comment

"We already have sensible, relevant workforce solutions—we need action" **DAVID OLIVER**
"For many of us, general practice feels increasingly like firefighting" **HELEN SALISBURY**
PLUS Omicron in the UK; learning from the care of chronic conditions

THE BOTTOM LINE Partha Kar

Let's plan ahead to support GPs

"It really hurts," he said, sipping his beer in his usual languid style. "All those years of staying on, not giving enough time to family, the late hours—then to be told this? It doesn't feel worth it." Let's call him Peter Parker. He's a GP, and his long day had just ended with an abusive patient telling him that GPs weren't working hard enough or giving patients enough time.

I've known Peter for more than a decade and have never heard him complain. He's incredibly relaxed, a fabulous friend, and a wonderful family man. He's at the extreme edge of my guide on how NHS morale is holding up. I've always thought, if Peter ever felt like giving up, we'd be well and truly in turmoil. And then he said it: "It doesn't feel worth it." Into those words was etched the pain of a professional, far from his home country, who had devoted so much, at the expense of so much personal stuff, to care for others. How did we get here?

We live in a country purported to have one of the strongest vaccine programmes, and we've pinned our faith on boosters. Yet we've had to halt a huge amount of routine care to deliver them. And mixed messages have made many wonder about the healthcare system's role.

Understandable public frustration is often directed at frontline workers. The challenge ahead is not just how we catch up, but how we do so when many like Peter are saying, "I'm done." You can only make so many calls to workers' altruism, especially when sections of the media use them as a punchbag.

So, what can we do? For starters, let's prepare for the next possible variant or dosing requirements. If it's not needed, great—but at least we can plan ahead. A vaccine delivery workforce could mean not having to depend (again) on primary care or suspend most other work. We need a strategy so that we're not caught on the hop again in 2022. If we believe "vaccine holds the key," we also need to factor in that some people won't take the vaccine, whatever the restrictions or rewards. We need to estimate what level of admission or intensive care support they need and plan for it.

The next step has to be a move away from jingoistic nationalism. The virus couldn't care less about how great your country is. We have a variant in play, as many had predicted from the vaccine apartheid. If you don't look after the poor countries, the rich ones eventually get bitten, and their economies are hit.

Finally, we need a genuine effort to help primary care deliver, especially for long term conditions. Without this, no amount of digital innovation can hold the NHS together. If even Peter decides "it's not worth it," there's no other option bar investing in primary care. And we should strain every sinew to do so—not more money for the NHS with a small portion for primary care, but a sustained focus on increasing its funding.

We must plan better to ensure that Peter doesn't lose his zeal, his passion, or simply his love to help patients do better. We all owe him that.

Partha Kar, consultant in diabetes and endocrinology, Portsmouth Hospitals NHS Trust drparthakar@gmail.com
Twitter @parthaskar
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We should strain every sinew to invest more in primary care

OPINION Azeem Majeed

London is a vital barometer of the UK's omicron wave

The fall in infection rates in the city is positive news, but we can't relax

Over the last few weeks, the UK has experienced a record number of covid-19 infections, driven by the rapid spread of the omicron variant, with the daily reported case numbers approaching 200 000 on some days. This has placed considerable pressure on the NHS through a combination of people seriously ill from covid-19 and staff absences. Other parts of the economy, such as public transport, have also been badly affected.

A sustained period of high infection rates would be very damaging for the UK. But there are now signs that the number of cases in London—the first area of the UK to face omicron—may have peaked. In which case, a similar pattern of declining case numbers may be seen elsewhere later this month.

There were several factors that drove the early rise in omicron cases in London. The city is the UK's main international travel hub with the country's busiest airports nearby. It hosts many overseas travellers and it is also very densely populated, with many overcrowded, multigenerational households.

London also has a lower covid vaccine uptake than other parts of the UK. Around 20% of people aged 12 and over in the city remain unvaccinated, compared with a national average of about 10%. This lower rate will lead to infections from omicron spreading more quickly, as well as increasing the likelihood of severe disease. This would in turn increase hospital admissions from covid-19 and pressures across the NHS in London.

Abating wave

After increasing very rapidly, the omicron wave in London now shows signs of abating with the number of cases and hospital admission dropping in recent days. We don't know the fall will continue; nor what the impact will be of schools, universities, and workplaces reopening after Christmas. But if the decline is sustained, other parts of the UK can also expect to see similar falls later this month. This means that the outcome of the omicron wave well may be less severe than predicted in the more pessimistic government models, particularly in the areas of the UK with the highest vaccination rates.

However, we can't yet relax our control measures. The number of UK cases will remain high—compared with previous waves—for some time. The NHS will continue to be under pressure, perhaps for many months, trying to cope with the impact of covid-19 on top of the usual winter pressures, while also trying to deal with the backlog of work that has built up during the pandemic.

Ministers may wish to declare "victory" and end plan B measures, but they should refrain from doing so

The NHS will also continue to be affected by staff shortages due to illness. Although the government may wish to declare "victory" against omicron and end its plan B measures later in January, it should refrain from doing so. The public also need to continue to practise good infection control measures, building on the "three C approach" to personal safety limit the impact of covid-19.

Measures such as wearing face masks in indoor settings should remain in place, with the government and public health agencies encouraging people to use well fitting FFP2

OPINION Charlotte Augst

Learning to live with covid requires us to listen to people living with ill health

VICTORIA JONES/PA/ALMAY

Like last January, all eyes are on acute medicine and ambulance queues outside A&E. The question on decision makers' minds seems to be: will we scrape through this crisis without further mitigations? Can acute medicine stem the tide of infections we are doing so little to control?

The members of National Voices—nearly 200 health and care charities—know what people living with chronic ill health actually need and want. If covid is here to stay, we could do a lot worse than listen to the many people our members support. They can show us how to maintain enjoyable, productive, independent lives, despite it all.

Everyone living with chronic ill health or disability knows that it is better to prevent a crisis than to treat it. If decision makers applied this insight to collectively managing covid, then the first question would not be: "Do we have enough critical care beds?" Instead, we would ask, "What can we do to prevent people catching the virus?" And like individuals building a life around a chronic condition, we need to balance clinical concerns with our need to have a life outside of health. This is why it is so damaging to pretend those arguing for stronger mitigations are demanding constant lockdowns. There is a lot we can do that enables us to both to have a life and reduce risks: wear masks, ventilate schools and indoor spaces, move activities outdoors.

