Innumerable aspects of England’s new secretary of state for health and social care, Thérèse Coffey, could instil anything from disquiet to dread in an NHS doctor. I recoil at her record on same sex marriage, for example: she voted against it in 2013 and 2019. Then there’s her record on welfare and poverty: she voted for a cut in spending on welfare benefits some 52 times from 2012 to 2021, not to mention consistently voting against increasing benefits for people unable to work because of illness or disability. It’s a record likely to provoke deep unease in anyone committed to dealing with harmful consequences of socioeconomic gradients in health.

On women’s reproductive rights and a woman’s right to choose, Coffey has previously voted against extending access to abortion care. As a backbencher in 2010 she also introduced a motion in parliament calling for “mental health assessments for women seeking an abortion.” She defended the former health secretary Jeremy Hunt when he said he believed the abortion limit should be reduced to 12 weeks, and after this year’s repeal of Roe v Wade in the US she stated, “I would prefer that people didn’t have abortions, but I am not going to condemn people that do.”

Coffey says that she doesn’t intend to try changing the UK’s abortion laws, but I find this track record deeply unnerving, having seen how the religious right in the US has trampled on women’s bodily autonomy. Does anyone, anywhere, feel complacent these days about a woman’s right to choose?

But several features of the new health secretary simply should not, in 2022, be up for attack: her weight, size, appearance, and sex. The torrent of fat shaming, abuse, and misogyny that accompanied her appointment has been utterly dismal to witness. A photograph of Coffey at a party seven years ago, smoking a cigar while clutching a flute of champagne, has been shared with vicious glee on social media. Strangely, Ken Clarke, a former health secretary famously fond of cigars and beer, was treated more as one of the boys than as an object of disgust. Sneering at appearance is a gendered phenomenon, and women receive a vastly disproportionate number of attacks.

Coffey can and should be vigorously judged on her policies, her voting record, and how, precisely, she intends to tackle the catastrophic state of the NHS after 12 years of Tory governments (no clear plans have been revealed at the time of writing). But her size? That’s not accountability—it’s nothing but nasty and weaponised sexism.

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The torrent of fat shaming, abuse, and misogyny has been utterly dismal to witness.
When I was at school in the 1960s, it was common for teachers to beat children. At my primary school I saw a teacher beating a child on his legs with a handful of rulers in front of the whole class. The boy must have been about 7. At my secondary school it was done in private, with a cane.

Thinking back on the boys who were usually punished, it’s easy to deduce that most would have been from troubled backgrounds, the kind of children whom paediatricians and child psychologists would now recognise as being affected by adverse childhood experiences.

At that time abortion was illegal, as was consensual sex between men. No woman would have dared go to an NHS doctor to ask for an unwanted pregnancy to be terminated. She would have proceeded with the pregnancy against her will, perhaps to give the baby up for adoption, or sought an illegal termination from a private abortion provider, putting her health and life at risk. A man who sought help because of the distress caused by his feelings of attraction towards other men, in a society that regarded this as pathological, might have been referred for aversion therapy with electric shocks, or oestrogen treatment to reduce his libido. Men who were discovered having sex with each other were imprisoned.

Capital punishment
Within wider society, capital punishment still existed. The last hanging in Britain was in 1964. Some people who were hanged were later found to have been wrongfully convicted. Overt racism was widely accepted. People letting out rooms in London openly stipulated that “no Blacks or Irish” should apply. Elite clubs, including golf clubs, excluded Jews. When people with black or brown skin were abused at work, there was no legal means of redress.

If today’s medical students or doctors early in their careers are surprised that some of their teachers were brought up in that world, it’s a tribute to the campaigners who made it almost unimaginable that those barbarities might ever return.

Healthcare is not about the one-off heroic intervention
Society has to recognise the role of prevention in keeping us healthy

Being a surgeon is a huge privilege. Each patient puts their trust in you and the perioperative team. There are hours, days, even months of planning—all for the critical minutes of concentration in the operating theatre. Minutes when everyone is focused on one outcome and you have everything you need: lighting, equipment, position. It’s all “perfect.”

The whole team’s efforts—before, during, and after the operation—enable the surgeon to do their very best. All of those years spent acquiring knowledge, skills, and experience pay off. For surgery, read any intervention: the same applies to operations, radiologically guided interventions, clot busting, or delivering babies. These procedures are palpable proof of how far medicine has come, and it’s easy to see why they capture the public’s imagination.

Yet there are consequences when people start to think that this concentrated, focused time is what healthcare is all about. Most healthcare isn’t about one-off heroic interventions, but the public and the media have a vision that fuels this myth. The press seizes on cases where diagnoses were missed or treatments delayed—contributing to an ethos of “more, better, sooner” for tests and interventions. Paradoxically, this increases people’s passivity regarding their health and dependence on healthcare professionals, under the guise of advocacy.

We need to think too about the negative outcomes of interventions: complications, regret, the medicalisation of things that wouldn’t have progressed, and iatrogenic disorders. Can doctors take a leading role in conveying the subtlety of shared decision making to politicians and the public, without this becoming a debate of extremes?

