all the patients who should have been referred in 2020 but were not.

Fourthly, a proper conversation with the public is required. The NHS and the public will not be well served by overly optimistic commitments on recovery that cannot be delivered. This will mean living through a period when patients’ overall expectations are not going to be met and making some tough prioritisation decisions until capacity and productivity recover.

Despite the tragedy of the pandemic, the health and care system enters this new era having learnt some valuable lessons from the response to covid-19. The digital experience has shown the NHS capable of large scale change at pace. The stronger relationships forged with both local government and parts of the voluntary sector also offer the chance to provide a more integrated service that should be better at tackling the longstanding inequalities that often need a system-wide approach. If it all sounds too daunting, remember this has been done before. After years of decline, the NHS Plan in 2000 kicked off a decade of improving access and consistent and rapid increases in staff numbers—backed of course by a proper workforce plan and improving outcomes. If the government provides the resources, history shows the NHS can deliver.
INVESTIGATION

Chronic fatigue syndrome and long covid: moving beyond the controversy

Many patients with long covid are experiencing extreme fatigue, a situation that has re-polarised approaches to treatment and rehabilitation. Melanie Newman reports

“I submitted the first positive trial of cognitive behavioural therapy (CBT) as a treatment for chronic fatigue in the ‘90s,” recalls Michael Sharpe, a professor of psychological medicine who was then a lecturer at Oxford University. “Next thing, my head of department got an unsigned letter, sent to The BMJ, saying that the research study was made up.”

It was the start of a lengthy campaign to prevent and undermine Sharpe’s research by some advocates of chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME) who object to suggestions that their illness has a psychological element.

After a period of “a lot of awfulness” Sharpe moved to Edinburgh University, where he initially decided to abandon the field but was drawn back by the Pace trial. Pace examined the effectiveness of CBT and graded exercise therapy (GET), in which the patient does progressively more exercise over time, combined with medical care. It was always going to be controversial.

“The Medical Research Council was being lobbied, people were trying to stop participants joining the trial—we had so much flak,” he says. Published in 2011 in the Lancet, the Pace trial found that both CBT and GET led to greater improvements in some participants than medical care alone. Since then the trial has been a lightning rod for ME/CFS advocates’ anger, drawing ceaseless attacks on the conduct of the research, the researchers, and the results.

A decade after publication it seems unlikely that a consensus will ever be reached. NICE has since reviewed its guidance on ME/CFS, which has had a controversial reception, and the draft guidance expresses concerns about inappropriate use of exercise and CBT, stating that the evidence is mixed or unclear.

Tensions have now resurfaced with the advent of the pandemic and long covid patients have also told The BMJ that, despite the challenges, long covid provides an opportunity to progress the understanding of postviral syndromes and to acknowledge that they are a very real condition.

Challenged for speaking out

The pandemic has seen Sharpe back in Oxford, helping to set up a multidisciplinary long covid clinic involving specialists, physiotherapists, occupational health practitioners, and psychologists. Clinics of this sort, with a similar range of expertise, have been set up around the UK.

The insurance company Swiss Re—with which Sharpe makes clear he has no financial link—asked him to do a presentation on early observations at the clinic. The slides from his talk showed that long covid encompasses a range of conditions, with symptoms influenced by biological, psychological, and social factors, including media coverage, and that it has some similarities with CFS/ME.

“We need to balance ‘keeping an open mind’ with a pragmatic approach to management,” the slides advised. “Patients need to feel listened to and believed—physicians must manage uncertainty.” Referencing the Pace trial, they added, “At present the best treatment is psychologically informed rehabilitation.” However, while most patients will improve, “there is likely to be some long term disability.”

Sharpe’s inclusion of the Pace trial in his presentation—and, as an example of the role of media coverage, a quote from the Guardian journalist...
DOES EXERCISE MAKE PATIENTS WORSE?

Ben Marsh was an NHS consultant paediatrician who “ran half marathons to relax” before contracting viral pericarditis in 2017. He went back to work after six months but developed more severe symptoms and has not recovered despite “extensive professional input.”

For some people with low level postviral fatigue, Marsh explains that rest in the early stages, followed by a gradual increase in activity with or without psychological support, can be appropriate. “However, for some people this approach is detrimental to their health,” he adds. “The flaw is that this other side of rehab is rarely understood by practitioners or explained to the patient. There is a need to screen patients with fatigue during rehab for PEM [post-exertional malaise].”

