comment

"Every time we see or hear mistruths we need to call them out" **DAVID OLIVER**
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PLUS Tackling medicine's gender inequality; how to measure long covid

TAKING STOCK Rammya Mathew

Is home working bad for our health?

During the covid-19 pandemic most healthcare professionals have been going into work as we have always done. Amid the long days, the busier shifts, and the darkness that this pandemic has cast over us, we have been privileged enough to be able to get up every day, come to our places of work, and see, meet, and greet people in the flesh.

By contrast, so many others around us have been catapulted into the realms of remote working without any opportunity to process what this might mean for them, and in particular how it might affect their physical, emotional, and mental wellbeing.

When it was all still a novelty, I saw many around me overjoyed as they said goodbye to their daily commute and embraced the "new normal" of their makeshift home office. But, almost a year in, the mood has changed. From the conversations that I am having with patients, it seems that we are now experiencing the fallout from a lack of daily routine, increasing physical inactivity, and the loss of human interaction, all of which work once provided.

For some people, the daily commute and the trips up and down the flights of stairs at the office were the only physical activity that they had in their day. Now this has been replaced by endless Zoom calls and Microsoft Teams meetings, which have allowed us to move seamlessly from one virtual space into the next but have us physically chained to our desks—often sedentary for hours on end. The long term effect of these enforced changes cannot be underestimated; there is good evidence that physical inactivity significantly increases the risk of many health problems, including stroke, heart disease, type 2 diabetes, falls, and even hip fractures.

The effect on mental health is equally concerning. The jarred on-screen business talk is no replacement for the real life conversations and the in-person support that once kept us meaningfully connected to our colleagues. Even if you aren't a fan of office banter, these interactions used to help break up and breathe life into the working day. Working from home means we miss out on these moments and instead spend our days physically isolated, with no one to easily turn to when things get tough or we start to feel under pressure.

I hear from friends and family in office jobs that their employers have no plans to bring their staff back into the office, even when the threat of covid-19 passes. Although we may have made these changes for the sake of public health, we have a duty to evaluate their effect on our health and wellbeing. Otherwise we will find ourselves walking head-on into the next public health disaster as we strip away many of the health benefits of our pre-covid working lives.

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Virtual meetings have us physically chained to our desks—often sedentary for hours on end

PERSONAL VIEW Clare Marx

Outdated career ideals that stifle women hurt us all

Tackling all kinds of inequality is essential to deliver first class care

It was my pleasure to welcome five brilliant women to the GMC's council recently. From ethical leadership to immersive technologies, the expertise they bring with them is testament to the profound impact of women in public life. They'll fill the seats of five other trailblazing women who have left a wonderful legacy.

The success and standing of these women is also a sign of how things have moved on; when I qualified as a doctor 43 years ago, such representation seemed like an impossible dream.

I have been extremely fortunate to have had inspirational teachers, mentors, and role models throughout my career, all of them men. But I've also seen poorly disguised undermining and sexism masquerading as "joking." I've been in roles where people questioned if I was "strong enough" or "had big enough hands" to be an orthopaedic surgeon. Or when I planned to "leave the playing field to the boys." Even passing my surgeons' exam was met with a degree of disbelief. "Oh my God, we'll have to take you seriously now," was one memorable response.

I thought it would stop as I got more senior, but it's become more blatant, even as the medical landscape has become more diverse.

At a glance, the numbers look good. Women make up a greater proportion of licensed doctors than ever before at 48%, according to this year's *State of Medical Education and Practice in the UK*. And in the past few years there have been higher numbers of female students attending medical school.

But put the profession under a microscope—pay is as good a place to start as any—and you'll find glaring disparities. The independent review into gender pay gaps, chaired by Jane Dacre and published recently, identified a pay gap of 24.4% for hospital doctors, 33.5% for GPs, and 21.4% for clinical academics. In my specialty, representation is improving at a glacial pace, with the ratio of male to female consultant surgeons still about 8:1.

Pipeline of talent

The pipeline of female talent has never been healthier, so why isn't this translating into genuine parity in medicine? It's complicated, but a few matters come to mind.

For one, society and workplaces are still set up around old fashioned assumptions and rigid structures—the premise that the mother, rather than the father, should be the first contact for the nursery when there is a problem, for example. But this isn't what the doctors of today say they want—neither men nor women. One in five doctors reduced their hours last year, work-life balance being an important factor for both sexes. Meanwhile, there are signs that doctors also want more flexible training pathways—the number of doctors pausing training after foundation year 2 is higher than ever.

Inequality is insidious. It creeps into our professional lives, undermining confidence and the care we provide

In short, this is still a service model designed for a predominantly male workforce. While there is now no shortage of women, the workplaces they enter haven't adapted.