We need to acknowledge the complexity of healthcare users who have multiple comorbidities—not single conditions—and whose care requires ongoing monitoring and continuous adjustments, all with their individual input on how this fits their lifestyle and preferences. We need to consider resource use, duplication of effort, and waste.

Reductions in road traffic collisions, food poisoning, or falls from ladders are worthy but not exciting.
Almost unimaginable—but not entirely. In the United States, the Supreme Court’s decision to overturn the constitutional right to an abortion is a chilling alarm signal. People who would like to turn the clock back to the mid-20th century or beyond have not vanished. Nor have they lost the will to seize their moment.

Reversing progress
One warning sign in Britain is the increasing use of the term “woke” to denigrate anyone who believes in further advancement of equality and human rights, such as by teaching history from the perspective of people who were enslaved or providing safe routes for asylum seekers. On the surface, the term is mocking. Underneath, it’s part of a wider movement to reverse the progress some of us have seen in our lifetimes.

If you hear someone being described as woke, take a closer look at the argument or idea that someone else is trying to dismiss. And if you’re accused of being woke yourself, wear it as a badge of pride.

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What should the health community be saying to our new PM, asks Martin McKee

Even for people conditioned to long waits—whether in airport queues, for passport renewals, or for Sue Gray’s report—many found the Conservative Party leadership campaign interminable. But now the wait is over. Liz Truss is Britain’s new prime minister. So what should the health community be asking of a Truss premiership?

To answer this question involves resolving a paradox. The leadership debates allowed her to explain her policies at length, but we still know very little about what she will do now. A degree of ambiguity in an election campaign is understandable, allowing candidates to appeal to voters with widely divergent views. The difficulty arises when they win and must make hard choices. Then they must create something resembling coherent policies.

Demoralised
Few would envy Truss. Her inbox will be overflowing as her predecessor spent most of the summer on holiday. Her staff are deeply demoralised, and few of her problems have easy solutions.

Worryingly, based on her performance to date—whether negotiating highly disadvantageous trade deals, failing to stop sewage flowing into rivers, or forgetting in addition to being a leadership candidate she was also foreign secretary, being unable to decide whether the French president was a “friend or foe”—there seem to be few problems that she is not capable of exacerbating. And she will no doubt be mindful that while she gained the support of a majority of party members, she was not the MPs’ favourite, with dissent already being voiced. But she will also wonder what comes next. She will doubtless know the words attributed to Harold Macmillan when asked what his most troubling problems were: “Events, dear boy, events.” She can expect many “events,” not least those generated by Vladimir Putin and increasingly extreme weather as a result of the climate emergency.

Amid these challenges, we in the health community must make our voices heard. We need to say clearly that the country is facing a major health crisis. Without a concerted response on a scale similar to that in the pandemic, large numbers of people will die unnecessarily and many more will suffer prolonged ill health. There is a real risk of a downward spiral of worsening health and declining prosperity, each reinforcing the other.

We all know that this winter will be harsh. But the UK is already experiencing death rates well above normal. The precise reasons are still being debated, but it seems likely some are caused by continued covid infections, some by the long term consequences of covid, but many by the enormous pressure facing the NHS as it struggles with a decade of underinvestment. This against a background of years in which life expectancy gains fell behind those in comparable countries. Many of the problems in the NHS reflect severe staff shortages. Here too, there are several reasons, some a direct consequence of policies pursued by governments Truss was a member of, including Brexit and pension taxation, but also the UK’s failure, unique among industrialised countries, to bring people back into the workforce after the pandemic.

While the cost of living crisis is superimposed on this situation, the outlook for the UK is dire. While some problems, such as the loss of Russian gas, threaten many countries, the UK is especially vulnerable as it has failed to invest in renewables or gas storage capacity. It also faces threats to food supply, again reflecting global factors, but also national ones, in particular Brexit.

Inflation is the highest in the G7 and the value of the pound is plummeting. Many people will have no choice about whether to “heat or eat.” They risk being unable to afford either.

Yet these concerns overlook one of Truss’s greatest strengths—adaptability. She has changed her party allegiance and her attitude to the monarchy and the EU. She owes her success in the leadership campaign, in large part, to the fluidity of her opinions. Maybe she will surprise us and come up with a package to safeguard health and the economy. We can at least hope.

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Death—the great leveller?

Ideas of what counts as a good death are probably quite varied, but most would agree that it should occur in old age and with minimum suffering. Roger McGough famously asked for a young man’s death in his poem, describing (among other possibilities) revenge from a jealous lover at the age of 104. I had a family friend who died at 84 while playing tennis—still with full use of his limbs, eyes, and brain and, right up until the final moment, still actively engaged and in good company.

But sudden stops are hard on the people left behind, so perhaps, given the choice, we’d opt for a brief but painless illness, allowing time to gather the people we loved around us and say goodbye, with a chance for those last conversations that survivors often regret not having.

As a GP I’ve been lucky to witness some good and gentle deaths. I particularly remember a patient cared for at home who, after a long life and a short illness, was offered mouth care by the family using those little pink sponges-on-sticks, dipped in champagne. I’ve also listened to the often overwhelming distress of relatives recounting deaths that were anything but gentle, with uncontrolled symptoms or unwanted medical interventions.