The NHS’s Your Covid Recovery website tells patients to gradually build up to 30 minutes’ activity five days a week and not to give up if they have setbacks. It does not warn of PEM.

Marsh thinks that it should. He says physical therapy should be treated like a medicine or surgery. “If you take a drug you have to be told the side effects and what to look out for,” he says. Asked whether over-emphasising side effects may risk causing them, he responds, “There may be a small number of people with a psychological vulnerability who somatise, but that does not justify failure to make doctors and patients aware of the risks.”

Mixed results

The BMJ has spoken to other doctors and healthcare professionals helping long covid patients and found them to be very aware of these concerns, as well as the risk of PEM and the ME/CFS literature.

Away from the fire and fury of social media, they are quietly working out how best to treat each patient without causing harm. Results are—predictably, given the early stage of the research—mixed.

Sally Singh, professor of pulmonary and cardiac rehabilitation at the University of Leicester, says she was “aware of the rhetoric around exercise making people worse, and it was an absolute priority that we didn’t do that, which is why we added in a measure of fatigue when monitoring outcomes.”

She studied 30 patients who took part in an individually tailored six-week rehabilitation programme of aerobic exercise, strength training, and educational discussions. Of the 30 participants only one patient, a stroke survivor, did not improve either exercise capacity or fatigue, while four reported an increase in fatigue but also in exercise capacity.

Meanwhile, in the community rehabilitation arm of the Oxford long covid clinic, Rachael Rogers, a CFS/ME specialist who works alongside a respiratory medicine consultant, has seen some patients with PEM. She says, “We are not advocating exercise for them—we try to establish a baseline of activity that stops the relapsing pattern, the boom and bust. But it’s certainly not all long covid patients who get PEM, and there is another set of patients for whom exercise is appropriate.”

The key is careful screening, assessment, and individualised treatments, explains Rogers, as “it’s not one size fits all.” Difficulties may arise, she says, where services are not funded to screen patients properly.

Diverse groups

Paul Whitaker, a respiratory consultant who set up the first long covid clinic in Yorkshire, told The BMJ he had studied CFS and postviral literature and was aware of the ME/CFS views around exercise from the outset. “For my longstanding patients with long covid who fulfil the criteria for CFS, they do seem to get worse with strenuous aerobic exercise,” he says. “However, long covid patients are a very diverse group, and there are many others who do need an exercise based regimen.” Defining which groups will benefit from exercise remains a challenge.

Long covid patients are a very diverse group

Paul Whitaker

Rob Barker-Davies is a squadron leader, postdoctoral researcher, and registrar in rehabilitation, sport, and exercise medicine at the Defence Medical Rehabilitation Centre. He told a BMJ webinar on long covid, “We are not advocating fixed increments in activity or assuming linear resolution of symptoms.” He describes the programme offered at the centre as “symptom titrated physical activity,” as opposed to graded exercise therapy.

“We mustn’t shirk away from the key training principle of progression,” he says. “But . . . we need to understand the effect of the change we’ve made before proceeding. Otherwise we risk a stepwise deterioration.” His patients, who as military personnel are fitter and younger than average, also need educating on managing their activity to avoid “boom and bust,” he says.

Barker-Davies draws a comparison between long covid symptoms and those of “over-training syndrome,” where athletes over-exercise and can experience fatigue, depression, tachycardia, insomnia, and irritability. He explains that possible causes of over-training syndrome—such as autonomic dysregulation, increased inflammatory cytokines, and dysregulation of the hypothalamus—are all mechanisms that have also been proposed as explanations for long covid.

George Monbiot—set the hares running. In April Monbiot wrote a follow-up piece that began, “A super-spreader has been identified . . . it’s me.” He went on to rehash criticisms of the Pace trial without mentioning that they had been investigated by the Health Research Authority.

Many readers castigated Sharpe for suggesting that the disease was “all in the mind” or created by the media, while others defended him on the same basis. One patient said in the comments section, “As someone who is lying in bed, yet again unable to work and in agony due to long covid, I find this professor’s comments so hurtful. This is a serious physical illness, not some social hysteria.”

Other doctors who have entered the debate have quickly found themselves under fire. Trish Greenhalgh, professor of primary care at Oxford University, commented on exercise and the Pace trial at a public webinar on long covid, hosted in January by the Canadian Institute of Musculoskeletal Health and Arthritis. Her remarks are not publicly available, but Greenhalgh says that she summarised the controversy and that her position was misrepresented as pro-GET; however, other attendees say that she went beyond this and criticised CFS/ME activists.

