Caring for unvaccinated patients

As some intensive care units fill up once again, the patients with covid-19 feel almost familiar. Not all, but many, of them are overweight; similarly, many have diabetes or high blood pressure. The difference this time, however, is that another common factor has been added to our lists: patients who are unvaccinated. Certainly not all, but many. How does it feel to care for someone at the edge of life when you know that it didn’t necessarily have to be this way?

Some health professionals may feel angry at having to care for patients who have made unwise decisions. But we all make poor choices at some points in our lives. You may eat too much, you may have texted while driving, or perhaps you drank too much at the office party. And perhaps you got away with it. Through luck rather than judgment, you didn’t crash your car or break your ankle. We are so much more than our worst decisions, and so are the patients who made poor choices and were less fortunate.

Many of the people who turned down having the vaccine are thoughtful and intelligent. Yet the world is full of bad ideas and bad incentives, and people are often influenced by them. Untangling the net of influence is difficult, and often the harder other people try to help, the tighter the knots become. Even exposing bad science to help explain the faulty logic behind it can reinforce those very same false beliefs, through quirks of human psychology that are hard to understand.

And so, what should we do? How should we feel about it all? For one thing, we should continue to explain how the vaccine is safe. We should say that, even if you accept the vaccine’s potential risks—which may have been inflated through bad science—the vaccine is still far safer than actually having covid.

We should also say that choosing a disease filled with risks and uncertainties over a vaccine with far fewer risks and far less uncertainty is still an individual choice, but it’s a choice I find impossible to understand when viewed in this way.

However, we should resist continually poking fun or shaming bad science or bad ideas, even if we do so only to expose them. In this increasingly polarised world, repeated exposure only serves to strengthen beliefs, even after they’re dismantled through logic.

And yet, I still feel angry and cheated. But not at the patients; rather, at the people promoting, fuelling, and exploiting the bad ideas and bad incentives that influence so many people. I am angry with the liars, not those who have been lied to.

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All of us are so much more than our worst decisions
How universities can be made safer this autumn

Institutions should consider five key factors ahead of the start of the new academic year, say Simon Williams and Gavin Yamey

A year ago, when US universities reopened for the fall semester, the outcome was disastrous. At that time the country had about 55 000 new daily cases and had “no federal covid-19 control plan or coordinated vision for safely reopening universities.” In the UK chaotic reopenings sparked outbreaks that plunged entire flats and halls of residence into lockdown.

Now higher education institutions are once again confronting the challenges posed by SARS-CoV-2 in their planning for safe operations. These are heightened by the delta variant, which is estimated to be twice as transmissible as the original coronavirus strain and is dominant in the US and the UK.

It remains critically important to protect students from covid. While it’s true it rarely kills young adults, they can become ill and develop long term symptoms. Infected students can infect older, vulnerable adults on campus. Evidence also shows outbreaks can drive infection in local communities.

So, what steps can universities take to make autumn reopening safer? We believe that there are five key considerations.

First is the level of vaccination coverage. A modelling study found that colleges which achieve over 90% vaccine coverage may safely return to normality. Such high coverage rates will be difficult to attain unless colleges have a mandate—and indeed many US universities require all students, staff, and faculty to be vaccinated before returning. If coverage is below 90%, colleges will have to rely on measures such as regular testing, masking, and distancing to keep campuses safe.

Vaccination incentive schemes

Students in England, at the time of writing, will not be required to show proof of vaccination. And the government is trying out various incentive schemes to boost the number of young people getting vaccinated.

The reasons for vaccine hesitancy are complex, but one is a lack of urgency due to a reduced perception of individual risk and the inconvenience of making appointments. Universities can increase uptake by offering vaccinations on site. Planning ahead, booster jab discussions are under way and health service and vaccine providers can work with universities to facilitate booster uptake.

Second, universities on both sides of the Atlantic are considering delaying or phasing in their autumn reopening or incorporating a blended learning approach. A phased return would avoid a mass migration of all students over a matter of weeks (the UK, for example, has about two million university students).

Third, universities, governments, and funders should invest in ensuring adequate ventilation throughout campuses. There’s sufficient time before reopening for substantial investment in high efficiency particulate air (HEPA) filters and CO2 monitors to ensure adequate ventilation in all university buildings. This investment will provide benefits not just in the short term but also in the longer term, for covid and other respiratory diseases including “freshers’ flu,” a group of illnesses caused by various viruses. In the initial weeks of term, outdoor classrooms and social spaces should be introduced and encouraged.

Fourth, effective contact tracing, combined with effective on-campus testing, isolation,

We can have influence in many arenas, even if it doesn’t feel like it

A couple of weeks ago thunderstorms raged over London. The rain was dramatic, pelting down. But I looked on from the safety of my home, thinking only vaguely that I might have a bit of a soggy cycle later. The next morning, as I prepped my list ready for the ward round, one of the consultants warned me and my colleague to be prepared for a busy day. One of the district general hospitals had been flooded overnight by the heavy rain and needed to transfer a large number of patients. Another hospital in the trust had its emergency department flooded.