Death is the proverbial “great leveller” because we can’t take our status, wealth, or fame with us. But, right up until that moment, inequality is present, for patients and for those around them. As a GP I’ve been lucky to witness some good and gentle deaths.

I suspect having a doctor who knows you also affects your chances of access to palliative care. Someone who sees you over time will not only note your failing health but is more likely to be a person you trust enough to talk about death. What’s certain is that more resources for the community palliative care service, along with improved continuity of care from GPs, would help more patients to have a good death.

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LATEST PODCAST

Sharp Scratch: raising concerns about a colleague

It can be difficult to tackle unprofessional behaviour, especially if you’re a medical student, so this episode of the Sharp Scratch podcast discusses ways to manage these situations as a junior member of the team. Charlotte Rees and Lynn Monrouxe, who are coauthors of the book, Healthcare Professionalism: Improving Practice through Reflections on Workplace Dilemmas, share what they’ve learnt from their research. Monrouxe begins by talking through these dilemmas in the context of hygiene policy violations: “It’s a very embarrassing thing to have to pull somebody up on hygiene and students are notoriously not very good at saying something out loud about hand washing. Sometimes students use bodily acts of resistance to combat these hygiene dilemmas. One of the easiest things that students do to correct these behaviours is to role model good practice themselves. They tend to role model them using verbal as well as bodily actions—so, for example, ‘We’re just about to do a patient examination, shall we wash our hands now?’ They’ll verbally nudge the context into a hand washing rather than an examination context.”

Rees acknowledges it can be tricky to speak up in front of the person who’s potentially receiving suboptimal care: “Admonishing a colleague in front of a patient—you’ve got to question is this the right time or place? What a lot of students do is they say, ‘I’m just going to have a coffee’ and they’ve just said, ‘I’m going for a coffee’ and they’ve taken themselves out of the room.”

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Edited by Kelly Brendel, deputy digital content editor, The BMJ
A
n estimated 40.5 million people worldwide met criteria for opioid dependence in 2017, and 109 500 people had fatal opioid overdoses. Treatment with buprenorphine, a partial agonist at the μ-opioid receptor, is associated with reduced fatal and non-fatal overdoses among people with opioid dependence and opioid use disorder. Guidelines in many countries, including Australia, Canada, and the UK, require clients starting buprenorphine to attend a pharmacy or clinic daily and be supervised while taking the medication. However, supervision frameworks were temporarily relaxed in many jurisdictions in response to the need to restrict contacts during covid-19. For example, in Ontario, Canada, dispensing intervals could be extended based on a clinical assessment of clients' ability to safely manage doses at home, and doses administered at pharmacies did not need to be witnessed.

These changes were welcomed by clients, who have previously described freedom from daily attendance for opioid agonist treatment as increasing their independence and sense of “normality” and reducing stigma. We consider the evidence from relaxing supervision frameworks during the pandemic and elsewhere and suggest that buprenorphine prescribing guidelines should be permanently revised for many clients.

Buprenorphine supervision models are similar to those adopted for methadone, despite a better safety profile

Sublingual buprenorphine and buprenorphine-naloxone combination products are treatments for opioid use disorder that have been able to overcome several safety and regulatory limitations with methadone. Although methadone has been used to treat opioid use disorder since the 1960s, concerns about overprescribing, diversion to illicit markets, and fatal overdoses led to regulations restricting access in many countries. Buprenorphine is safer than methadone because it produces less respiratory depression and has a lower risk of overdose.

Despite this better safety profile, buprenorphine supervision models in Australia, Canada, and the UK remain similar to those adopted for methadone. In the UK, NICE guidelines indicate that buprenorphine dosing should be supervised daily for at least three months and until “compliance is assured.” Guidelines from the UK departments of health state that most clients starting buprenorphine should have daily dosing under supervision.

In Australia, requirements differ by state and territory, but all states require supervised dosing in a clinic or pharmacy daily for the first one to three months of treatment. In Canada, the product monograph for buprenorphine-naloxone states that it “must be dispensed daily under the supervision of a healthcare professional, until the patient has sufficient clinical stability.” A recent synthesis of Canada’s various provincial and national treatment guidelines recommends supervised dosing at treatment initiation and a graduated introduction of take home doses.