A short while later she received an email from the organiser of another online conference at which she was due to speak about long covid. An ME
advocate had contacted the organiser to complain about Greenhalgh’s participation on the basis of her “maligning characterisation” of CFS/ME patients and her “promotion of discredited and harmful research.” The message concluded, “Dr Greenhalgh is a patient safety threat to all Canadians living with ME and long covid,” and it asked for her removal from the speaker line-up. The organiser told Greenhalgh it knew people in the UK with similar experiences who had subsequently refused to have anything more to do with CFS/ME.

In the spotlight
But few opinions on long covid have proved as contentious as those of Paul Garner, professor at the Liverpool School of Tropical Medicine. A few months after contracting the virus in March 2020, and after a period of fatigue and other symptoms of long covid, Garner, who had been extremely fit, felt a little better, went for a long cycle ride, and took part in a high impact exercise class. He immediately relapsed.

Experiencing fatigue and what he describes as “brain fog,” he found the medical literature and guidance “pretty hopeless” on convalescence, while the CFS/ME literature was “very helpful.” It explained that he was experiencing “post-exertional malaise”: a hallmark symptom of ME/CFS in which exercise triggers a worsening of symptoms. Garner took advice to accept the limits imposed by the virus. The ME Association recommends “pacing”: slowly building up activity levels while monitoring one’s response to exertion and limiting activities accordingly to prevent post-exertional malaise. It says vigorous exercise should be avoided until some time after complete recovery.

He attempted pacing but struggled to discover a pattern between his activities and symptoms that might help him recover. Three months after contracting covid, he says, he was unable to get out of bed for more than a few hours a day. “I kept trying to convince myself I was getting better, but I wasn’t, and I became too insecure to do anything,” he says.

Weeks turned into months. A CFS/ME advocate wrote an open letter to people with long covid telling them to “brace yourself,” as “you might not end up being sick for a couple of months or a year or even five years. Think decades. Maybe even the rest of your life.” Garner says he became stressed, locked into a pattern of symptom monitoring and an unconscious fear of “overdoing it.”

He then spoke to a recovered CFS/ME patient, who committed to helping him recover. Core to this was a compelling explanation of what was happening in relation to the brain and body, which, he says, “changed my understanding of the symptoms I was experiencing.” The support included a credible explanation of his symptoms, his hope of recovery, and techniques to reduce his symptoms and stress. He went on a short bike ride and then, under physician supervision, increased the ride lengths over several weeks—a process he says was essentially GET. “It stopped me doing too much,” he says. “It was very gradual.” He progressed to full health within a few weeks.

Garner believes the non-specific concept of post-exertional malaise can cause patients to fear overexertion. He also suggests the malaise after exercise is normal early on but that it then becomes a learnt automatic brain response. “I think it’s really important not to emphasise post-exertional malaise as if it is a disease,” he explains. “Early on I got suckered into it as something that might never go away. Part of my recovery has been around changing my thoughts around different body signals. If you see any signal as abnormal, the most minor feelings get exaggerated by your brain, and you take to your bed.”

Perhaps unsurprisingly, having written in The BMJ that he had “looked down the barrel of the ME/CFS gun and disarmed it,” Garner found that the CFS/ME community, which had embraced him, turned on him. And, having previously criticised Cochrane’s recommendation of exercise therapy, he added fuel to the flames when he called for more research on GET and claimed trials had not harmed patients.

His theory was that rest and pacing, as advocated by CFS/ME charities, were as vital as convalescence in the first few months but symptom monitoring may become counterproductive. For such patients, he said, gradually increasing physical activity would be beneficial. This was interpreted as an order forcing exercise on unwilling patients and was rejected by the CFS/ME community.

Garner says some advocates actively oppose research on exercise. “They believe the disease lasts for life,” he says. “They reject any research that examines psychological approaches to treatment or that evaluates the role of progressive physical activity in recovery in ME/CFS, and I would assume by extension to long covid.”

Not against “exercise”
The ME Association’s website carries a statement from its medical adviser, Charles Shepherd, that “the percentage of people who recover [from severe ME/CFS] and return to full normal health is small and . . . ‘spontaneous recovery’ is almost unheard of.”

Shepherd told The BMJ, “We have never issued anything to say that the prognosis indications for long covid are the same as ME. I fear that some do have a long term condition, but it’s also clear that many people are recovering.”