And let's look at those doctors later in their careers. A BMA survey this year illustrated the problems perfectly. Some 90% of respondents said symptoms of the menopause had affected their working lives. But the majority were not receiving support from their employer to make their symptoms more manageable, running the risk they would leave the profession altogether. Losing this talent would be a profound waste.

BMJ OPINION Nisreen Alwan

How do we measure long covid?

It is likely there are multiple underlying mechanisms at play in people with long covid. What we do know is that it is not uncommon. The UK Office for National Statistics estimates that one in five people continue to experience symptoms for five weeks or longer after a positive test, and one in 10 people for 12 weeks or longer.

Applying the basic principles of public health, there are three levels of prevention with regards to long covid.

Primary prevention: To stop people getting covid-19 in the first place we need effective public health measures to control the spread of the virus, aiming for elimination. This also means telling people of the real risk of getting long covid even if they are young and healthy. This requires clear messaging.

Secondary prevention: We still don't know how to prevent acute covid-19 infection from progressing to long covid, and we urgently need research to tell us which early interventions are effective, even in non-hospitalised patients.

Reporting is critically important. We cannot fight what we do not measure

Tertiary prevention: Treating people with long covid to prevent complications and disability can happen only if the condition is properly recognised. That requires everyone with it to be given a thorough physical assessment and appropriate medical investigations to detect possible organ damage and treatable pathology. It also requires research to identify the risk factors for progression of disease.

The All-Party Group on Coronavirus called for three things in the first parliamentary debate on long covid last month: reporting,

Luckily, there is an antidote—enabling fair, inclusive cultures that help everyone to work at the top of their game. Today's doctors have diverse needs, and to get the best out of them, training programmes, assessment methods, and the workplace should accommodate those needs. That means listening, showing compassion, being flexible, and being open about balancing the needs of the person and the needs of the service.

This is not only in the interests of the doctors, but also their patients. As a recent report for the GMC by Michael West and the late Denise Coia showed, doctors who work in supportive environments deliver better care. Where working environments are inflexible or cliquey, patient care is compromised.

Inequality is insidious. Throughout my career as a surgeon, I've seen it take many forms. Sometimes it's as ostentatious as a sexist slur or a hand on the knee. But most of the time, it creeps quietly into our professional lives, undermining confidence and the care we provide. That's why combating inequality of any kind is not a distraction from delivering first class care. It's an essential part of it.

Clare Marx, chair, General Medical Council

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recognition, and research. Recognition must include employment rights, financial support, and compensation if exposure was occupational. This will help to break the cycle of inequalities where disadvantaged people and lower paid, high exposure occupations have worse outcomes from covid.

Reporting means counting long covid. This is critically important. We cannot fight what we do not measure. One way to count is by establishing patient registers. For that we need universal and inclusive clinical diagnostic criteria not entirely dependent on lab confirmation. This needs proper coding in electronic health systems. We also need to follow up people with acute covid-19 and those who test positive to assess their recovery, using existing test and trace infrastructures.

Nisreen A Alwan, associate professor in public health, University of Southampton

ACUTE PERSPECTIVE David Oliver

Mistruths about covid-19 deaths

I want to set the record straight about some serious misinformation surrounding covid-19 death certification and mortality statistics. I will paraphrase some of the claims that I have heard repeatedly in the media:

"People are not dying from, but with, covid-19," "deaths classified as from covid-19 result from largely false positive polymerase chain reaction (PCR) test results," "deaths are mostly from other causes and underlying conditions," and "death numbers are grossly inflated."

According to the Office for National Statistics (ONS), the total number of deaths with covid-19 recorded on the death certificate in England and Wales has now passed 100 000. The government's daily press releases, however, report "deaths within 28 days of a positive test result"—a definition repeated faithfully by journalists and on social media. This approach probably under-recognises the real number of deaths by around 20%. Having two parallel reporting methods plays into the "What are they not telling us?" narrative of covid denialists, conspiracy theorists, and lockdown sceptics.

ONS data are based on what doctors responsible for patients in their final illness write on the death certificate to the "best of their knowledge and belief," and do not take into account how recently the deceased had a positive test result. I would advise anyone therefore to trust ONS data above the government's. The Nuffield Trust has issued a similar warning about death statistics.

In the first few months of the pandemic, access to testing was scarce even for clearly infected hospital patients, let alone for those in care homes or private residences. Some death certificates might therefore have mentioned "covid-19" despite the absence of a positive result if the clinical picture was clear. In other cases, doctors might have been reluctant to put covid-19 on a certificate in the absence of a test even though the clinical picture was clear.