There are no discernible school, workforce, or recovery plans

Everyone living with a chronic condition also knows not every crisis can be prevented. So people make plans. Plans for prevention, but also for what needs to happen when things take a turn for the worse. Together with their care teams, people document

VICTORIA JONES/PA/ALMAY

masks that provide better protection for the wearer, rather than loosely fitting surgical or cloth masks. More targeted use also needs to be made of publicly funded lateral flow tests. Finally, the vaccination drive must continue—for the unvaccinated as well as for those who are now eligible for a booster. A high uptake of a booster will protect against serious illness and buy time until modified vaccines that target omicron are available later this year.

The experience of London offers some positive news for the rest of the UK and for the government. But we must remain cautious and continue with our covid-19 control measures until infection rates are substantially lower than they are now. We also need to be fully prepared to deliver another booster vaccination programme later this year, while also continuing to target the 10% of people aged 12 and over in the UK who remain unvaccinated.

Azeem Majeed, professor of primary care and public health, Imperial College London

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what they want and need, and who will do what to make things go according to plan.

We don't seem to have applied this learning to the second winter peak of covid. There is no discernible plan for schools, for the workforce, for recovery. There is something called a plan for supporting primary care access, but as it obsesses about digital consultations it misses the point. We still have one of the lowest levels of statutory sick pay in Europe. We still have not sorted help for people on low wages to repeatedly self-isolate. There is no plan for people who are clinically vulnerable or have caught long covid to be protected from job loss.

Together, let's develop a plan that weans us off an addiction to crisis medicine and centres on the fundamentals of good care for chronic conditions.

Charlotte Augst, chief executive, National Voices

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ACUTE PERSPECTIVE David Oliver

Workforce solutions exist, so let's act

The growing workforce crisis in the NHS and social care is the biggest, most pressing threat to the viability of services. Covid-19, Brexit, and points based immigration rules have accelerated issues around recruitment, retention, workload, and wellbeing that were affecting the workforce even before the pandemic.

We've had several false dawns where workforce plans have been promised, but the announced deadlines have lapsed. We are in January 2022, and the NHS Operating Framework for 2022-23 merely says NHS England and NHS Improvement "will work with systems to develop workforce plans." This is six years on from the initial pledge.

Yet in 2019 there were some concrete proposals from the Health Foundation, the King's Fund, and the Nuffield Trust. Their report, *Closing the Gap: Key Areas for Action on the Health and Care Workforce*, set out sensible recommendations that remain relevant. They included at least 5000 more nurses to start training each year by 2021, with greater financial support and with funded, high quality clinical placements, and at least 5000 more internationally recruited nurses each year until at least 2023-24.

They also advised concerted action to tackle the growing shortfall of GPs, giving them more support by expanding the numbers of pharmacists, allied health professionals, and nurses in team based primary care. The think tanks were clear that current implementation was too slow. The report added that the NHS should become a far better place to work, with a clear "universal offer" to staff—around wellbeing and work-life balance, but also personal and career development, tackling discrimination, and inclusive leadership.

Better financial terms and contracts were explicitly mentioned. Pay would have to continue to rise in real terms, given the real terms reductions in pay over the past decade. The damaging impact of pension tax rules for more highly paid staff would have to be tackled to avoid losing senior clinicians.

In social care, which faces workforce gaps and threats to its viability at least as bad as those facing the NHS, the report highlighted the need for "sector specific immigration routes" after Brexit and the impact of "points based" immigration rules. The failure to plan for this has hit the social workforce even harder than it has the NHS.

Although the government has belatedly announced that care workers, home care workers, and care assistants can be granted 12 month work visas, the poor remuneration for such work is still a problem when other industries also have big vacancy rates.

Closing the Gap represents a coherent, well evidenced set of actions. If three think tanks employing many former senior civil servants, NHS managers, or clinicians can devise them, so could the government.

Many of these levers can be pulled only at national level because they require central funding, planning, and legislative changes. They simply cannot be left to local integrated care systems. We don't need more pledges, analysis, or consultation. We need a relentless focus on implementing and resourcing solutions.

David Oliver, consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com
Twitter @mancunianmedic

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We don't need more pledges, analysis, or consultation

PRIMARY COLOUR Helen Salisbury

Consequences of letting covid rip

With no centralised data collection, it's hard to know exactly how short staffed general practice is in this omicron wave. There's no reason to think the absence rate will be dramatically different from in hospitals—estimated at one in 10 staff members—but as most practices are small organisations and the blows fall randomly and unevenly, some may be relatively unscathed while others are on their knees.

Our practice currently has some staff absent with covid, and others working from home while we try to access PCR tests. Staff must isolate when they have household contacts with proven covid, to keep patients and colleagues safe. If they test positive, the shortening of the isolation period from 10 days to as few as seven has not helped hugely, as many remain unwell or still test positive at the end of the first week.

The difficulty of predicting which staff will be in the building on any given day makes it hard to organise a good service for patients. We managed last week, but the margins are very tight, and I worry about more doctors going down.

Of course, we always have a duty doctor available to see anyone who needs urgent assessment, but such on-the-day emergencies should be only a small part of general practice. If we repeatedly cancel routine clinics, when do we see those displaced patients, who aren't sure whether they should be worried about their weight loss or who can't sleep because of pain? If we only have the capacity to see the most urgent cases, eventually they become emergencies because the patient is more unwell or the pain is intolerable.

We can manage a few days with an emergency-only primary care service—we do it each Christmas and Easter. But with the acute stress of the pandemic, coupled with an underlying shortage of GPs, for many of us general practice feels increasingly like firefighting. If every day is spent dealing with the urgent, there's never time to consider the important, including the preventive work around long term conditions such as diabetes, hypertension, asthma, and cancer screening. Crucially, it involves knowing our patients, which might mean visiting housebound patients with 15 medications and five intersecting diagnoses, helping them achieve the most comfortable life they can, or getting to know complex families so we can contribute to child safeguarding when they're in trouble.

It's difficult not to be angry, as this was all preventable: we had a chance to flatten this wave, and our government chose to do nothing. As a direct result, patients risk having poorer, less safe care, in hospitals and in the community.

Helen Salisbury, GP, Oxford
helen.salisbury@phc.ox.ac.uk
Twitter @HelenRSalisbury

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It's difficult not to be angry, as this was all preventable

LATEST PODCAST

Doctor Informed: Who is responsible for patient safety?