I have an interest in climate change and health. I’ve given talks on it and I always make it a point to say we are already seeing the effects of the climate emergency on health. One of the resources I use is a 2019 report commissioned by the Greater London Authority. It lists the specific risks of the climate emergency to Londoners’ health, one of which is that two fifths of the city’s hospitals are at risk of a one in 30 year flood event.

A couple of weeks ago the reality of this hit me. This is climate breakdown. And it is having a real effect on our patients, our community, our healthcare systems. Today, not in some imagined, worst case scenario. Patients were transferred across London because of a hospital flooding. Operations were cancelled. Care was delayed. Clinicians were stressed. I found it hard to concentrate that morning. How can we not all be talking about this?

When faced with emergencies we take action. This is an emergency—right here and
ACUTE PERSPECTIVE David Oliver

Were Nightingale units ever workable?

Research has found that around one in nine inpatients with covid-19 acquired it in hospital. Much of the commentary on our pandemic response included calls for patients with covid to be moved out of wards and away from other patients. Some commentators urged a modern revival of “fever hospitals,” solely for isolation and care of people with infectious diseases.

But was the idea of fever hospitals ever workable? The data are telling. During the first pandemic wave in March to June 2020, the number of people with covid in English hospitals peaked at 21 000. It reached 17 000 again by November, rose to 38 000 in January, and didn’t fall back below 20 000 until early March. We have only 102 000 general and acute beds in the NHS.

Daily covid admissions peaked at 3000 in April 2020 and then 4000 in January 2021. We don’t have mothballed but fully equipped hospitals ready to use as infectious disease units. Even if we did, the logistics of transporting patients from emergency departments would present big problems and patients would still need the full facilities of an acute general hospital, including 24 hour on-call teams, critical care, and imaging.

Furthermore, hospitals need staff. One in eight NHS nursing posts and one in 11 other clinical positions are unfilled. Where would the staff come from? For all of these reasons the idea of fever hospitals at scale, for a disease as overwhelming as covid, was never more than a soundbite.

However, the Nightingale hospitals—set up at impressive speed with fanfares from media and politicians—were concrete entities. Their creation was understandable given the modelling of unchecked demand and experiences in China, Italy, and New York, weeks before covid hit the UK.

As well as the 4000 beds in the Nightingale at London’s ExCeL Centre—for people requiring intensive or high dependency care and equal to the entire pre-pandemic intensive care bed base in England—six further sites were set up with the potential for 15 000 beds. These were not set up for intensive care. Some were nominally designated for post-acute patients, but even if these patients didn’t need ventilators or organ support they’d still need nurses and healthcare assistants, medical cover, and allied health professionals for rehabilitation and imaging.

The Health Service Journal estimated the Nightingales’ set-up costs at £220m, with a further £200m for running costs, yet they admitted fewer than 1000 patients. There were simply never enough staff. It’s testimony to the NHS that our existing bed base coped and flexed as well as it did—including intensive care beds, which reached double their usual capacity at times.

What we need when planning future pandemic responses is more support for those facilities, more capacity on those sites, and an urgent plan to tackle staffing gaps. We must stop putting infrastructure before the people to staff them—or headlines before workable solutions.

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Cite this as: BMJ 2021;374:n2013

and support, are key to minimising the effects of transmission on and beyond campuses. Additional resources should be allocated to encourage adherence and mitigate any negative impact of self-isolation.

Finally, masks still have a role to play. In the US, the Centers for Disease Control recently changed its guidance to say that everyone, not just unvaccinated people, should wear a mask indoors in places with high levels of transmission. Its new guidance was based on data suggesting that, if a vaccinated person becomes infected, the cycle threshold value—an indication of how much virus a person is carrying—may be the same as in an unvaccinated infected person.

Social distancing in large classrooms should be retained where local community rates are high. Where this is not possible, and where large group classrooms are pedagogically important, masks should be required as a precautionary measure.

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Cite this as: BMJ 2021;374:n2019

now. We can’t ignore it. But what action can and should we take? We can have influence in many arenas, even if it doesn’t feel like we can—we be it in our personal choices, professionally, or how we use our political voice. All actions will have an impact.

When I speak about taking personal action, some are cynical. It is true we can’t let those in power shift all responsibility onto individuals. But any changes to our own actions have a ripple effect, influencing those around us.

As professionals we have a responsibility to ensure healthcare doesn’t harm the communities we hope to help. This is achievable only through a massive group effort, which has to include rethinking our clinical practice and how we deliver services, so as to reduce our impact on the climate.

Florence Wedmore, medical education fellow, London
Lifelong lessons in learning

When I first became a GP registrar (having made a happy escape from a hospital specialty), I found my new colleagues’ willingness to own up to the gaps in their knowledge very refreshing. The contrast between this and the fiercely competitive environment of academic grand rounds—where no one would dream of admitting ignorance—was crystallised one morning when a senior GP fished a paper result from his pigeonhole at coffee time, read it aloud, and asked, “Does anyone know what on earth this means?”

Early in our careers it can be hard to admit ignorance but, for me, the licence not to know was one of the attractions of general practice. One cannot be expert in every area of medicine, so my role is often to look things up or to ask a specialist and then translate the response into something meaningful to the patient in front of me.