We have far better access to testing now, but systematic review has shown that PCR tests still have an initial false negative rate of 2-29% in people who then go on to test positive or develop clinical features.

Death certification is a serious professional duty. It is done with diligence and, for deaths in hospital, is usually discussed with a medical examiner (although this step was suspended for a few months in the first pandemic wave). The personal and professional consequences of fabricating or distorting certificates would be serious, and there is no mass conspiracy or incentive, financial or otherwise, to do so.

We sometimes certify deaths in patients who died from covid or its complications well beyond 28 days. A Leicester University study followed more than 40 000 people with covid-19 discharged from hospital for 140 days and found a readmission rate of 31%, with 9% dying on readmission. Obviously not all those deaths were from covid complications, but it seems clear that many were accelerated by them.

Every time we see or hear mistruths we need to call them out.

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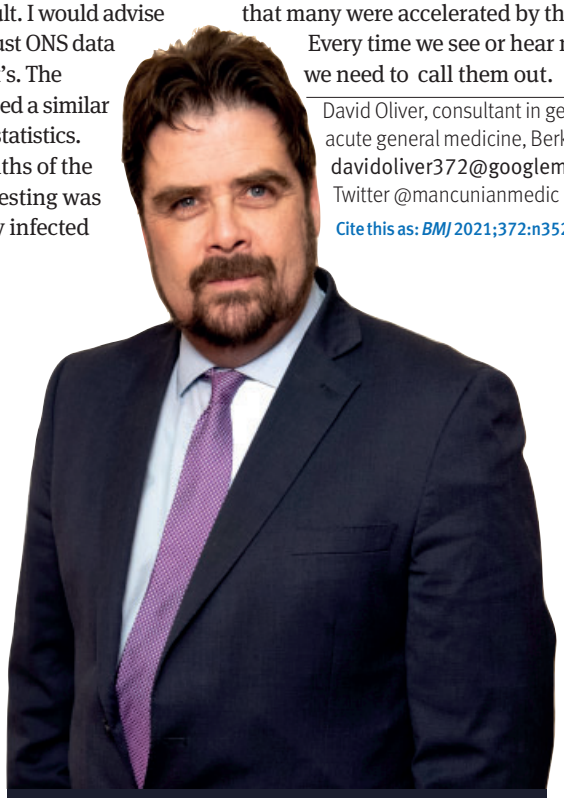
There is no mass conspiracy to fabricate death certificates



PRIMARY COLOUR Helen Salisbury

Everyone wants to feel useful

It's been a hard year. As we're bombarded with daily images of desperately ill patients and exhausted intensive care staff, it's not surprising that we're fearful and anxious. The pandemic has left many people feeling helpless, cut adrift from the activities that gave their life purpose and meaning, whether that was work, volunteering in the community, or interacting with friends and family.

Even if you are furloughed and being paid at least some of your wages for doing nothing, such inaction can be deeply depressing. At a time of international crisis people want to get involved, to feel useful—which is difficult when the public message is that "the most helpful thing you can do is to stay at home."

Some of us in general practice have also struggled with feeling a bit useless. While our colleagues in hospitals are coping with large numbers of very ill patients, we're trying to continue our normal work but without our usual tools, and we miss the sense of connection with our patients. We've found it difficult to adapt to mainly remote consultations, and although we're doing our best, it often doesn't feel good enough.

The vaccination programme has been a welcome shot in the arm for general practice. For the first time our primary care network has come together with enthusiasm and a clear, shared sense of purpose. Everyone is keen to be involved, and we have more staff wanting to work at each vaccination session than we can possibly use. Receptionists, admin staff, doctors, nurses, and community volunteers are all queuing up to play their part. The work itself isn't difficult or complicated; on a superficial level, it's not even very interesting. But it's probably the most practical and helpful thing any of us will achieve this year, and both we and the patients know it. The atmosphere of goodwill and hope pervading the surgery during vaccination clinics gives us a psychological boost that can stay with us for days.

Will it last? All novel experiences dull with time. When lockdown eases and we can do more at the weekend—beyond the same local walk or another box set—will the enthusiasm for extra shifts wane? We're still uncertain about our vaccine supply, and there may be new hazards as the virus mutates.

But, for the moment, it's genuinely a pleasure to stand in our scrubs and plastic aprons, in a draughty waiting room, asking the same questions and performing the same simple procedure again and again. We know that we're the lucky ones: it's hard to beat that feeling of working in a team, doing something that everyone recognises as hugely useful.