Clinicians are taught that patient safety is everyone's responsibility, but on the ground it can be hard for doctors to know how to raise their concerns. This episode of Doctor Informed features two guests who talk about the NHS's systems for reporting safety concerns and how well they work. Henrietta Hughes, who implemented the rollout of "freedom to speak up" guardians across the NHS, explains how this initiative works:

"Every trust in England has at least one freedom to speak up guardian and they are an independent role. A guardian will listen to you, offer you support, and escalate the matter—if you choose—to whoever's the right person in the organisation. One of the things I hear very often is that organisations are so large and confusing that it's not always obvious who might be responsible. But the guardians will be able to ensure that the right person will be aware and will be able to conduct whatever investigation might be needed or to make changes. The guardian will also feed back to you what's been done as a result, and they will ensure that the changes and information will lead to learning and improvement."

Bill Kirkup, who's led independent investigations into failings in the NHS, describes how he thinks the current way of responding to safety problems needs to improve: "I don't think this is a system that is working effectively or helpfully at present: if the tool is a hammer, every problem is a nail and every problem is a fitness to practise one if it goes to the GMC. It might be the most complex, multifactorial problem related to team working in systems, but it all has to be boiled down to whether that practitioner was fit to practise at that point in time."

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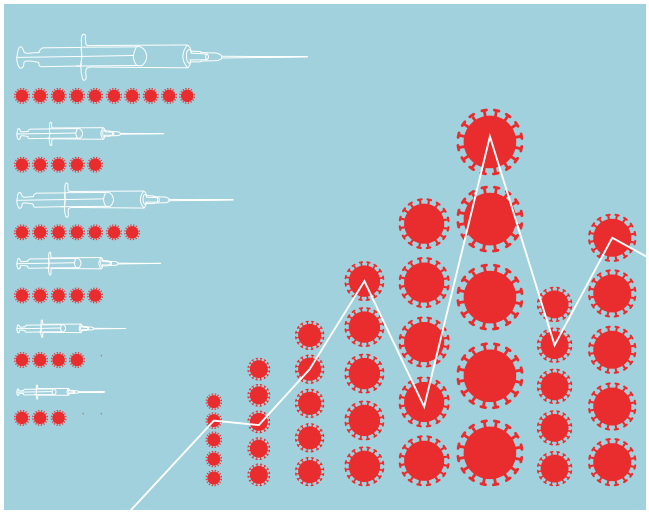
Edited by Kelly Brendel, deputy digital content editor, *The BMJ*

ANALYSIS

Evaluating covid-19 vaccine efficacy and safety in the phase after authorisation

Studies following regulator approval may have little practical value unless there is greater engagement and scrutiny from the wider scientific community, argue **Christof Prugger and colleagues**



Expedited approval pathways have been increasingly used over the past 30 years to bring new medicines to market. The basic premise has been to give patients earlier access to medicines, often achieved by relying on less robust forms of evidence at the time of approval, such as showing efficacy against surrogate endpoints rather than patient outcomes.[1]

Expedited approvals are often coupled with requirements to conduct post-authorisation studies to confirm that the medicines safely provide the anticipated benefit. But a long history of concerns has emerged about the wisdom of shifting clinically important efficacy and safety assessments from before to after authorisation.[1-4] Post-authorisation studies often fail to deliver—lots of studies are never started, many take years longer than planned, and some fail to confirm pre-authorisation results. Evidence on relevant outcomes often remains inconclusive for several years,[5-7] and post-authorisation safety events are seen more frequently for drugs with expedited approval.[8] Regulators only rarely sanction companies for not adhering to post-authorisation study requirements, and drugs are only rarely withdrawn.[2]

Covid-19 vaccines are the most recent and prominent example of expedited regulatory approval. Here, we discuss the need to strengthen the design, conduct, reporting, and dissemination of post-authorisation studies, using covid-19 vaccines as a case study.

Covid-19 vaccines are the most recent and prominent example of expedited regulatory approval

KEY MESSAGES

- Expedited approval of medicines often postpones the evaluation of important efficacy and safety endpoints until after medicines are widely available
- For such medicines, well designed post-authorisation studies are vital to ensuring confidence that benefits actually outweigh risks
- Post-authorisation safety and efficacy studies often remain relatively unknown outside of specialist circles, and there is a history of insufficient compliance and regulatory oversight
- Independent researchers must help scrutinise post-authorisation studies, particularly for global public health interventions such as covid-19 vaccines

Limited evidence at time of conditional approval

The European Medicines Agency (EMA) granted conditional marketing authorisations for four covid vaccines after the results of interim analyses of phase III randomised controlled trials. The EU authorisations for the vaccines by Pfizer-BioNTech, Moderna, AstraZeneca, and Janssen are "conditional," reflecting that, at the time of authorisation, less evidence than traditionally required for full approval was available on their safety and efficacy.[9-12]

At the two month mark, when the trials were assessed, manufacturers reported high efficacy relative to controls against laboratory confirmed covid-19 (of essentially any severity), but important unknowns remained. These included efficacy against SARS-CoV-2 infection, as well as severe covid-19 and the durability of efficacy after two years (the planned duration of the Pfizer-BioNTech pivotal trial (NCT04368728)).[13-16]

The US Food and Drug Administration (FDA) listed important remaining unknowns in its review in December 2020: whether covid-19 vaccines reduce the risk of hospital admission, intensive care unit admission, severe covid-19, and mortality, as well as whether the vaccines are effective in populations at high risk of severe covid-19.[17 18] Groups of particular interest, such as older, chronically ill, or immunocompromised people, were under-represented in or excluded from trials.[19-21] Ongoing transmission in countries with high levels of vaccination highlights the importance of continued assessment of real world effectiveness.

Safety data on uncommon adverse events, as well as medium or long term harms of any frequency, were necessarily limited at the time of mass vaccine rollout, leaving some of the most important questions about efficacy and safety to the post-authorisation phase. Since authorisation and vaccine rollout, numerous studies have been published reporting high vaccine effectiveness at the population level and among particular groups such as healthcare workers and elderly people.[22-27] But many of these studies have important limitations, including lack of data on hospital admissions, death, and high risk populations such as nursing home residents and people with comorbidities. Perhaps, more importantly, these studies were conducted outside of the regulatory framework—while they can be relevant they do not answer specific questions asked by regulators.

Practical ways in which researchers can get involved in the appraisal of post-authorisation studies

Ensuring transparency—Study documents should be available in registration databases, such as the EU electronic register of post-authorisation studies,[32] but they are not always accessible in practice.