ME/CFS advocates say Garner’s experience has acquired disproportionate importance while being essentially a single anecdotal account from a person who never fulfilled the criteria for an ME/CFS diagnosis. Shepherd suggests Garner has received so much media attention because his account seems to confirm a long held theory about ME: that postviral patients were developing...
abnormal beliefs and behaviours and becoming deconditioned, which could be fixed with CBT and GET.

The ME Association’s view is that there is an as yet poorly understood physiological explanation for ME/CFS and long covid, which may be linked to increased levels of inflammatory cytokines after initial infection. It believes research should focus on this process rather than on exercise and psychological therapies—and that any recommendation for exercise should come with a health warning. “We are not against exercise,” Shepherd told The BMJ. “Our view is that graded exercise can be harmful.”

In a 2019 survey of more than 2000 ME/CFS patients commissioned by the charity Forward ME, most patients reported worse symptoms after GET. In NICE’s recent draft guidelines on ME/CFS—which considered other research, as well as criticism of therapist delivered treatments—a recommendation for GET/CBT has been removed, saying that the evidence is mixed or unclear. Meanwhile, long covid researchers are also learning to live with the increased level of scrutiny and complaints that teams working on CFS/ME have come to expect.

Gordon McGregor, a clinical exercise physiologist, is leading the University of Warwick’s Regain trial, a National Institute for Health Research University of Warwick’s Regain trial, a National Institute for Health Research-funded study on whether physical activity with psychological support benefits long covid patients who were admitted to hospital. He told The BMJ that he had engaged with a number of CFS/ME patient and advocacy groups. “We had constructive conversations and made a number of amendments to the trial protocol as a result,” he says. “We will be screening participants regularly for PEM [post-exertional malaise].”

However, some individuals who believe that physical activity should be avoided at all costs remain deeply unhappy and have emailed McGregor, colleagues, and funders with their views. “The impact has been tangible,” he says, “but the research is continuing.”

COMMENTARY

How power imbalances around long covid can harm patients

CA Chew-Graham and colleagues argue that patients are still struggling to get their voices heard above doctors, a situation that risks “structural iatrogenesis”

Social media platforms have brought together thousands of people with long covid, allowing them to discuss, share, and compare their experiences of relapsing and remitting symptoms. This phenomenon has disrupted and flattened traditional power structures, where doctors were always the experts and patients’ opinions were less valid. But power imbalances remain, especially in the creation of health knowledge, where prominent names in medicine seem to get easy access to the media—leaving less well resourced lay people who are affected by long covid feeling aggrieved and disempowered.

Several research papers describe abnormalities confirming pathophysiological damage ranging from abnormal blood tests to organ damage seen on MRI imaging or in postmortem findings. These publications run counter to the tendency among many doctors to put long covid symptoms down to anxiety or to attribute other psychological labels, which then allows them to avoid investigating symptoms to look for organic pathology. Organic disease processes are clearly at work. This has been recognised by recent interim guidance from the US Centers for Disease Control on managing people with long covid.

We don’t deny that all symptoms will have a psychological impact on the individual, and we would not wish psychological impacts to be stigmatised or ignored, but organic illness must be investigated and should be excluded only after appropriate investigation. People with long covid describe feeling “gaslighted” because the opinions of a few have tended to dominate the evolution of treatment, investigation, and a growing knowledge base.

We believe this is a form of “structural iatrogenesis,” where patients are harmed by power imbalances in the bureaucratic and cultural systems within medicine. Narratives on social media reveal research produced by patients themselves has encountered more obstacles to publication, with journals claiming that it comes from the “wrong sort of expert.”

Twitter and other social media are correcting this imbalance, although the results aren’t always pleasant. Behind the Twitter “spats” are thousands of individual patients with long covid who believe that advocating for graded exercise therapy rather than pacing to manage fatigue in long covid may lead to management regimens that make symptoms worse.

Knowledge production in this new condition of long covid must therefore involve and engage patients and the public, not only to ensure co-production of knowledge but also to avoid top-down hierarchical service provision, which may make logical sense to people who have never experienced the condition but will be totally inappropriate to those affected.

Ultimately, topping endemic power imbalances in medicine requires the input of people who have experienced the cognitive dissonance of confronting personal and healthcare structural biases, so that those providing healthcare fully comprehend the lived realities of the individuals they seek to serve. This is work that cannot be avoided.