Not all countries use supervised buprenorphine dosing frameworks. Sublingual buprenorphine became widely available in France in 1996 with minimal restrictions on take home doses. In the US, insufficient availability of treatment for opioid use disorder and lower risks of buprenorphine led Congress to pass a law in 2000 allowing buprenorphine to be prescribed outside the specialised clinics that dispensed methadone. Physicians were required to complete an 8 hour course, although in 2021 this requirement was waived for those prescribing buprenorphine to 30 clients or fewer.
Sublingual buprenorphine in the US is usually provided in combination products containing naloxone, which is thought to reduce the risk of diversion, misuse, and overdose, and unsupervised dosing is allowed as soon as treatment is initiated.\(^2\)\(^{-}\)\(^{21}\)

**Benefits of reduced supervision**

Unsupervised dosing is more convenient for clients, provides greater flexibility and ability to organise their lives, and facilitates adherence with treatment.\(^7\) Clients indicate that the enhanced flexibility from unsupervised dosing makes it easier to obtain work, attend school, take holidays, and manage their daily responsibilities.\(^5\)\(^{-}\)\(^{22}\)

Unsupervised dosing also saves clients both time and money, as they are not required to travel to the pharmacy or clinic daily and pay daily dispensing fees.\(^1\)

In a US trial randomising people with dependence to dispensing once or three times a week with different counselling intensities, client satisfaction was significantly higher in the weekly dispensing group.\(^21\)

Furthermore, people with opioid use disorder who were outside treatment programmes report that requirements for supervised dosing dissuade them from accessing opioid agonist treatment and lead them to continue using non-prescribed opioids.\(^22\)

Unsupervised dosing can also reduce the shame and stigma experienced by people with opioid use disorder, especially for those living in rural communities or who have to obtain supervised doses in settings where privacy and confidentiality are not well preserved.\(^24\)

**Unsupervised dosing is safe and effective**

Guidelines justify the need to supervise buprenorphine consumption by highlighting the risks of overdose to clients and communities from unsupervised dosing.\(^13\)\(^{-}\)\(^{18}\)

However, population level surveillance data suggest that fatal buprenorphine overdoses are rare in jurisdictions with unsupervised buprenorphine and buprenorphine-naloxone dosing. In France, after the introduction of buprenorphine with relatively few restrictions, 13 deaths were attributed to buprenorphine in 1998 among the estimated 55,000 clients receiving buprenorphine treatment that year.\(^17\)

The rate of deaths involving methadone per client treated was estimated to be over three times higher, despite the more stringent regulations for methadone treatment.\(^15\)

In Rhode Island, US, 29 of 534 deaths from opioid associated overdoses over two years involved buprenorphine or its metabolite, norbuprenorphine.\(^26\) An average of 5377 clients received buprenorphine treatment each month. Additional opioids, predominantly fentanyl, were involved in 26 of the 29 deaths, and there was no other contributing substance beyond buprenorphine in only one buprenorphine associated death. By contrast, methadone was found in 66 of the 534 people dying from overdose, and it was the only opioid detected in 29, despite methadone being subject to more stringent dosing supervision requirements.\(^26\)

Several lines of evidence support unsupervised buprenorphine as an efficacious and effective treatment for opioid use disorder. Randomised controlled trials have shown that unsupervised buprenorphine-naloxone provides superior outcomes to non-pharmacological interventions or being put on a waiting list and equivalent outcomes to more closely supervised methadone dosing.\(^27\)\(^{-}\)\(^{29}\)

In one study of 329 clients with opioid dependence treated at an emergency department in the US, buprenorphine-naloxone prescribed on discharge without supervised dosing improved treatment retention and reduced self-reported days of illicit opioid use compared with a behavioural intervention or referral.\(^27\)

An Australian trial in 50 people found that unsupervised buprenorphine-naloxone was associated with a significant reduction in heroin use (19 fewer days/month, 95% confidence interval 15 to 23) and improved quality of life (0.95 point difference on question 1 of WHO Quality of Life BREF Scale, 0.62 to 1.28) compared with those randomly assigned to a waiting list control without treatment.\(^28\)

In a Canadian trial with 272 participants, clients with prescription opioid use disorder treated with buprenorphine-naloxone on a flexible supervision framework determined by the treating physician had similar reductions in opioid use to clients treated with more closely supervised methadone dosing.\(^29\)

Evidence supports unsupervised buprenorphine as an effective treatment for opioid use disorder

Two randomised trials have directly compared supervised and unsupervised buprenorphine dosing.\(^30\)\(^{-}\)\(^{31}\) In an Australian trial with 119 participants, those randomly assigned to supervised or unsupervised buprenorphine-naloxone dosing at treatment initiation had no differences in heroin use (reduction of 18.5 days (95% CI 15.3 to 21.8) in unsupervised group v 22.0 days (19.7 to 24.3) in supervised group) or treatment retention (70 days (62.4 to 77.9) in unsupervised group v 68 days (59.6 to 76.4) in supervised group).\(^30\)

The cost of unsupervised treatment was significantly lower, although it did not make a significant difference to quality of life. A trial in the UK of 293 people randomly assigned to three months of supervised treatment (32% receiving sublingual buprenorphine products) or one month of supervised treatment followed by unsupervised dosing found lower rates of criminal activity in the one month supervision group with no
difference in treatment retention between groups in intention-to-treat analyses. Treatment retention was improved and illicit substance use reduced in the one month supervision group in per protocol analyses.

A retrospective propensity weighted cohort study of 3773 buprenorphine-naloxone recipients receiving five to six take home doses a week in Ontario before the pandemic showed that receiving extended home doses (≥13) was associated with decreased interruption in treatment (9.5% vs 12.9% per person year among those not receiving extended take home doses) and no differences in opioid overdoses (fatal opioid overdoses and non-fatal opioid overdoses resulting in emergency department visits or hospital admissions) or treatment discontinuation rates. The 662 individuals receiving daily dispensed buprenorphine-naloxone before the pandemic who received extended take home doses also had no differences in those outcomes compared with individuals continuing to receive daily dispensing.