Evaluating study methods—Are studies well designed? Are the right questions being asked? Are the methods for answering the research questions appropriate?

Monitor study progress—Analyse entries in study registers to consider whether important milestones, such as submission of interim analyses and final clinical study reports, are being achieved on time, as specified in risk management plans.

Examining results—Was the study carried out and analysed as specified in the study protocol? For example, were pre-specified primary endpoints analysed? Are results transparently and consistently reported across different study reports?

Post-authorisation studies

After conditional marketing authorisation by the EMA, vaccine manufacturers Pfizer-BioNTech and Moderna agreed to carry out 13 and 8 post-authorisation studies, respectively,[28 29] to assess important unknowns, including: risk of vaccine associated enhanced disease;[28 29] effects in pregnant and breastfeeding women, people who were immunocompromised, frail, or with comorbidities or autoimmune or inflammatory disorders; potential interaction between different vaccines; and long term safety.

Conditional authorisation ensures that all post-authorisation obligations are legally binding and evaluated by the EMA. The requirements are codified in risk management plans written by the manufacturer and agreed by the regulator before authorisation. Risk management plans are publicly available documents detailing all planned and ongoing post-authorisation studies mandated by the EMA (see supplementary box on bmj.com). These post-authorisation (phase IV) studies contribute to the EU's pharmacovigilance system alongside the more familiar spontaneous adverse event reporting schemes, EudraVigilance and the UK regulator's Yellow Card Scheme.

Although the drug industry is officially responsible for conducting post-authorisation studies and meeting agreed deadlines for milestones (such as protocol development and study completion), the actual work of designing, conducting, and reporting these important studies can be done by various non-industry actors, such as academic institutions. The EMA also commissions academic and private sector partners to conduct some post-authorisation studies through the ACCESS (vaccine covid-19 monitoring readiness) project.[31]

Conditional authorisation ensures that all post-authorisation obligations are legally binding and evaluated by the European Medicines Agency

Independent scrutiny

We think that researchers should be involved in both the planning and appraisal of post-authorisation studies. Independent scrutiny of regulator sanctioned studies can help close knowledge gaps on the efficacy and safety of medicines, by ensuring the right questions are asked and answered in a timely manner. Independent researchers can ensure transparency, evaluate study methods, monitor progress, and appraise results (box).

Patient and public participation in the process is also vital, particularly at the design stage. This can ensure that regulator mandated studies tackle the issues that matter most to patients. Moreover, specific informed consent should be obtained to allow sharing of individual patient data for independent scrutiny.

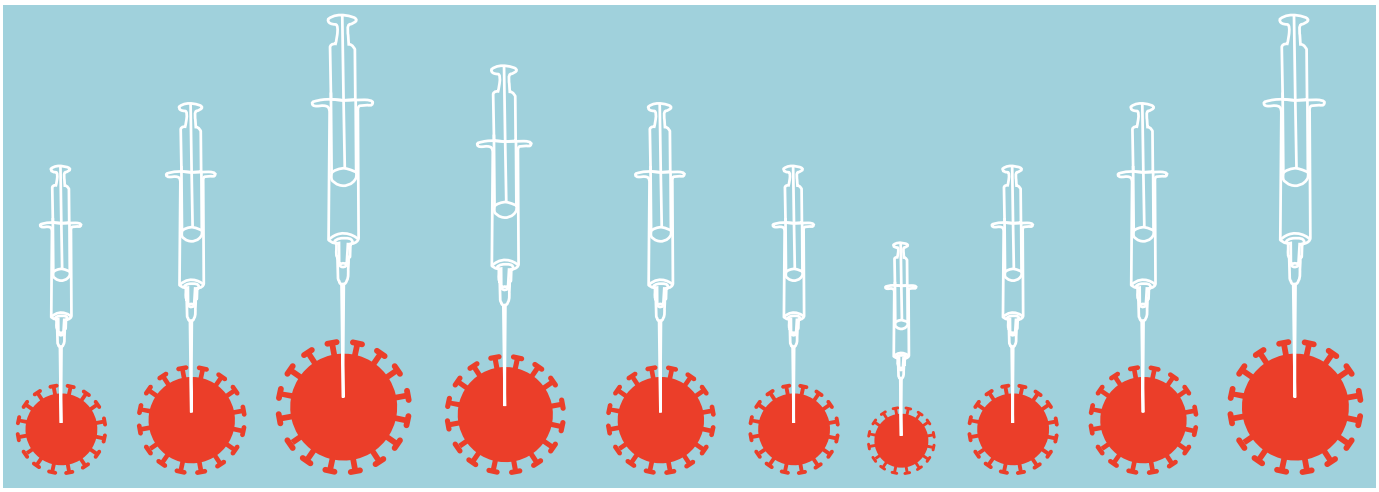
Independent scrutiny matters. Mayo-Wilson and colleagues, for example, found serious discrepancies in the reporting of trials of gabapentin for neuropathic pain and quetiapine for bipolar depression across different sources. These discrepancies among key trial characteristics, such as effect size and significance level, were large enough to influence the interpretation of trial results affecting drug approval and further research.[34] Similar scrutiny of post-authorisation studies has also identified major inconsistencies and inaccuracies; for example, a post-authorisation study of dabigatran etexilate for patients with moderate renal impairment having hip or knee replacement surgery saw important changes in sample size and an interim analysis that occurred between the protocol and the final study report (which was late).[35 36]

We argue for an open review of proposed study designs by independent scientists and patients, tackling issues such as study objectives, special populations of interest, study size and duration, primary and secondary outcomes, and the optimal time frame for reporting results. Such transparency is of even greater importance in view of emerging reports of "poor research conduct, lax data management, and a lack of regulatory oversight" at one of the contract research companies involved in a pivotal covid-19 vaccine trial.[37]

To illustrate the range of post-authorisation studies in need of third party scrutiny, we compiled a list of 21 studies specified in risk management plans after conditional authorisation by the EMA of Pfizer-BioNTech and Moderna vaccines against covid-19 (see supplementary table on bmj.com). Study protocols or summary information were available for only five of the 13 Pfizer-BioNTech studies, and five of the eight Moderna studies. Two Pfizer-BioNTech studies aimed to inform the development of new versions of the vaccine or to study the adverse effects of a booster dose in healthy populations and immunocompromised patients (C4591001, BNT162-01 Cohort 13). Similarly, two Moderna studies aimed to test the effects of different doses or a booster dose on serious adverse events and immunogenicity as primary end points in healthy populations (20-0003, mRNA-1273-P201). One of the more interesting studies in the risk management plan (EU-PAS 40404) evaluates safety outcomes of four vaccines in specific populations of interest (Pfizer-BioNTech, Moderna, AstraZeneca, and Janssen). EU-PAS 40404 is also the only study independent of vaccine manufacturers.