In the old days this meant keeping a cumbersome paper list of things that I needed to find out, but my continuous professional development now happens in real time, often exactly when I need it. It’s rare for my clinic to finish without a dozen computer tabs open at obscure acronyms, drug doses or interactions, or quick refreshers on NICE guidelines for a condition I rarely see.

Of course, there are limits to how much ignorance is acceptable, and some students and doctors worry about how they will maintain a patient’s trust if the gaps in their knowledge become too visible. However, most patients would rather you checked the dose of a drug before prescribing instead of relying on memory, and they are quite happy for you to say up front that something is outside your expertise. In other specialties such a statement might imply “and therefore this is not my business,” but in general practice it will always be my business to find out, to skill up, and to learn together with my patient when we find ourselves in previously uncharted waters—especially as it may be many months before a hospital appointment for that expert opinion comes to our aid.

Pretending to know when we do not, or failing to check because we are afraid to look uncertain, is dangerous. As senior doctors we have a duty not only to share the knowledge and wisdom we’ve acquired over years of practice but also to be frank about what we don’t know, what we’ve forgotten, or things we never actually learnt. We may find our juniors teaching us valuable new information (because medicine does keep changing), but, more importantly, we act as role models. We are all fallible individuals and are more effective as a team, pooling our knowledge and our skills.

Pretending to know when we do not is dangerous

Gender inequalities—legislating for change

In the last of our three podcasts on women’s health and gender inequalities, Hina Jilani, a pioneering lawyer and activist, talks about her work campaigning for women’s rights in Pakistan and what’s kept her motivated over the past four decades:

“T’m not a particularly courageous person, but we have no option when we are living under certain circumstances and under a level of injustice which is absolutely unacceptable. Then your outrage has to be vented. There has to be some steps that you take to change the situation. So I think it’s more the need rather than courage that drives you to keep fighting.”

“I’m optimistic about our successes. I believe that human rights defenders cannot afford the luxury of pessimism. Even the small successes keep me energised to fight more and more. This struggle will be painful, it has been painful, but it’s worth investing our time and our energies in. If you really look objectively at where we have come from since the 1980s, it is amazing the successes we have had.”

The benefits of intercalation

Many medical students will step out of their medical programme and intercalate. In this Sharp Scratch episode the team are joined by Douglas Corfield from the University of Manchester medical school to talk about the logistics of having a year out, its benefits, and the potential drawbacks:

“Medical careers have many different pathways, and all of them require a different set of skills in addition to just medical practice, and that will include critical appraisal of information, report writing, and working with teams outside the clinical arena. There are a lot of transferable skills that come from the intercalation, whether it’s a science based or a humanities based one, which are important in that respect.”

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Improving the quality of healthcare is complex. It requires input not just from healthcare providers but also from patients and families to identify gaps, develop meaningful interventions, and ensure that interventions improve care and outcomes, and consider value from their perspective. Closing gaps in healthcare quality, improving workflows, and implementing evidence based interventions require change, but not all changes are successful, and most come with unintended consequences.

Numerous approaches are available to making changes in healthcare systems such as lean, six sigma, the model for improvement, healthcare delivery science, and implementation science. These are usually used in isolation, although there is some overlap in their approaches, particularly quality improvement and implementation science. When looking to build and disseminate knowledge about making change, collaboration between approaches might help create changes more successfully and efficiently.

ANALYSIS

Different approaches to making and testing change in healthcare

Greg Ogrinc and colleagues call for greater exploitation of the synergies between quality improvement and implementation science in improving care

Improving the quality of healthcare is complex. It requires input not just from healthcare providers but also from patients and families to identify gaps, develop meaningful interventions, and ensure that interventions improve care and outcomes, and consider value from their perspective. Closing gaps in healthcare quality, improving workflows, and implementing evidence based interventions require change, but not all changes are successful, and most come with unintended consequences.

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KEY MESSAGES

- Implementation science and quality improvement both use tests of change to adapt interventions in a particular context
- The context in which the changes are made affects the effectiveness of tests of change, irrespective of the methods that are used
- Fidelity in tests of change refers to both the faithful use of data to drive the iterations of the interventions as well as implementation of the intervention as designed
- The common features of implementation science and quality improvement can be used to improve the conduct and reporting of changes to interventions

Interdisciplinary tensions

Over the past several years we have recognised a tension and, at times, a competition between quality improvement (QI) and implementation science (IS), two commonly used systematic approaches to improve the quality, safety, and value of healthcare services and to disseminate what is learnt from those efforts. This tension is unnecessary and wasteful when so many gaps in healthcare quality need to be addressed. QI focuses on the highly relevant work within a particular context while IS focuses on framing the work to make findings generalisable. Both approaches are important, and there is considerable overlap from which each can learn. Failure to recognise the overlap can lead to replication of interventions, delay in the dissemination of effective interventions, and missed opportunities to work together to improve healthcare. Others have also recently noticed overlap in QI and IS such as the potential to use both to improve cancer care.