Although these studies suggest that treatment retention and reduction in opioid use is comparable between unsupervised and unsupervised dosing, they were not powered to detect differences in rare events such as fatal overdoses. Moreover, several of the trials excluded people who may be at highest risk of adverse events, including those with unstable medical or psychiatric illnesses, concurrent substance use disorders, and experiencing homelessness. The suitability of unsupervised dosing for these groups is therefore less clear, although unsupervised dosing was adopted for some of these clients during covid-19. Few trials have compared supervised and unsupervised dosing of sublingual buprenorphine not combined with naloxone, and comparative data from real world settings are also limited.

Discriminatory response to risk
Although the available evidence has limits, most suggests that unsupervised buprenorphine-naloxone dosing is efficacious and that its safety risks are low. Another argument for supervised buprenorphine is the risk of diversion and misuse. All opioids, however, have the potential to be diverted and used in ways other than intended. Data from the 2015-19 US national surveys on drug use suggest that buprenorphine is misused less often than hydrocodone, oxycodone, codeine, and tramadol; none of these medications is subject to supervised dosing requirements in Australia, Canada, the US, or the UK. Moreover, most people who use illicitly acquired buprenorphine in community settings use it to manage opioid withdrawal symptoms, with only a minority of individuals using it to obtain a euphoric effect.

Requiring supervised buprenorphine-naloxone dosing without clear evidence that it is superior to unsupervised dosing is discriminatory; few other client groups are required by default to attend a healthcare facility daily to receive ambulatory treatment. People with pain, for example, are rarely required to have minimum periods of supervised dosing at a pharmacy or prove clinical stability before being provided full agonist, prescription opioids to take at home. This differential practice occurs despite well documented risks of fatal overdose, diversion, and potential for developing dependence with prescription opioids. Requirements for supervised dosing also infringe on personal autonomy and create clear harms for many recipients, including acting as a barrier to starting treatment.

Adopting a more flexible approach
Further epidemiological studies are needed to examine unsupervised dosing outcomes among higher risk clients, but national and local guidelines should no longer require or strongly recommend daily, supervised buprenorphine-naloxone dosing for all clients. Instead, guidelines should emphasise a more flexible approach to supervision and dosing interval, both when starting treatment and for ongoing care.

Unsupervised dosing with less frequent (eg, weekly) dispensing from treatment initiation should be recognised as a valid approach for clients who are able to store the medication safely, are not at risk of intentional overdose, are not using combinations of substances in a way that increases the risk of unintentional overdose, and do not have a high risk of diverting or misusing medications. These criteria are similar to those used in a multicentre Canadian randomised trial of flexible buprenorphine dosing and those suggested by the 2020 Ontario guidance on assessing suitability for unsupervised buprenorphine dosing in the pandemic. Prescribers should discuss with clients the potential benefits (eg, structure, professional monitoring, and accountability of daily dosing) and harms (eg, inconvenience, need for additional travel, costs) of supervised dosing, allowing clients to make an informed choice between supervised and unsupervised dosing. Where available, longer acting, depot buprenorphine formulations could also be offered. All clients should be provided with take home intramuscular or intranasal naloxone to reverse opioid overdoses. Training for providers may also be needed alongside a change in guidelines.

Embracing a more flexible model of buprenorphine-naloxone dosing would allow better alignment of prescribing practices with the needs and preferences of clients. Revising guidelines in Australia, Canada, and the UK would align their models with those already in place in France and the US and the evidence supporting unsupervised buprenorphine-naloxone dosing. All jurisdictions should strive to enable buprenorphine-naloxone treatment for opioid use disorder that is safe and effective, minimises intrusiveness in clients’ lives, and respects client autonomy.

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Self-testing for covid-19

Adding oropharyngeal to nasal sampling is not the answer to underperforming tests

In a linked paper (p 398), Schuit and colleagues tackle the issue of self-testing for covid-19. Despite a recent meta-analysis of the sensitivity and specificity of single sample testing, self-testing remains a vexing problem with many open questions.

The authors attempt to answer two of the main ones: does augmentation of nasal sampling with sampling from additional sites, such as the oropharynx, increase sensitivity, specificity, or both? And do these performance metrics change with the emergence of different viral types such as omicron subvariants?

Schuit and colleagues conducted a prospective study within the Netherlands public testing programme to evaluate three widely used tests: Flowflex (Acon Laboratories), MPBio (MP Biomedicals), and Clinistest (Siemens-Healthineers). Between December 2021 and February 2022, the authors identified and recruited 3076 adults seeking self-testing who had symptoms consistent with covid, been in close contact with an infected individual, a recent positive antigen self-test result, or returned from a high prevalence region.

All participants had a polymerase chain reaction test for covid-19, then performed an antigen based self-test at home “as soon as possible, and within three hours.” This approach, the authors hoped, would alleviate concerns of a Hawthorne effect altering self-testing behaviour.