We could not locate either a protocol or summary information for the other eight Pfizer-BioNTech and three Moderna studies. Judging by the titles, some might provide information on hard outcomes such as severe covid-19 or hospital admissions (C4591011, C4591012, W1235284, W1235286). But the lack of publicly available study documents indicates that these studies remain at a very early stage.

The post-authorisation studies being prioritised by manufacturers seem to be those aimed at developing new vaccines or obtaining approval for additional doses. The need for data on hard outcomes such as hospital and intensive care admissions or death in high risk populations is being overlooked.



Accessing study documents

Documents and data from post-authorisation studies can be accessed from databases or registers. Some of the most important studies for covid-19 vaccines are continuations of phase III trials, required by regulators. Fortunately, the EMA has started publishing documents from EU trials in the European Clinical Trials Register, making public important information on trial protocols, status, and clinical study reports.[39] Likewise, clinical study reports and other documents that supported conditional market authorisation are now available on the EMA's Clinical Data Publication website.[40]

The EMA plans to launch its new clinical trials information system this month as a single entry point for submitting clinical trial data in the EU. Clinical study reports and possibly other information in this system will be made public, subject to EU transparency rules. The EMA says that the system is already fully functional and that researchers should consider participating in its training programme on how to use it. The EMA is currently implementing a data analysis and real world interrogation network to generate timely evidence on the safety and effectiveness of medicines from healthcare databases.

The EMA is the only regulator that provides access to data and documents from mandated post-authorisation studies, making summary data from protocols and study reports available through the EU electronic Register of Post-Authorisation Studies (EU PAS Register).[32] The register allows for public access to administrative details, study objectives and main results, methodological details, and published documents including the full protocol with a signed checklist, conflicts of interest and the signed code of conduct, but not all these data are consistently provided. Basic study information from post-authorisation studies required by the EMA can also be found in other registration databases such as ClinicalTrials.gov.

Although the US FDA and Health Canada also require post-authorisation studies, no proactive release of trial documents and data is yet in place. Health Canada does, however, provide easy, public access to clinical information related to studies underpinning authorisation.[43,44] To our knowledge, the UK Medicines and Healthcare Products Regulatory Agency does not have any plans for proactive release of data.

Without external scrutiny, we risk repeating the mistakes of the past

Making it happen

As mandated post-authorisation studies contribute considerably to assessment of the efficacy and safety of medicines and vaccines, public access to data held by regulators is critical and should include patient level data, if available. Access would ideally be established at the planning stage to allow debate between regulators, marketing authorisation holders, and the scientific community throughout the process—from protocol preparation to submission of study reports.

Independent researcher engagement with regulatory studies largely remains unfunded. Funding bodies should consider giving a higher priority to these endeavours as it would help improve the reliability, value, and timeliness of important post-authorisation studies. Journals also have a role in providing a place for third party critiques and analyses of post-authorisation studies.

Rigorous evaluation of covid-19 vaccines' safety and efficacy in the post-authorisation phase is critically important and increasingly possible thanks to strengthened transparency requirements for regulators. Without external scrutiny, we risk repeating the mistakes of the past—with many promises made but little follow through.

Regulatory agencies should continue to improve transparency by granting full access to all regulatory documents and available study data. And researchers should get involved in the independent evaluation of this material. Research independent of manufacturers and political interests might relieve pressure on regulators[47] and improve public trust by helping to ensure the safety, efficacy, and value of all medicines, including covid-19 vaccines—particularly those authorised through expedited regulatory pathways.

Christof Prugger, senior lecturer, Charité-Universitätsmedizin Berlin
christof.prugger@charite.de

Angela Spelsberg, epidemiologist, Comprehensive Cancer Centre Aachen, Germany

Ulrich Keil, professor, University of Münster, Germany

Juan Erviti, researcher, Navarre Health Service, Pamplona, Spain

Peter Doshi, associate professor, University of Maryland School of Pharmacy, Baltimore, Maryland

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Isotonitazene: a new synthetic opioid in the UK

The Centers for Disease Control and Prevention reported a record number of overdose deaths in the US during the pandemic (News Online, 22 November). The UK has also seen a rise in drug poisoning deaths, approximately two thirds of which were related to drug misuse with opioids.

Isotonitazene is a derivative of benzimidazole and an opioid analgesic that is not medically authorised. It is 500 times more potent than morphine and has slightly greater potency than fentanyl. Its effects are like morphine and fentanyl, causing relaxation, euphoria, and respiratory depression. The European Monitoring Centre for Drugs and Drug Addiction became aware of isotonitazene being available on the drugs market in 2019. It is presumed to be used by high risk opioid users. Although data are limited, deaths associated with isotonitazene have been observed in Canada, Europe, and the US.

At the end of July 2021, the Toxicology Unit at Imperial College London became aware of isotonitazene becoming a problem in the UK. Information came to light that batches of heroin were being contaminated or mixed with isotonitazene, and this could potentially be contributing to death. In response to this concern, we started to screen for isotonitazene in the blood of all postmortem cases with a history of, or toxicological results indicating, potential heroin use. Since the start of the screening programme isotonitazene has been regularly detected, primarily in combination with other drugs and often unexpectedly.

Isotonitazene is a risk to public health and a real danger to those who misuse drugs, especially both heroin and cocaine users. The extent of its use is still emerging in the UK and its existence should be known to staff at emergency departments, general practitioners, and drug treatment centres so that relevant advice and potentially lifesaving treatment can be provided.

Limon K Nahar, senior toxicologist; Rebecca Andrews, deputy head; Sue Paterson, head, Toxicology Unit, Imperial College London

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E-CONSULTATIONS AND WORKLOAD IN GENERAL PRACTICE

The problem is capacity, not access

Salisbury argues that electronic consultations are increasing the workload of general practitioners (Helen Salisbury, 27 November). E-consultations are a good solution to the wrong problem. They are a solution to GP access problems. Unfortunately, however, UK general practice does not have access problems. It has capacity problems.

An access problem would mean a surgery list full of empty slots, unfilled because people were unable to contact the practice to book them. I doubt that any such access problem arises anywhere in NHS general practice. A capacity problem means that the surgery list is fully booked and still people are contacting the practice seeking medical advice.