The response of healthcare systems to the covid-19 pandemic exemplifies this challenge. Early in the pandemic, local systems experienced a rapid influx of patients with covid-19 and dwindling supplies of personal protective equipment (PPE). Institutions relied on sound QI methods to determine how to solve the particular problem of PPE in their particular context. While this was necessary and helpful, there was, perhaps, a missed opportunity. If IS methods had been used to help solve those problems, it might have been easier to share answers with others. Both QI and IS bring a rich base of knowledge and skills. Both are needed but their potential summative effects have been underused during the covid-19 pandemic, partly because these fields see themselves as competitors and not collaborators.

QI and IS approach change from different philosophical underpinnings, yet we feel they share similarities that suggest combining their lenses would be beneficial. While QI comes from system operations and IS from behavioural sciences, both recognise that changes occur in a specific context and are affected by the context itself, requiring that each context be considered unique. The outcomes of interest in QI are generally improving quality of care: safety, timeliness, effectiveness, equity, efficiency, and patient centredness. The outcomes of interest in IS generally include the uptake and application of evidence based care with attention to acceptability, cost, and feasibility. Both fields focus on disseminating findings to others through peer reviewed publications. Overall, this tension has been accurately described as the work of moving evidence into practice.
Different approaches to change

Making and documenting changes to interventions is difficult, and reporting of QI and IS varies, limiting impact. The Standards for Quality Improvement Reporting Excellence (SQUIRE) were developed to improve the reliability of reporting among those using QI, IS, or any other of the approaches to improvement.

The challenge of reporting is prominently manifest in how the intervention changes in response to the local context. An intervention has an initial structure, but the intervention is typically modified throughout the process of improvement or implementation to make it more effective in a particular context. Both fields use imperfect approaches to capturing the data related to these processes, and each has something to offer the other.

In QI, changes are widely promoted to be accomplished through “tests of change” to predict, test, and assess the effect in the local microsystem. Careful use of tests of change, such as through plan-do-study-act (PDSA) cycles, are viewed as key to learning about the microsystem and the context to inform the change process.

In IS, the concept for modifying the intervention is referred to as “adaptation” and is recognised as key to identifying how to spread effective interventions to new contexts, rather than on making the change work in one specific context. Making, assessing, and reporting these adaptations are viewed as an essential part of generating knowledge that can be readily shared with others. The strength of IS is in the methods and approaches to the assessment and reporting of adaptations, and these could be usefully applied to QI, which does not emphasise spread to other contexts as strongly.

PDSA versus adaptation

PDSA cycles are often used in QI for tests of change in a system. PDSA changes should be small, focused, and deliberate. The goal is to try an intervention in a microsystem to learn about how the microsystem reacts. Sometimes the test of the intervention is successful and the system moves closer to its goal. Other times, the PDSA change may not be successful, and the team learns how the microsystem absorbs or ignores the intervention. Making successive changes in a system is often messy and complex. Key to successful PDSA projects is collecting data that clearly align with the goal and analysing each PDSA cycle. Healthcare improvement teams may be frustrated when a step in a PDSA cycle is unsuccessful or they may worry that testing a “small” change will not lead to the improvement that they seek. But although the overall objective is improvement towards the goal, PDSA is about learning and gaining insight into the system, from both the successes and the failures.

In contrast, IS develops an initial, detailed plan for the implementation process. IS considers the contextual factors in the development of the initial implementation strategy to determine which may be facilitators and which may be barriers to the intervention. IS often addresses this by adapting the intervention. In IS, there may be tension between fidelity to the planned implementation strategy and adaptation. Adaptation, in some ways like PDSA cycles, plays a central role in the “fit” between the context and the intervention.
Fidelity in QI and IS

Understanding the fidelity of the intervention in both PDSA and adaptation is vital to successful execution of change. Haphazard execution is a risk during iterations and limits learning. Fidelity in IS is the extent to which an intervention adheres to the planned protocol. The intervention may adapt, but the core elements are intended to be implemented as initially designed. In QI, interventions are expected to be modified through each PDSA cycle of change as the team gains insight into what works, for whom, and in what context.

In QI, fidelity refers to both the adherence to the planned protocol within each PDSA cycle and to the faithful use of data to inform the next test of change. This ensures that changes are driven by the findings of the previous iteration and lead to the accumulation of insights about the intervention, thus increasing the possibility that the intervention will be sustained within the system.

Context and change

The context changes in complex systems in response to alterations in processes, people, policy, or any other perturbation. Context and healthcare improvement interventions interact, so it is important to account for how the context and the intervention change over time to make the changes more sustainable. In QI, context is defined as the physical and sociocultural makeup up of the local environment and the interpretation of these factors by the stakeholders in the environment. It is considered fluid and consists of specific factors but also individuals’ interpretation of the relationships between the factors.

Context in IS may be identified and assessed through process analysis tools such as process flow, cause-effect, or workflow diagrams. These tools are used in the design of interventions to provide insights into the context, enabling the initial intervention to be tailored to the specific microsystem. The intervention is then modified through successive PDSA cycles, based on how the local context reacts to the intervention.