Overall, nasal sampling yielded sensitivities between 69.9% and 79.0% and specificities all greater than 92%. Although these sensitivities and specificities are lower than manufacturers’ claims, they are broadly consistent with the findings of a previous meta-analysis and these authors’ previous work.

However, confirmatory tests had markedly higher sensitivities than tests done for other reasons—roughly 20% higher. The reason emerges from the subanalyses of viral loads—tests perform better in adults with higher viral loads, which reviews suggest increase infectivity.

Second site
Sensitivities increased slightly to 77.3% and 83.0% when oropharyngeal sampling was added to nasal sampling. Specificities remained comparable with nasal sampling alone, at greater than 93%. Notably, adding oropharyngeal testing was the only scenario in which overall test results satisfied thresholds for performance promoted by the World Health Organization. The increase in sensitivity was test dependent: no test, however, reached anywhere near the level of performance advertised by the manufacturers. It is not yet clear whether this is a design limitation of the tests and whether new tests designed specifically for use at both sites would perform better, or whether oropharyngeal samples simply do not add much viral material beyond that obtained by nasal swabbing.

One bright spot in these data is that test sensitivities remained fairly robust to the increasing prevalence of omicron variants. Helpfully for consumers, recent variants seem to have had little effect on the usefulness of tests done at home. However, we need to remain vigilant as new variants emerge.

What should we take from this study? First, that members of the general public are capable of doing their own nasal (and potentially oropharyngeal) sampling for covid-19 testing, but the real world performance of antigen tests remains highly variable. Second, adding oropharyngeal testing may provide some benefit, although it is unclear how many test kits are capable of expanded use, and serial testing could be a more workable change to testing protocols. Finally, and most importantly, are the policy implications. In the UK and the US, policies governing use of tests to enable a return to normal activities are confusing, poorly explained, and frequently change. In the US, a single negative test result currently allows an individual to return to work or school in many situations. In the UK, government guidance suggests that a negative result “means it’s likely you are not infectious.”

Such simple guidance is inconsistent with Schuit and colleagues’ findings—a single negative test result cannot be interpreted in a vacuum. Individuals must also consider their reason for being tested; have they been exposed to an infected person or been in a high risk situation such as a crowded indoor space; has enough time passed to accrue a high viral load; and, of course, do they have symptoms consistent with covid-19? All are important considerations that will help optimise the value of these tests in limiting spread and containing new variants as we learn to live with covid-19.

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Vitamin D testing is often not necessary but is frequently prompted by symptoms

McChesney and colleagues are to be applauded for drawing attention to the costly practice of unnecessary vitamin D testing (Change (Education), 6-13 August). But tackling the testing of asymptomatic populations may be something of a straw man—as a GP I have never encountered such practice, or its advocacy.

By contrast, vitamin D testing for patients who have symptoms such as generalised aches without plausible clinical suspicion of a relevant condition, such as osteomalacia, does seem to be a common and problematic practice. The finding of a treatable abnormality may provide a convenient explanation and management plan for clinicians but is unlikely to benefit patients who may well present again with the same symptoms.

The suggested responses to requests from patients for asymptomatic testing are helpful, but implicit in the discussion of shared decision making is that the successful conclusion of this process is persuading patients that testing is not necessary. While the authors are no doubt correct that when adequate information is presented many, or even most, patients will agree that testing is not warranted, if we are sincere about shared decision making then we must accept that some patients will still opt for testing.

The authors do not explain whether the option of testing should remain to patients, but the corollary of sharing the decision suggests that it must be. Otherwise, this would not be shared decision making at all, but merely informing patients why asymptomatic vitamin D testing is not available to them.

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A strong doctor-patient relationship is the only safety net needed

Edwards and colleagues’ article on safety netting in the consultation has, surprisingly, barely a mention of the doctor-patient relationship (Practice Pointer, 6-13 August).

Even the patient adviser had her “key issue” of access demoted to the last sentence of text—presumably by the “academic clinicians” listed as coauthors.

It is this sort of purely medicolegal activity, among many other activities of dubious value, that has hammered general practice and the wider NHS. Almost every consultation involves a degree of uncertainty, and it is impossible to safety-net everything.

The only safety net necessary is a strong, reliable relationship with a named, contactable, and available GP. If you doubt it, do the study—but you would be wasting more time.

Roger E Stephenson, retired GP, Crediton

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A life saver for both patient and clinician

Safety netting was never part of my training, although admittedly that was many years ago. I could not disagree more with Stephenson (above). In my practice of about 30 000 patients, we have over 50 clinicians who might see or assess a patient—doctors, paramedics, nurse practitioners, and others. None of these people work full time in terms of clinical sessions. Rapid access to the same clinician, if needed, simply cannot be guaranteed. I suspect that, with modern working patterns, this is so in most general practices.

And, of course, none of us are there out of hours. It is crucial, therefore, that a patient receives clear information on how to seek help, including overnight and at weekends or bank holidays, if symptoms change or worsen or do not progress as expected. I can think of many instances in my practice where safety netting has been a life saver—literally—for all concerned.