As a profession we need to respond to demands that we "improve access" by pointing out that access is not a problem—capacity is the problem. Only by defining the problem correctly can we hope for improvement.

Dylan J Summers, GP, York

Cite this as: *BMJ* 2021;375:n3070

Ease of access increases low risk presentations

Most trusts have some form of ambulatory care unit where patients can be seen and assessed. This process has enormously increased the ease of access that Salisbury discusses. The referral may be taken by a senior nurse and made by a practitioner in the community who is not a GP. We now see far more patients with low risk presentations that would previously have been managed in the community, especially presentations such as headache and vague thoracic and back pains.

In creating these new pathways, have we met an unmet need or simply lowered the threshold for referral to emergency secondary care? We need to ensure there aren't barriers for those patients who need to come to hospital. But at the same time, as in primary care, we are seeing a considerable extra cohort of patients who don't need tests or to see a consultant in an internal medicine specialty.

Zac Etheridge, consultant physician, Reading

Cite this as: *BMJ* 2021;375:n3071

PRIORITY SETTING AND NET ZERO HEALTHCARE

Reducing unnecessary blood transfusions

Bhopal and Norheim argue that cutting carbon emissions requires trade-offs that must be included when evaluating interventions (Analysis, 20 November). The transfusion medicine community has been working to reduce inappropriate blood transfusions for years, aiming to reduce risks, conserve blood, and save money. A further but unexplored rationale is limiting our ecological footprint.

NHS Blood and Transplant produced around 15 000 tonnes of carbon dioxide in 2019, mostly attributable to blood donation and testing and the manufacture, storage, and distribution of blood components. This does not include emissions from laboratory testing in hospitals and the transfusion process itself, or the full effect of clinical waste disposal. But accounting for the calculated emissions alone works out at roughly 6.5 kg of carbon dioxide emissions per blood component. Over 20% of all blood transfusions are unnecessary, equating to 460 000 components—3000 tonnes of carbon dioxide emissions—without any benefit to patients.

Stephen P Hibbs, haematology registrar; Stephen Thomas, associate director, technical and scientific development, NHS Blood and Transplant, London; Michael F Murphy, professor of transfusion medicine, Oxford

Cite this as: *BMJ* 2021;375:n3112

AMBIENT HEAT AND EMERGENCY ADMISSION

Preventing heat related illness

Sun and colleagues show the burden of raised temperature extremes on the healthcare system and morbidity in the US (Research, 27 November). Emergency preparedness deserves further comment.

Steps to aid critical emergency preparedness must occur across the US. Federal law must be enacted and funding allocated for backup power at smaller healthcare facilities, such as dialysis centres and ambulatory care clinics, and large indoor spaces that can be used as cooler centres. Mobilisation of the national guard to run cooling centres and provide lower acuity healthcare services will also be crucial.

As with many preventable illnesses, much progress has been made in treatment and less by way of prevention. The cycle of cooling ourselves with energy that worsens global warming, then using more of the same energy source to cool ourselves must be broken. If not, this preventable public health emergency will no longer be preventable, and will inevitably be untreatable.

Adam Edward Lang, clinical pharmacist, Fort Eustis, US

Cite this as: *BMJ* 2021;375:n3117

DEINTENSIFYING TYPE 2 DIABETES CARE

Reducing the burden in care homes

We support the need for an individualised approach to deintensifying type 2 diabetes care for frail older people (Practice Pointer, 20 November). This is particularly important in care homes, where up to one quarter of residents have type 2 diabetes. Deprescribing diabetic medications using the shared decision making principles outlined by Aubert and colleagues will lessen some of this burden. We suggest a fifth step: medication simplification.

Using a validated, five step tool, we have found that two thirds of residents can take their medications in a simpler way. The first step involves discussing resident preferences, followed by consideration of facility and regulatory requirements, drug interactions, alternative formulations, and follow-up strategies to mitigate unintended consequences. An estimated 85 hours of nursing time per 100 residents per month can be diverted from medication administration to other care activities, thereby reducing burden for residents with type 2 diabetes and care home staff.

Janet K Sluggett, senior research fellow, Adelaide; Debbie Rigby, adjunct associate professor, Woolloongabba

Cite this as: *BMJ* 2022;376:n3158

DANGERS OF FOLLOWING THE CONSENSUS

Condemning consensus is not helpful

Abbasi cautions against reliance on consensus based clinical guidelines and questions consensus led views on covid related health policies (Editor's Choice, 27 November). Is it possible to reject consensus and to rely only on "evidence?"

Scientific evidence can inform us about the world as it is, but it cannot tell us what we ought to do. Clinical trials can tell us about differences in vaccine efficacy, but to choose between vaccines we place value on the pros and cons of each. In a diverse society people will hold different values. Ultimately, the choice will reflect some value judgments.

John Rawls has argued that fair or equitable value judgment can be reached only through an "overlapping consensus." The nature of this consensus can be debated, but if it has been reached properly, it cannot be harmful because it is only through consensus that we can decide what is good or bad.

Abeezar Sarela, consultant surgeon, Leeds

Cite this as: *BMJ* 2021;375:n3073

RACISM IN THE NHS

Racism in the NHS is subtle, insidious, and pervasive

Kar's article about racism in the NHS resonates strongly with me (Partha Kar, 27 November). When I was training as a GP in the 1980s, the well meaning course organiser told me that I wouldn't get a job in Norfolk because of the colour of my skin. He advised I apply to London or the Midlands instead.

After training, I applied for every GP vacancy in *The BMJ*, Pulse, and GP journals and magazines. I didn't receive a single acknowledgment. Meanwhile my (white British) colleagues were regularly attending interviews and being offered GP jobs.

Eventually I got a job at a general practice in a small town, where I worked for nearly 30 wonderful years. My patients nominated me for an MBE, which I was given in June 2018 for services to the local community.

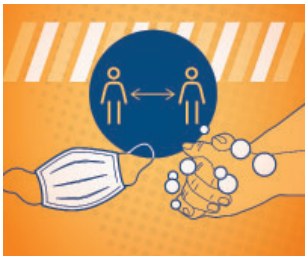
Racism—subtle and insidious—is pervasive in the NHS; it must be called out and tackled openly.