In IS, models such as the consolidated framework for implementation research (CFIR), provide a framework of domains of context. These help inform the design of interventions and are especially useful for formative evaluations of change. CFIR domains, for example, are prespecified contextual factors and sub-constructs that include adaptability and trialability of the intervention. CFIR also recognises that PDSAs are one way to adapt the intervention to a specific context. Importantly, both QI and IS note that there is bidirectional interaction, with the intervention affecting the context and the context affecting the intervention.

Learning from one another

The different origins of healthcare QI (systems operations3) and IS (behavioural change4) sometimes obscure their common goal of creating improvements in the quality, safety, and value of healthcare services in partnership with patients, families, and communities. Each field has much to offer the other in the work of initiating and evaluating change.

The figure (left) lists the main characteristics of intervention modification in QI and IS, showing the substantial overlap between the intent and execution of change within each field. While each has a specific approach, there is much in common and much that can be learnt through collaborations. QI can learn from IS by incorporating framework driven approaches to development, planning, and evaluating outcomes that are helpful to make the work more easily generalisable. IS can learn from QI by incorporating data driven flexibility, needed to show how interventions can be successful in a wide variety of contexts.

We see many opportunities for these fields to work together. Organisations that focus on QI should bring in IS strategies, specifically to learn what to measure to spread work to other microsystems and contexts. IS should expand the integration of QI within its work, perhaps by explicitly embedding PDSA cycles within IS sustainability efforts.

Funding organisations and journals have long recognised IS because of its similarity to the research model. Funders and healthcare journals should encourage use of QI and IS methods together. This would expand the study of both and speed the growth of knowledge about how to make and sustain change in healthcare. Neither of these fields has led to the system transformation that was hoped for, and the emerging improvers and researchers in health professions should be steeped in both. Perhaps this will lead to the emergence of a new set of knowledge and methods that will have a more lasting effect. By working together and combining knowledge and methods from both fields, QI and IS can develop a unified approach with more depth and effectiveness than either has on its own.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

UK workers with occupational covid-19 have been ignored

Workers with long covid will raise major questions and challenges for UK governments (This Week, 3 July). In 3872 covid-19 “workplace” outbreaks and 4253 education outbreaks, occupational morbidity has been seriously underestimated. If all employee covid-19 cases in these outbreaks were listed as occupational, Industrial Injuries Disablement Board benefits would be triggered, assuming the UK Industrial Injuries Advisory Council (IIAC) so advised. Yet covid-19 is still not recognised as a prescribed industrial disease in the UK.

By contrast, much has been done “at pace” to tackle other covid-19 challenges. Billions of pounds have been spent on personal protective equipment and test and trace schemes on the basis of phone calls from UK ministers to businesses. The government should quickly prescribe occupational covid-19 to “level up” care and support for workers. Other European countries already list covid-19 as an occupational disease. IIAC is still examining the evidence. This unnecessary and damaging delay for affected workers reveals failures in the UK system, which looks increasingly unfit for purpose during the pandemic.

IIAC has recognised that several UK occupations are at more than double the risk of getting covid-19, including social care, nursing, transport, food processing, and retail work. But it argued that socioeconomic influences could contribute to these cases, so no action was taken. This is bizarre. Many occupational diseases have occurred in populations experiencing deprivation, but this has not been used as an obstacle to their prescription. IIAC supposedly uses a “balance of probabilities” argument, but then looks for a doubling of risk, which ironically it has already shown.

IIAC denies justice to some of the most vulnerable UK workers who did and do bear the brunt of keeping society functioning during the pandemic. Any public inquiry should entail detailed examination of these failures and how to rectify them urgently.

Andrew Watterson, professor, Stirling
Cite this as: BMJ 2021;374:n2018

LONG Covid IN GP RECORDS

GP s must be aware of post-covid ME/CFS

Wise reports that GPs might be under-reporting long covid in patient records (This Week, 10 July). Approximately 25% of people with SARS-CoV-1 developed debilitating fatigue and other symptoms that met diagnostic criteria for myalgic encephalomyelitis (ME) or chronic fatigue syndrome (CFS) that continued for more than four years. Patients with long covid who have had chronic fatigue for six or more months, with other mandatory symptoms, are likely to receive diagnoses of ME/CFS.

GP s should follow-up patients with suspected long covid to determine whether those still experiencing severe fatigue after six months meet the other diagnostic criteria for ME/CFS. Without enough awareness, patients presenting with long covid symptoms might not be believed by some GPs or might receive misdiagnoses for mental conditions. Not all patients with long covid have ME/CFS but, for those who do, GPs must identify the need for appropriate support, including referrals to occupational rehabilitation support services.

Caroline Kamau-Mitchell, senior lecturer, London
Cite this as: BMJ 2021;374:n1995

COVID-19 IMMUNITY

Estimating vaccine efficacy from medical records

Baraniuk reviews what we know about immunity to SARS-CoV-2 (Briefing, 3 July). We do not yet have information on how long vaccine induced immunity will last or on how well it will protect against new variants. Longitudinal data on “vaccine failures” or re-infections can help guide national policies on how frequently booster doses of vaccines are needed and on whether vaccines need modification to protect against new variants.