Harpreet Singh Arshi, GP, Exeter

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“Safety netting” just means “come back if it’s worse”

The truth about safety netting lies somewhere between the two responses by Stephenson and Arshi (above). Most “safety netting” just means “come back if it’s worse,” which surely does not need to be spelt out. In some situations, symptoms that are of less significance to the patient than the doctor are important, such as imminent cauda equina compression, as emphasised by Edwards and colleagues.

Just writing “safety netting done” or similar in the clinical record is neither necessary nor sufficient to defend yourself against a negligence allegation. Anything specific needs to be spelt out, and anything that is not specific can, to some degree, be assumed.

My understanding of Roger Neighbour’s work is that in The Inner Consultation he was describing the mechanics of consultation rather than making recommendations. But deaneries have now adopted his description as being how a consultation should happen. I probably part company with the training community on this.

Jeremy Platt, GP, Bracknell

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OBITUARIES

Ronald Ferguson Ingle
Senior lecturer in family medicine Medical University of South Africa (b 1927; q Cambridge/London, 1952; MA), died from frailty of old age on 28 July 2022
Ronald Ferguson Ingle was posted by the Society for the Propagation of the Gospel to All Saints Hospital, Engcobo, Transkei, South Africa, in 1958. He joined Pauline Marshall, who had been the sole doctor there since 1954. In 1960 they married, and in 1976 they left the hospital with burnout. Ronald joined the Transkei’s Health Department as chief medical officer of primary care. In 1982 he became tuberculosis officer in the health department in East London. In 1985 he became a senior lecturer in family medicine at the Medical University of South Africa. He retired from clinical work in 1992 and university work in 1997. Predeceased by Pauline, Ronald leaves Gill Browne, his partner of 16 years, and three nieces.

Cite this as: BMJ 2022;378:o2043

Godfrey Fowler
Professor of general practice Oxford University (b 1931; q University College Oxford 1954; OBE, FRCP, FRCPG, FFPH), died from old age and vascular dementia on 29 March 2022
Godfrey Fowler joined Alan Richards in his Oxford practice in 1959. By the early 1970s he was well known as a leading Oxford GP. Richard Doll, regius professor of medicine at the time, asked him to make a case for a university appointment in general practice. The university agreed and Doll persuaded Godfrey to apply. He was appointed and took up the post in 1978. His department became what is now the Nuffield Department of Primary Care Sciences. He was the author of several books and edited a series on general practice for Oxford University Press. He retired in 1997 but remained active. Predeceased by a son in 1995, Godfrey leaves his wife, Sissel, and a son.

David Cranston
Cite this as: BMJ 2022;378:o2114

Sankar Prasad Maker
GP (b 1933; q Calcutta Medical School, India, 1957; FRCS (Ed)), died from a stroke on 25 October 2021
Sankar Prasad Maker was educated at the village school and district town college in India before his admittance to Calcutta Medical College in 1951. After qualifying he went to the UK. While working in various hospitals to fund his postgraduate course he met and fell in love with a nurse named Joy, who was to become his wife of 46 years. Sankar returned to India in 1967, but because of the political unrest at the time and having a young family he returned to the UK. He joined a general practice in Barking and Dagenham, Essex, in 1967. He became a well established and dedicated GP. He retired in 1993 and enjoyed gardening, travel, and photography. Sankar leaves two daughters and two grandsons.

Sita Maker
Cite this as: BMJ 2022;378:o2116

Venkataramana Alladi
Associate specialist in anaesthesia (b 1948; q 1971; FRCS (Edin), DA, FFARCSI, FRCA), died from pancreatic cancer on 28 April 2022
Venkataramana Alladi (“Ramana”) came to the UK in 1975 to work as a surgeon. During his eight year surgical training, he was offered a post in anaesthesia in Darlington and decided to change careers. Unfortunately, barriers to obtaining a senior registrar post meant that he was unable to progress to consultant in anaesthesia. He worked at a private hospital and as a locum until being invited to become an associate specialist at Tameside Hospital, Manchester, in 1991. He retired from Tameside in 2015, although friends and colleagues continued to seek him out for help in managing their chronic pain. His passion for teaching and training was enormous. Ramana will be fondly remembered and leaves his wife, Nandini; two children; his son in law; and two grandchildren.

Akbkar Vohra
Cite this as: BMJ 2022;378:o2110

Edward Daniel Gilby
Physician and medical oncologist Royal United Hospital Bath (b 1942; q University College London 1965; MSc), died from a subdural haematoma after a slip from his bicycle on 25 May 2022
Edward Daniel Gilby (“Ed”) was renowned for his successful development of cancer services both locally and nationally. In 1976 he was appointed to the post of physician with an interest in medical oncology at the Royal United Hospital in Bath. He promoted the creation of the Bath Cancer Unit Appeal, which raised nearly £1 million to install a linear accelerator to secure modern radiotherapy in order to treat a range of cancers. In 1987 Ed was appointed clinical director for medicine, a position he held for 10 years. At the national level Ed served on the Cancer Collaborative, whose work resulted in the National Cancer Plan. After a 47 year career, Ed retired in 2012. He leaves his wife, Sue; four sons; and two grandchildren.