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The atmosphere of goodwill and hope during vaccination clinics gives us a boost

LATEST PODCASTS

The NHS and covid-19—one year on

It has now been more than a year since the World Health Organization declared that covid-19 was a "public health emergency of international concern." As the UK ramps up testing for the South African virus variant, this episode of the Second Wave podcast focuses on what we've learnt in the past year and the challenges ahead. Helen Salisbury explains how GPs face greater difficulties in establishing whether a patient's symptoms are likely to be from covid-19:

"The symptoms that might be covid, particularly with the newer variants, are getting wider and wider. We're hearing that more often it's going to be traditional cold and flu type symptoms like sore throat. As a GP, certainly in our area, you have to decide when you talk to someone on the phone, is this likely to be coronavirus? Does this person need a test? Does this person sound ill enough that they need to be assessed face to face, and where should that happen?"

Tom Frieden on why we thought we were prepared

Tom Frieden is the former director of the US Centers for Disease Control and Prevention and has a long history of public health leadership. In this interview, he talks about the gap between our theoretical readiness for a pandemic and the reality:

"On the one hand, strong public health systems have been important in the covid response and have been associated with better testing rates, better treatment rates, more organised responses. On the other hand, bad governance can trump good public health in any country. We've seen that in countries around the world, where even a well prepared public health system is undermined by disregard for science or political considerations."

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

Covid-19: Social murder, they wrote—elected, unaccountable, and unrepentant

After two million deaths worldwide, we must have redress for mishandling the pandemic

Murder is an emotive word. In law, it requires premeditation. Death must be deemed to be unlawful. How could "murder" apply to failures of a pandemic response? Perhaps it can't, but it is worth considering.

When politicians and experts say they are willing to allow tens of thousands of premature deaths for the sake of population immunity or in the hope of propping up the economy, is that not premeditated and reckless indifference to human life? If policy failures lead to recurrent and mistimed lockdowns, who is responsible for the resulting non-covid excess deaths? When politicians wilfully neglect scientific advice, international and historical experience, and their own alarming statistics and modelling because to act goes against their political strategy or ideology, is that lawful? Is inaction, action?[1] How big an omission is not acting immediately after the World Health Organization declared a public health emergency of international concern on 30 January 2020?

At the very least, covid-19 might be classified as "social murder," as recently explained by two professors of criminology.[2] The philosopher Friedrich Engels coined the phrase when describing the political and social power held by the ruling elite in 19th century England. His argument was that the conditions created by privileged classes inevitably led to premature and "unnatural" death among the poorest classes.[3] In *The Road to Wigan Pier*, George Orwell echoed these themes in describing the life and living conditions of working class people in England's industrial north.[4] Today, "social murder" may describe the lack of political attention to social determinants and inequities that exacerbate the pandemic. Michael Marmot argues that as we emerge from covid-19 we must build back fairer.[5]

More than a few countries have failed in their response to the virus; the global missteps are many

Kamran Abbasi, executive editor, *The BMJ*, London

International accountability

A pandemic has implications both for the residents of a country and for the international community, so sovereign governments should arguably be held accountable to the international community for their actions and omissions on covid-19. Crimes against humanity, as adjudicated by the International Criminal Court (ICC), do not include public health.[6] But David Scheffer, a former US ambassador for war crimes, suggests we could broaden the application of public health malpractice "to account for the administration of public health during pandemics."[7] In that case, public health malpractice might become a crime against humanity, for leaders who intentionally unleash an infectious disease. Others have argued similarly for environmental crimes.[8]

If not murder or a crime against humanity, are we seeing involuntary manslaughter, misconduct in public office, or criminal negligence? Laws on political misconduct or negligence are complex and not designed to react to unprecedented events, but as more than two million people have died, we must not look on impotently as elected representatives around the world remain unaccountable and unrepentant. What standard should leaders be judged by? Is it the small number of deaths in countries such as New Zealand and Taiwan, or the harsher standard of zero excess deaths? Deaths do not come as single spies but as a battalion of bereaved families, shattered lives, long term illness, and economic ruin.

From the US to India, from the UK to Brazil, people feel vulnerable and betrayed by their leaders' failures. The more than 400 000 deaths from covid-19 in the US, 250 000 in Brazil, 150 000 each in India and Mexico, and 100 000 in the UK comprise half of the world's covid death toll—on the hands of only five nations.[9] Donald Trump was a political determinant of health who damaged scientific institutions.[10] He suffered electoral defeat, but does Trump remain accountable? Bolsonaro, Modi, and Johnson have had their competence questioned, and McKee and colleagues argue that populist leaders have undermined pandemic responses.[11] The prospect of accountability in autocracies such as China and Russia is more distant still and relies on strong international institutions and the bravery of citizens.