CA Chew-Graham, GP and professor of general practice research

AU Lokugamage, consultant obstetrician and gynaecologist and honorary associate professor, University College London and Whittington Hospital NHS Trust, London

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Vaccine outreach: “local knowledge, contacts, and credibility really matter”

Emma Wilkinson looks at initiatives to tackle poorer vaccination uptake for underserved groups

In East Sussex the rates of those who have had their first and second doses of covid-19 vaccine are 80% and 65%, respectively. Conversely, in Newham in east London the rates are 44% and 26%, according to the government dashboard.

Given the higher transmissibility of the delta variant and lower vaccine uptake among those most vulnerable to covid, this disparity is worrying, says Farzana Hussain, a GP in Newham.

Early on she noticed that only about half of her patients aged over 65 were coming forward for vaccination and so she started to call them one by one. “I wanted to ask if they had any questions and I found there was a lot of misinformation. The overarching concern back then was about safety and we had to debunk myths around it containing animal products,” she said. “Looking at my practice levels we now have around 80% of the over 65s vaccinated. It’s the rate of younger people with long term conditions that’s not as high, although we’re still above average.”

The concerns have changed over time, she adds. “Younger people are more worried about fertility. As we move down the cohorts, it’s more ‘why should I have it, I’m not at risk.’”

Keeping it local

Reports from community level suggest that vaccine confidence among ethnic minorities is improving. The national picture, however, suggests that more work needs to be done.

Samia Latif, consultant in communicable disease control and chair of Public Health England’s Black and Minority Ethnic Network, says that in December a consortium of more than 40 ethnic minority health networks worked to identify the concerns in their communities and share good practice. “Covid made everyone realise that you can’t leave anyone behind. We knew we needed to talk to these communities and understand their concerns but also they needed to trust the person the message is coming from,” she says, stressing these are not “hard to reach” groups but historically underserved populations.

Salman Waqar, a GP who has worked on vaccine initiatives with the British Islamic

We had to debunk myths around [the vaccine] containing animal products Farzana Hussain

Medical Association, says it boils down to a matter of trust and helping people to navigate the contradictory advice they’ve been hearing. “We’ve been trying to recognise that we’re not operating in a vacuum and we have to validate concerns around inequality and inequity. But there was also targeted disinformation about things like whether the vaccine is halal or whether the vaccines contained aborted fetal cells.”

He believes a local response is key but says it is resource intensive. As time has passed it’s not so much the fringe views people are airing but legitimate concerns about safety, effectiveness, and side effects. “We’re not going to undo decades, if not centuries, of inequalities in 18 months,” he adds. “There’s a lot of institutional memory about being used and abused, for want of a better phrase.”

In Sheffield, the city council and clinical commissioning group have invested £300 000 in more than 30 community groups. There have been pop-up clinics in mosques, hostels, and a supermarket, and a vaccine bus which has travelled to areas of high deprivation. Sheffield has about 66% uptake of a first dose but it remains low among some communities including black African and African Caribbean populations.

The investment in community groups has led to “incredible message delivery about effectiveness and safety in ways that are far more nuanced,” says Greg Fell, the city’s director of public health. “Local knowledge, contacts, and credibility really, really matter,” he says. Sometimes it can be small things, such as organising transport, that get people over the line, he adds.

Gulnaz Hussain is chief executive of the Firvale Community Hub, a Sheffield charity working to improve social equality. The areas it covers are some of the city’s most deprived and were hit hard by covid—yet people often weren’t accessing public health information.

“We’ve done a lot of work around vaccination. We had a health coordinator who was making sure the messages were getting out. We also opened a vaccine helpline that is available in community languages. As we move to younger age groups, we’re doing work with youth centres and youth clubs.”

Every opportunity

Hussain says they use every opportunity to provide information, often when people are seeking advice on welfare or immigration. “We’re able to convince them and we can speak to other family members who might be saying not to get the vaccine.” The hub ran a successful vaccine clinic for the Roma community and has plans for others.

Ade Williams, a community pharmacist in Bristol, has worked across social media and in person to dispel vaccine myths. He has spoken to faith groups and the Traveller community, and most recently been involved in efforts to promote the vaccine through pubs and hairdressers. Uptake in the city is just under 60%, with 40% having had two doses.

Williams runs a vaccination site in a church and from day one has encouraged people to pop in, take a look, and ask questions. “Some people have anxiety about vaccination itself so that helps,” he says. “Sometimes people are struggling to navigate the booking system. “Everyone has questions about safety and fertility,” he adds. “I’ve also had to reassure people they will not be compelled to have it, our system will always give you a choice.”

He says it’s important not to get frustrated but to have compassion for populations where health inequalities have never been tackled.

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