Parameswara Venugopal Prasad, GP returner, locum GP, Chester

Cite this as: *BMJ* 2021;375:n3136

PRESCRIPTION OPIOIDS FOR NON-CANCER PAIN

We need a comprehensive approach



Wilton and colleagues' study is part of a larger retrospective linkage study including more than one million people (Research, 20 November). Patients were prescribed opioids for non-cancer pain between 1996 and 2015. Most prescriptions were for dental or post-surgical pain. Less than 10% of patients reported chronic use.

Wilton and colleagues found that the likelihood of initiating injected drug use at five years was highest in people with chronic opioid use (4.0%), then episodic use (1.3%), acute use (0.7%), and those who were opioid naive (0.4%). This could have a major effect on public health strategies to reduce higher risk prescriptions while protecting access to optimal analgesia and advocating against indiscriminately reducing or stopping prescription opioid treatment. But most patients received prescriptions for acute and episodic use, so focusing on chronic use is likely to miss most people at risk of starting intravenous drug use and should not be recommended.

Patrice Forget, clinical chair in anaesthesia and honorary consultant, Aberdeen

Cite this as: *BMJ* 2021;375:n3045

Eleanor Kay Ashton

GP, Douglas, Isle of Man (b 1930; q Liverpool 1954; DPM), died from lower limb ischaemia on 23 August 2021

Eleanor Kay Ashton was born on the Isle of Man. After qualifying, she worked in the casualty department at Noble's Hospital on the island and at hospitals in Liverpool. Eleanor married Keith Frazer in 1956 and emigrated to Australia in 1958. On arrival she worked in a private pathology laboratory in Perth before moving to Melbourne, where she worked at the Repatriation Hospital. She returned to Perth in 1962 and worked at the Perth Children's Hospital. In 1967 she returned to the Isle of Man and in 1973 entered general practice. She ran a private clinic on the Isle of Man until well into her 80s. Her membership of the BMA was only cancelled on her death. She leaves two sons and five grandchildren.

She ran a private clinic on the island until well into her 80s

Scott Frazer

Cite this as: *BMJ* 2021;375:n2624

David Gateshill Hardy

GP (b 1922; q Leeds 1945), died from old age on 20 September 2021

David Gateshill Hardy was a general practitioner at the Health Centre in Bartholomew Avenue, Goole, East Yorkshire. After qualifying from Leeds in 1945, he worked at the Leeds Public Dispensary for two years. He was the eldest of three sons to qualify in medicine from the University of Leeds. After serving in the Royal Army Medical Corps he worked in Leeds, Bradford, and Wakefield before settling in Goole, in the East Riding of Yorkshire, where he brought up his family and worked for 33 years. David Hardy also worked as a clinical assistant anaesthetist at Bartholomew Hospital, Goole. He was much respected by his patients and their families and by the NHS staff in the town. He died at the local Westfield Park Care Home and leaves his wife, Dorothy; three children; seven grandchildren; and three great grandchildren.

Gillian Hardy

Cite this as: *BMJ* 2021;375:n2615

Alexander Addison

GP (b 1930; q Aberdeen 1954; FRCGP, MBE), died from pneumonia and old age on 16 September 2021

Alexander Addison ("Sandy") was born in Kerala, south India. He spent his early years in India and Ceylon before returning to Scotland after the sudden death of his father. The family eventually moved to Aberdeen. After house jobs Sandy spent three years in the Royal Army Medical Corps based at Cowglen Military Hospital in Glasgow. After completing his training he became a GP in Douglas, a small village in rural south Lanarkshire. Sandy was a tutor for the Royal College of GPs and spent many hours attending local and national NHS and BMA committees. He retired from practice in 1995 and was awarded an MBE for services to healthcare in 1996. In 1955 Sandy married Joan Wood, theatre nurse at Woodend Hospital. He leaves their sons and granddaughters.

John Addison, Lindsay Addison, Gordon Addison

Cite this as: *BMJ* 2021;375:n2604

Bernard Helmut "Ury" Baruch

Psychoanalyst; consultant psychiatrist St Bernard's Hospital, Southall, and Ashford Hospital, Middlesex (b 1920; q Queen's University, Ontario 1946; MD CM, FRCPsych), died from frailty of old age on 22 February 2021 28 days after contracting covid

Bernard Helmut Baruch ("Ury") came to the UK from Germany in 1930. He was interned in Canada with his brother as an enemy alien from Liverpool medical school in 1940. Having completed his medical training he returned to the UK to undertake psychiatric training. He met his future wife, Lucy, at St Bernard's Hospital in 1950, and became a consultant while training to become a psychoanalyst. He oversaw the student counselling service at Brunel University, for which he received the honorary degree of MUniv. He was involved with many professions and offered supervision to senior consultants and psychotherapists well into his retirement. He leaves Lucy, three children, six grandchildren, and five great grandchildren.

Anne Baruch , John Baruch

Cite this as: *BMJ* 2021;375:n2605

Brian Colston

GP (b 1922; q Bristol 1952; OBE, FRCGP), died from abdominal cancer on 18 September 2021

Brian Colston joined the Royal Signals and served in the Far East. He studied medicine at Bristol University, where he met his future wife, Enid. They married in 1951. As a GP senior partner in Birmingham's deprived Lee Bank, he improved primary healthcare by establishing multidisciplinary working with the health authority and the Medical Practitioners Union. His was the first practice to have asthma and diabetes clinics, social workers, and an academic appointment with the university. The practice was also instrumental in establishing a GP ward for maternity care. Brian received the OBE in 1989. He loved photography, squash, sailing, cooking, snooker, and the theatre. He was a determined, hardworking, practical and often generous and kind man. Predeceased by his eldest son in 2014, he leaves Enid, three children, and six grandchildren.

Nicola Jane Colston

Cite this as: *BMJ* 2021;375:n2614

Michael Joseph Wright

General practitioner Romford (b 1931; q Queen's University Belfast, 1956; MRCGP, DRCOG), died from heart failure after a neck of femur fracture on 26 September 2021

After hospital jobs Michael Joseph Wright served a short service commission in the Royal Air Force and achieved the rank of squadron leader. He was appointed assistant senior administrative medical officer to the then Manchester Regional Hospital Board before joining a GP partnership in Romford. He enjoyed a busy practice, combining this with occupational health and the post of HM Appointed Factory Doctor. He served as secretary and then chairman of the Barking and Havering BMA division and was elected chairman of the local medical committee. In retirement, first in Ireland and later in London, he enjoyed fly fishing, gardening, opera, and working with a homeless charity. Eileen, his wife of 58 years, predeceased him. He leaves five children and nine grandchildren.

