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Reappraising old friends: oxygen and primary care

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We should stop treating oxygen as an old friend, say Daniel Horner and Ronan O'Driscoll in an editorial this week (doi:10.1136/bmj.k4436). Supplementary oxygen for medical inpatients has been widely used since the early 20th century, but evidence of its harms for some patients is mounting. A recent systematic review and meta-analysis of randomised controlled trials found that acutely ill medical inpatients randomised to liberal oxygen therapy were more likely to die than those given restricted therapy (risk ratio 1.21 (95% confidence interval 1.03 to 1.43)).[1]

But evidence from systematic reviews can be hard to use in practice. Practising clinicians need more context, such as who the evidence is likely to apply to, when to offer to start and stop oxygen, and whether there are other practical considerations. The latest in our series of Rapid Recommendations from Reed Siemieniuk and colleagues gives guidance on when to start oxygen for patients with stroke or myocardial infarction and when to stop or reduce oxygen for almost all medical patients in or on their way to hospital (doi:10.1136/bmj.k4169).

Although several guidelines advise on when to start oxygen in particular groups of patients, the authors found few that say when to stop. Siemieniuk's team of clinicians, patients, and methodologists make a strong recommendation to stop supplementary oxygen once saturation reaches 96% in most acutely ill medical patients. Around 11 fewer per 1000 people will die if oxygen saturation is kept below 96%. Reducing use of supplementary oxygen also reduces its unpleasant effects, such as dry mouth and restricted mobility. But turning off oxygen requires a culture shift in many acute care settings. It may also increase the workload of nursing staff, who will need to monitor patients' oxygen saturation closely.

Another old friend, primary healthcare, requires reappraisal too. Forty years after the Alma Ata declaration set out a vision of primary healthcare as a means to achieve "health for all," last week the World Health Organization, Unicef, and health ministers renewed their commitment to the integral role of primary healthcare in achieving universal health coverage. To mark the event and support the principles of Alma Ata, *The BMJ* is publishing a series of articles debating the progress and future of primary healthcare (bmj.com/primaryhealthcare).

That future must include a greater focus on public health if primary care is to remain sustainable in the face of challenges such as ageing, socioeconomic inequalities, multimorbidity, and rising consultation rates, say Luke Allen, Trisha Greenhalgh, and colleagues (doi:10.1136/bmj.k4469). By shifting the emphasis from treatment to proactive care, prevention, and health promotion at the local population level, it may be possible to deal with health challenges at an earlier stage, they argue. But this shift will happen only when clinicians, managers, and policy makers understand that caring for populations as well as individuals is important and that it is their job to do so.

1 Chu DK, Kim LH, Young PJ, etal . Mortality and morbidity in acutely ill adults treated with liberal versus conservative oxygen therapy (IOTA): a systematic review and meta-analysis. *Lancet* 2018;391:1693-705. 10.1016/S0140-6736(18)30479-3 29726345

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