The UK is well placed to collect these data and to secure timely evaluation and integration with information provided by the research industry, to guide public health decision making. We also have computerised medical records for use in general practices on a population of around 67 million people. These records can be used to estimate the longer term efficacy of covid-19 vaccines. This will provide a valuable resource, not just for guiding public health policy in the UK, but for global health.

Azeem Majeed, professor of primary care and public health, London
Cite this as: BMJ 2021;374:n1976

MASK RELATED ACNE

Using barrier tape may contravene safety standards

Rudd and Walsh discuss facial skin irritation attributed to personal protective equipment (Practice Pointer, 12 June). They suggest applying a silicon based barrier tape to the nasal bridge and cheeks to help alleviate the condition—presumably between face and mask.

The Health and Safety Executive does not support this technique for respirator masks. Tight fitting respirators such as FFP3 masks require an effective seal between the mask and face, which might be compromised by tape.

The application of tape might also contravene British Standards regarding fit tests, which state: “A fit test shall not be conducted if there is any foreign material or substance between the sealing surface of the respiratory interface and the face or neck.”

Introducing tape would most likely be considered a modification to the respirator and contrary to manufacturers’ instructions. This in turn may invalidate the Conformité Européene or UK Conformity Assessed mark for the respirator.

Martin McMahon, HM inspector of health and safety, Health and Safety Executive
Cite this as: BMJ 2021;374:n1938
COVID-19 LABORATORY LEAK HYPOTHESIS

Questioning what we think we know

Thacker’s review of the Wuhan laboratory leak hypothesis makes for uncomfortable reading (Cover, 10 July). That a small group of scientists, with (apparently) hitherto undeclared links to the Wuhan Institute of Virology, were able to prevent open minded, critical analysis is regrettable.

We draw two key lessons. Firstly, journals should reflect on their declaration of interest policies. They should look carefully for loopholes and should not restrict conflicts of interest to the purely financial. Withdrawing articles if substantial undeclared associations come to light after publication might encourage those who would choose opacity to think twice.

Secondly, the “consensus” that covid-19 must have arisen from SARS-CoV-2 jumping the species barrier to the exclusion of all other possibilities has lessons for us all. It’s important for us all to think hard and critically about what we know, or in the case of the origin of SARS-CoV-2, what we think we know. Extraordinary claims need extraordinary evidence

Thacker’s piece does not provide much clarity on the various arguments for the virus having a natural origin (Cover, 10 July). The conspiracy is the major effort needed to cover up a lab leak, which would most likely involve hundreds of people. Such an extraordinary claim demands extraordinary evidence.

Confirmation in science is difficult and takes time. It took until 2017 for the likely origin of the 2003 SARS virus to be found in bats. Given that all known human coronaviruses have spilled over from animals, it is reasonable to assign a higher level of probability to this hypothesis in the absence of evidence to the contrary.

By treating two theories with wildly different likelihoods as equivalent, we risk normalising the idea that the laboratory leak hypothesis is equally valid, when no hard evidence for it has been produced. This could fuel racial abuse and harm future international cooperation.

Owain Donnelly, clinical lecturer in tropical medicine, Dublin
Cite this as: BMJ 2021;374:n2006

A convenient scapegoat

Debate on the origin of the SARS-CoV-2 pandemic is being conducted mainly in the world of journalism with all its varied perspectives, biases, and political leanings.

China is as unlikely to offer full cooperation and transparency as biosecure laboratories elsewhere—the United States, for example, protects the identity of farmers whose intensive animal rearing conditions lead to new influenza variants. Hard evidence is unlikely to emerge, and the “debate” will roll on.

A simple laboratory incident might be a convenient scapegoat to deflect attention from the harsh lessons we have to learn, allowing us to avoid the connections between climate and habitat destruction and our own globalised habits. These are not warnings: they are consequences.

Blaming a laboratory incident is the easy way out; tackling the harsh reality of what we are doing to this planet is our ethical and biological duty. Let’s not get distracted from this.

Colin Bannon, retired GP, Crapstone
Cite this as: BMJ 2021;374:n2010

VACCINE INFRASTRUCTURE

We need trials of intradermal covid-19 vaccination

Covid-19 vaccines save lives and mitigate illness, but there is simply not an adequate supply (Personal View, 26 June). One solution would be switching to intradermal vaccination because it uses a much smaller volume of vaccine.

But there have not yet been any human trials of intradermal covid-19 vaccine for efficacy and safety. Each type of vaccine would need to be trialled, and they may not all work. Vaccine manufacturers can sell all the vaccine they can produce, so there is no benefit for them in arranging trials and applying for variation of product licences. They may also find that the scarcity of the vaccine is of value to them.

Concerned health professionals should press for trials of intradermal covid-19 vaccines and for companies to proceed with licensing the vaccines that are shown to be safe and effective. Governments also have a role in making intradermal covid-19 vaccines available.

Martin Schweiger, retired consultant in public health, Leeds
Cite this as: BMJ 2021;374:n1980

IMPRISONMENT IN THE PANDEMIC

Immigration detention harms mental health

Alan Mitchell emphasises the impact of increased restrictions in prisons during the pandemic, including cells being locked for prolonged periods (Five Minutes With . . ., 10 July). Confinement alone or with a cellmate has extended to 22-24 hours each day.