John Wright

Cite this as: *BMJ* 2021;375:n2622

Michael Rutter

The UK's first professor of child psychiatry

Michael Rutter (b 1933; q Birmingham 1955; CBE, FRS, FRCP, FRCPsych, FMedSci), died from prostate cancer on 23 October 2021

Michael Rutter ("Mike") led the first research into psychiatric and physical disorders in children where researchers spoke directly to the children. The landmark Isle of Wight studies (1964-74) ridiculed the dogma that what children thought and said did not matter. Rutter, the genial author of more than 40 books and some 400 papers, insisted: "They do matter."

In *Fifteen Thousand Hours*, the time most children were estimated to spend in school, he challenged the strategy of despair that had left many schools as little more than institutions of containment for disadvantaged children. In a three year urban study, he and his colleagues showed conclusively that schools could make a difference and that some were demonstrably better than others.

Rutter was pivotal in the bitter nature versus nurture controversy dividing behaviour geneticists and psychosocial researchers. He concluded that the effects of genes and environment were inextricably interwoven.

He also helped to establish the genetic basis of autism. His prolific output included more than 120 papers on autism and 10 years as editor of the *Journal of Autism and Development*.

Early life and career

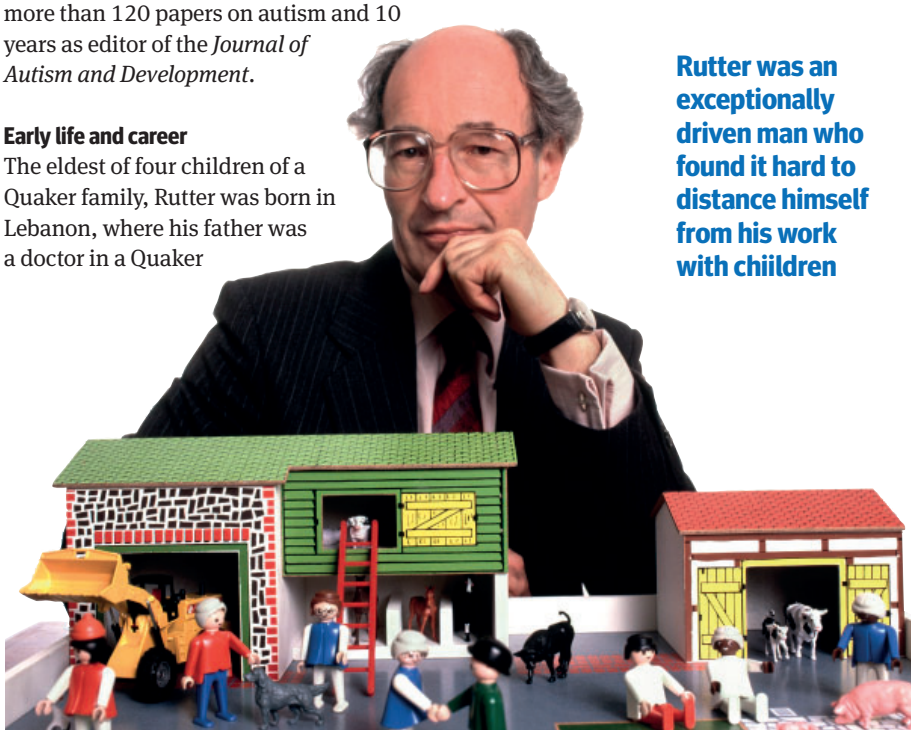
The eldest of four children of a Quaker family, Rutter was born in Lebanon, where his father was a doctor in a Quaker hospital in Brummana. Michael was fluent in both Arabic and English by the age of 3. A year later the family moved to Wolverhampton, where his father became a GP.

The Rutter children were evacuated to separate homes in the US in 1940 in fear of a German invasion. Michael returned in 1944, attending Wolverhampton Grammar School before boarding at the Quaker Bootham School in York. His physics teacher is reported to have fired his interest in Freud, prompting him to train himself to wake up and note his dreams.

Rutter's early mentors included the prominent Jewish psychiatrist Wilhelm Mayer-Gross, who had fled Nazi Germany. Recalling Mayer-Gross sending him to interview a patient, Rutter described feeling how he had "botched up" the interview. But Mayer-Gross told him he had made all the necessary observations for the diagnosis of hebephrenic schizophrenia. "He transformed what I had perceived as a humiliating experience into a positive one," Rutter said.

Perhaps Rutter's most important mentor was Australian born Aubrey Lewis, the first professor of psychiatry at the Institute of Psychiatry (IOP), in south London. Lewis was renowned as a talent spotter, and in Rutter he foresaw a child psychiatrist—even though Rutter had not seen himself thus.

Appointed as the UK's first professor of child psychiatry in 1973, Rutter also became professor of developmental psychopathology, a discipline he is credited with founding. He was actively involved in various bodies.



CORBIN O'GRADY STUDIO/SPL

Rutter was an exceptionally driven man who found it hard to distance himself from his work with chiildren

Family man

He spent 55 years at the IOP and the Maudsley Hospital, albeit with long periods away from home, according to his wife, Marjorie. They married in 1958. Marjorie was his co-author on the seminal *Developing Minds*, which charted human growth from cradle to grave. Recognising that he was an exceptionally driven man who found it hard to distance himself from work, Marjorie filled the gap with a distinguished nursing career in sexual health, becoming an author in her own right, with *Caring for Sexuality in Health and Illness*.

In 2014 Rutter revealed on BBC Radio 4's *The Life Scientific* that he was still working each day—at the age of 80—"from about half past eight until about four." Until a few weeks before his death, he retained contact with patients with autism he had known for 50 years or more.

The recipient of 21 honorary doctorates and numerous awards, he enjoyed music, reading, and walking in the Lake District. The family lived in Dulwich, south London, where he was renowned as a highly competitive tennis player who did not like to be beaten.

Friends pondered how the compassionate Rutter could reconcile his strong competitive streak with his Quaker beliefs. He expressed his ideas about aggression and competitiveness in sport in a Quaker lecture, "A measure of our values." Describing himself as a "non-theist Quaker," he drew a sharp distinction between aggression in war and sport. He was a conscientious objector during the Korean war, working as a hospital porter.

Named after him, the Michael Rutter Centre for Children and Adolescents is based at the Maudsley Hospital.

Rutter leaves Marjorie, three children, and seven grandchildren.

John Illman , London
john@jicmedia.org

Cite this as: *BMJ* 2021;375:n2791