



VIEWS AND REVIEWS

PRIMARY COLOUR

Helen Salisbury: Who is vulnerable?

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The Easter bank holidays were cancelled for general practices at short notice, to take the pressure off out-of-hours services in anticipation of a rise in demand. Most of my patients assumed that we were closed, so I spent the time trying to unravel the confusion generated by the government's shielding programme. People who are at high risk of complications if they contract coronavirus have received a letter advising them to be in strict isolation for at least 12 weeks from the end of March.

The accuracy of the centrally generated lists depends partly on the quality of prior coding in GP notes, and our list has certainly revealed some imperfections. Sometimes it was possible to work out the reason for a patient's inclusion, such as an episode of neutropenia in the context of a long forgotten illness, or a cancer that was treated successfully 15 years ago. But in other instances it really wasn't clear, and I ended up phoning patients to ask, "That letter you received from the government—do you have any idea why you got it?" When we concluded that it was an error, most patients were relieved not to be deemed high risk, although some felt cheated of prized grocery delivery slots. There are also significant numbers of people GPs believe are at high risk who don't appear on any lists—particularly those with neurological disorders and resulting poor respiratory function.

But can we be confident that the government is shielding the right people? If we look at the emerging data about who dies from this disease, underlying illnesses are certainly relevant, but other major factors seem to be age, sex, and ethnicity. Estimates suggest that ethnic minority workers comprise around 70% of the NHS staff who have died so far from the virus, despite making up only 20% of the workforce.¹ Even adjusting for different percentages among NHS workers in big, hard hit

cities and for possible discrepancies in prior health, this is a disparity we should not ignore.

An emergency medicine consultant in Wales, who revealed that 50% of his colleagues had tested positive for the virus,² has highlighted widespread fears that we can't rely on our current personal protective equipment (PPE) to protect us entirely. If that's the case, shouldn't we be making shielding lists within our own profession? Acting on a precautionary principle, we need to reassign older, male, ethnic minority doctors to non-face-to-face duties before we lose many more of our colleagues.

While we grieve for our lost medical friends, we also need to think about district nurses and social care workers who are arguably at even greater risk. Many of them have wholly inadequate PPE while providing close personal care—and, with so little testing in the community, they lack information about who may be infectious. Seeing a way out is not easy, but all agree that it must involve testing, contact tracing, and more testing. It has been promised, but—like so much PPE—it has not been delivered.

Competing interests: See www.bmj.com/about-bmj/freelance-contributors.

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- 1 Barr C, Siddique H. Failure to publish data on BAME deaths could put more lives at risk, MPs warn. *Guardian* 2020 Apr 16. <https://www.theguardian.com/world/2020/apr/16/data-on-bame-deaths-from-covid-19-must-be-published-politicians-warn>.
- 2 Giordano C. Coronavirus: Half of all A&E staff in one hospital test positive. *Independent* 2020 Apr 12. <https://www.independent.co.uk/news/health/coronavirus-update-royal-gwent-hospital-accident-emergency-department-cases-newport-a9461766.html>.

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