Isolation of people who are held in prison solely because of their immigration status causes worsening depression, severe anxiety, psychotic symptoms, exacerbation of post-traumatic stress disorder, self-harm, and thoughts of suicide. The UK remains the only country in Europe to sanction indefinite immigration detention; the uncertainty is particularly damaging to mental health.

Immigration detention has a negative impact on mental health that can last well beyond release. People with pre-existing mental health conditions or a history of trauma are at high risk. Yet, people with known vulnerabilities were detained in isolation for prolonged periods in the UK during the pandemic; the full impact of these combined harms remains unknown.

Rachel Bingham, GP and clinical adviser; Hilary Pickles, honorary treasurer and acting chair, Medical Justice
Cite this as: BMJ 2021;374:n2016
Paul Harker
Director of public health
(b 1944; q Barts 1967; DPH Eng, FFCM, FRCPCH), died after a short illness on 17 March 2021
In the late 1970s Paul Harker took a paediatrics post at Alder Hey Children’s Hospital, Liverpool, and also worked part time as a senior lecturer in child health at the University of Liverpool. It was a period of great turmoil in the city, fuelled by high levels of poverty and social deprivation. Paul’s witnessing of the impact of poverty on the health of young people made a lasting impression. In 1982 he switched to working in public health. He was appointed district medical officer for West Dorset and became Dorset’s director of public health a decade later. He remained in this role until his retirement in 2006. Diagnosed with pancreatic cancer in January he leaves Jackie, his wife of 54 years; three daughters; and six grandchildren.
Nicola Harker
Cite this as: BMJ 2021;373:n1288

Satya Prokash Mukherjee
General practitioner
(b 1934; q National Medical College, Calcutta, India, 1958; DCH, DPH, DIH, MRCGP), died from pneumonia on 6 April 2021
Satya Prokash Mukherjee was born in Howrah, India, and came to the UK in 1962. After spending time in London and south Wales, he moved to Sunderland in the north east of England. After working in paediatrics at the Sunderland Royal Infirmary, he went into general practice and joined Well Street Surgery in 1972, which moved to the newly opened Pallion Health Centre in 1978. The first GP trainer in Sunderland, he had to summarise medical histories manually for nearly 5000 patients and organise the practice to provide both supervision and training time for GP trainees. Mukherjee retired in 2004 and moved to London, where he pursued his loves of travel, art, reading, and cooking. He enjoyed spending time with his grandchildren.
Krishnendu Mukherjee
Cite this as: BMJ 2021;373:n1291

Brian Gerard Dooley
General practitioner
(b 1927; q University College Cork, 1950; FRCGP), died from old age and idiopathic pulmonary fibrosis on 10 April 2021
Brian Gerard Dooley was an accomplished and respected family doctor who, with his wife, Sylvia, built a thriving practice in Aylesbury from their first surgery in a council flat. He was the senior partner throughout his career, guiding and encouraging younger colleagues to fulfil their potential. A GP trainer, he provided occupational health advice for local companies and was a hospital practitioner in old age psychiatry. He chaired both his local medical committee and BMA branch and was a member of the Oxford Regional Health Authority. Devoted to his family, he lovingly cared for Sylvia throughout her declining years with dementia. She predeceased him in 2013. He leaves three daughters, two sons, nine grandchildren, and six great grandchildren.
Mike Thirlwall
Cite this as: BMJ 2021;373:n1287

Charlie Dalton
General practitioner
Hackney, London
(b 1917; q St Bartholomew’s Hospital, London, 1941), died from prostate cancer on 20 March 2021
Charlie Dalton was born Israel Sholame Rosenbloom near Brick Lane, East London, the youngest of five children of Orthodox Jewish immigrants. He married his beloved Eleanor in 1949 and, in 1954, was fortunate in obtaining a large singlehanded GP practice and home in Hackney. In 1961 his third child, Richard, was diagnosed with autism. Initially, Charlie mistook the psychiatrist’s use of the word “autistic” for “artistic” and was utterly confused. In 1962 Charlie and Eleanor became founder members of the National Society for Autistic Children (now the National Autistic Society), Charlie learnt to use a computer in his 80s and smartphone 10 years later. Predeceased by Eleanor and Richard, he leaves two children, six grandchildren, and two great grandchildren.
Laurel Farrington, Mitch Dalton
Cite this as: BMJ 2021;373:n1285

Donald Riddoch
Consultant neurologist
(b 1936; q Birmingham 1960; FRCP), died from malignant melanoma and Parkinson’s disease on 12 March 2021
Donald Riddoch held appointments at the Midlands Hospital for Neurology and Neurosurgery at Smethwick; the National Hospital for Neurology and Neurosurgery, Queen Square, London; and the Queen Elizabeth Hospital in Birmingham. He published numerous papers on neurological subjects, but his passion lay in patient care. Working in London in the early 1970s, he reacquainted himself with a neighbour from home, Elizabeth Chadwick, a trainee paediatrician, whom he married in 1972. He was appointed consultant at Coventry hospitals, including the new Walsgrave Hospital, with additional responsibilities in Warwick. As time went on he became involved in committee work. Predeceased by Liz in 1999, he leaves four children and seven grandchildren.
Fiona Riddoch, Frank Vince
Cite this as: BMJ 2021;373:n1293