Sue Gilby
Cite this as: BMJ 2022;378:o1800

David William Miles
Consultant physician Airedale General Hospital (b 1936; q Leeds, 1960; MD, FRCP), died from myeloma on 10 February 2022
David William Miles studied at Leeds University, intercalating a BSc in physiology. During house officer posts in Yorkshire, he met and married Glenys, a nurse. He was a Wellcome research fellow in Denmark and appointed consultant physician at the new Airedale General Hospital in 1970. David was a generalist, developing services in respiratory physiology, cardiology, pacemakers, and neurophysiology but he later focused on diabetes: an early adopter of self-testing for patients, seamless services from childhood to adulthood, and diabetes management in pregnancy. After “retiring” in 1993, he continued to run the neurophysiology service for 20 years. David was a keen French horn player and played in three local orchestras. He leaves Glenys, three children, and seven grandchildren.

Liz Moulton
Cite this as: BMJ 2022;378:o2117
Donald Singer
Pharmacologist who jointly founded the Hippocrates Prize for Poetry and Medicine

Donald Singer (b 1954; q Aberdeen, 1978; MD, FRCP), died after a ventricular arrhythmia causing a cardiac arrest on 11 June 2022

Donald Singer, an outstanding pharmacologist, co-founded the Hippocrates Prize for Poetry and Medicine—to the surprise of colleagues who initially undervalued the initiative.

Known as someone who never had a row and never had a bad word to say about anyone, Singer let the prize speak for itself. In 2011 it won the Times Higher Education award for excellence and innovation in the arts. Singer took great pride in encouraging healthcare professionals and patients from around the world to write poetry.

His co-founder, award winning poet Michael Hulse, who teaches poetry and comparative literature at Warwick University, said, “Donald was a very open, decent, proactive human being. He was a lot of fun with a tremendous sense of humour, but always focused on the job in hand.”

Recalling how they had arrived at a reception to find there were no nibbles, Hulse said, “Some professors are a bit up themselves, but Donald went straight to the supermarket. There was no sense of self-importance about him.”

Organiser and enthusiast
Singer was not himself a poet, more an organiser, initiator, and enthusiast renowned for great charm and diplomacy. He got things done. His extensive influence within pharmacology came not so much from centre stage, but from the wings of many committees, such as those governing the London Hypertension Society (president, 1990-2002), the British and Irish Hypertension Society, and the British Pharmacological Society. He was president of the Fellowship of Postgraduate Medicine from 2007 until his death.

His role as a catalyst even extended to taking up the violin to encourage his daughter Ellie to play. He went on to play in local orchestras. A devoted father and a busy academic and doctor, Singer went to great lengths to strike a rich life-work balance. For example, he took each of his three children in turn to international conferences. He took Ramsay, now an oncology registrar, to Montreal; Ellie, who is specialising in infectious disease and microbiology, to Florida; and Emma, a primary school teacher, to Washington, DC. Ramsay recalls sitting next to his father in a symposium, playing his Gameboy.

Early life and career
Born in Forres, in north Scotland, Singer spent his early years in Iraq and the Middle East. His parents were teachers. His father, a chemist, had worked previously in the Middle East oil industry. His mother learnt speaking French, German, and some Italian. Having aspirations to go into politics, Singer started university at Aberdeen studying economics, but, finding that it lacked “a human element,” he switched to medicine. He met his future wife, Fiona, at Aberdeen. She completed a five year foreign languages degree, a masters, and teacher training. He shared her love of languages, speaking French, German, and some Italian.

After Aberdeen, he moved to London, training at the Hammersmith Hospital, the Royal Postgraduate Medical School, Charing Cross and Westminster Medical School, and St George’s Hospital. He held clinical academic posts at St George’s Hospital and St George’s included Patrick Vallance, now government chief scientific adviser, and Franco Cappuccio, a close friend and now professor of cardiovascular medicine at Warwick.

Cappuccio recalls how Singer broke down a gulf between St George’s physicians and Harefield surgeons to set up a key collaboration resulting in critical studies into blood pressure and endocrine responses to changes in dietary sodium intake in cardiac transplant patients. “We were one of the first centres to measure atrial natriuretic peptide. The idea was Donald’s and a reflection of his diplomatic skills. He went to Harefield to persuade Magdi Yacoub to work with us. Donald was a great initiator and very fertile in his ideas. If he had one failing, it was that he didn’t follow up on things. There are some scientists who spend 40 years studying one molecule. This was not Donald.”

Singer’s other interests included personalised medicine, genomics, and public understanding of health and medicine.

Prize
His idea to found the Hippocrates Prize for Poetry and Medicine arose from a poetry competition at a Coventry hospital attracting 37 entries—far more than expected. He asked Hulse to help with the judging. The competition attracts about 1000 entries a year. With a prize fund of £5550 for winning poems in the open international category and £500 for the international young poet competition, it is one of the world’s highest value poetry awards.

Singer leaves his wife, Fiona, and their three children.

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