Egryn Meiron Jones
General practitioner
Heald Green, Stockport, Cheshire
(b 1937; q Cardiff 1962; MFFP, MRCGP), died from ischaemic heart disease and covid-19 on 14 April 2020
Egryn Meiron Jones was born in north Wales. From 1971 to 1972 he was resident medical officer at Manchester Royal Infirmary. Egryn then went into general practice at Heald Green Health Centre. He was a foundation member of the Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists (1993), and a committee member of the Association of Sexual and Marital Therapists. He was president of the Manchester Medico-Ethical Association in 2001 and an associate of the Faculty of Homeopathy, London. He had a special interest and involvement in the study of Tourette’s syndrome. He loved books, music, sport, and his regular visits to Glyndebourne opera. Egryn leaves his wife, Mary; three children; and five grandchildren.
Mary Winter Jones
Cite this as: BMJ 2021;373:n1289
Nigel John Standfield (b 1951; q King’s College London 1975; FRCS Ed, FRCS Eng), died from idiopathic pulmonary fibrosis on 15 March 2021

Nigel Standfield was born in Wuppertal, Germany, to John Standfield, who had served in the British and Indian armies during the second world war and then in British intelligence, and Mollie (née Taylor), a sports teacher who had trained in the army. The family moved to Street, Somerset, where John became an advertising manager, but he was also an amateur botanist.

Fortunately, Standfield inherited both his mother’s passion for sports and teaching and his father’s aptitude for science. At Sexey’s School, in Bruton, Somerset, he was popular with his fellow students and teachers alike and as an all-rounder he excelled at cricket and football, as well as academically. He was very much a west country man, solidly focused on home and family life.

Soon after starting out as a medical student at King’s College Hospital Medical School in London he lost both his parents but continued with his studies, more determined than ever to succeed in his ambition to become a surgeon. He met his future wife, Donna, a sister at the same hospital, at an anaesthetists’ party. Standfield invited her to a cricket match the following week, and their immediate spark was to last their long marriage. They had three sons.

Medical career
In 1990 Standfield was appointed consultant vascular surgeon at Hammersmith Hospital and Royal Postgraduate Medical School and the Royal Brompton Hospital, London. He was elected a council member of the Royal College of Surgeons of England in 2016.

Standfield had a varied clinical vascular practice with a particular interest in congenital vascular malformations, which was the focus of his inaugural professorial lecture “From Tolpuddle martyr to surgical innovator and trainer.” He spent some 30 years furthering understanding and medical management of this type of birthmark, which led to his being nationally and internationally recognised as a leading expert.

Standfield believed education and training was important to pass on skills to the next generation. He was appointed associate dean for surgery in the London Deanery in 2005 and the first head of the London Postgraduate School of Surgery in 2008, the largest single surgical training organisation in the world, responsible for managing more than 1000 trainees. Since 2001, he had been an intercollegiate examiner for general surgery and was made chairman of the intercollegiate specialty board in general surgery. He was appointed professor of vascular surgery and surgical education at Imperial College Healthcare NHS Trust, London, in 2011.

He trained many young surgeons within the UK and globally, many of whom are consultants today. Among these was vascular surgeon Stella Vig, who paid tribute: “Our paths crossed on so many occasions, initially in 1993 when I was a Welsh senior house officer in London for an exam course. Nigel was an outstanding educator and as head of the school of surgery was determined to develop all of us as individuals, especially female trainees. Aspiring to improve surgical training, he heavily invested in training surgical educators. Always supportive, he coordinated the petition of 5000 surgeons during the junior doctor’s strike, and despite his ill health stood outside the gates of St Mary’s Hospital with a banner urging Jeremy Hunt to go back to the negotiating table.”

On the international scene, Standfield helped develop surgical training programmes in west Africa and China and helped organise training posts for overseas doctors in London. Egypt benefited from this over 20 years which culminated in the establishment of the organ transplant centre in Cairo. Standfield also delivered philanthropic surgical services to children with complex vascular abnormalities in west Africa. He made several visits to Ghana, serving as an external trainer for the West African College of Surgeons from 2013.

Family man
Throughout his married life Standfield spent as much of his spare time as possible watching his sons play sport. Since childhood he had enjoyed fishing and was a keen ornithologist, both of which helped him unwind. He was housebound for the last six months of his life with idiopathic pulmonary fibrosis.

He leaves his wife, Donna, an emergency practitioner; three sons; four grandchildren; and his sister.

Rebecca Wallersteiner, London
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Cite this as: BMJ 2021;373:n1250

CORRECTION

Peter Dunn
An error in the print issue of this obituary (BMJ 2021;372:n769, published 19 March 2021) led to the previous week’s biography being duplicated. The biography should have read: “Peter McNaughton Dunn (b 1929; q Cambridge 1953; MD, FRCP Lond, FRCPI, FRCOG), died from probable carcinoma of bowel on 2 February 2021.” The online version is correct. We apologise for any distress and confusion caused to the family, authors, and readers.