More than a few countries have failed in their response to the virus; the global missteps are many and well documented by the Independent Panel for Pandemic Preparedness and Response.[12 13] Its report calls for comprehensive use of non-pharmaceutical interventions—the means, they say, by which these interventions curb a pandemic are "well known"—and for governments to support equity, reinvent and modernise the global pandemic

alert system, take pandemic threats seriously, and cooperate better with other nations and WHO. Acting urgently and collaboratively in these areas will allow the world to be best prepared for any future pandemic.

Hollow excuses

But the global picture does not absolve individuals and governments from responsibility.[14] Many of the panel's conclusions place the blame at the feet of leaders, although you will be hard pressed to find a single politician who has admitted responsibility for the extent of premature death, let alone resigned. Several have expressed contrition, but "sorry" rings hollow as deaths rise and policies that will save lives are deliberately avoided, delayed, or mishandled.

Others say they have done all they can or that the pandemic was uncharted territory; there was no playbook. None of these are true. They are self-serving political lies from "gaslighters in chief" around the globe.[15] Some attempt to defend their record by claiming their country has done more testing, counts deaths better, or has more obesity and population density. All of these may contribute, but counting methods or population factors do not explain the sheer scale of the variation.

If citizens feel disempowered, who might hold politicians to account? Experts in science might do so, but official scientific advisers have often struggled to convince politicians to act until it is too late or kept silent to avoid public criticism. So might doctors, with their responsibilities to public health.[16]

The media might help here, remembering their duty to hold elected officials accountable. And yet much of the media is complicit too, trapped in ideological silos that see the pandemic through a lens of political tribalism, worried about telling pandemic truths to their readers and viewers, owners, and political friends. In fact, truth has become dispensable as politicians and their allies are allowed to lie, mislead, and repaint history, with barely a hint of a challenge. Anybody who dares to speak truth to power is unpatriotic, disloyal, or a "hardliner."

Politicians must be held to account by any national and international constitutional means necessary

UK ministers, for example, interact with the media through sanitised interviews, stage managed press conferences, off-the-record briefings, and, when the going gets tough, by simply refusing to appear. It is this environment that has allowed covid denial to flourish, for unaccountability to prevail, and for the great lies of "world beating" pandemic responses to be spun. "The most important lessons from this pandemic," argue Bollycky and Kickbusch, "are less about the coronavirus itself but what it has revealed about the political systems that have responded to it."[17]

How many excess deaths does it take for a chief scientific or medical adviser to resign? How long should test and trace fail before a minister of health or chief adviser steps down? How many lucrative contracts for unscientific diagnostic tests that are awarded to cronies or errors in education policy will lead to a ministerial sacking?

Getting redress

Where then should citizens turn for accountability, if they don't find it in their leaders and feel unsupported by experts and the media? The law remains one form of redress, and indeed some legal avenues, including criminal negligence and misconduct in public office, are being explored,[18 19] although proving any such claims will be difficult and drawn out. But the notion of murder, at least "social murder," is hard to shake emotionally, and strengthens with every denial of responsibility and every refusal to be held accountable or to change course.

That leaves three options. The first is to push for a public inquiry, as *The BMJ* and others did last summer[20]—a rapid, forward looking review, rather than an exercise in apportioning blame, that will identify lessons and save lives. The second is to vote out governments that avoid accountability and remain unrepentant. The US showed a political reckoning is possible, perhaps a legal one can follow.[21] The third is for mechanisms of global governance, such as the ICC, to be broadened to cover state failings in pandemics.

In the UK, which was responsible for about 1% of global deaths in the 1918-19 flu pandemic and now accounts for 5% with a smaller proportion of the world's population,[9 22] elections are a few years off. As the government holds a parliamentary majority, avenues for redress seem blocked. What's left is for citizens to lobby their political representatives for a rapid public inquiry; for professionals in law, science, medicine, and the media, as well as holders of public office, to put their duty to the public above their loyalty to politicians and to dissent lawfully, to be active in calls for justice, especially for disadvantaged groups.

The "social murder" of populations is more than a relic of a bygone age. It is very real today, exposed and magnified by covid-19. It cannot be ignored or spun away. Politicians must be held to account by legal and electoral means, indeed by any national and international constitutional means necessary. State failures that led us to two million deaths are "actions" and "inactions" that should shame us all.

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Politics, economics, and global governance of covid-19

The latest independent panel report highlights key problems

The mandate of the Independent Panel for Pandemic Preparedness and Response is to "provide an evidence-based path for the future, grounded in lessons of the present and the past to ensure countries and global institutions, including specifically WHO, effectively address health threats."[1] These lessons are starting to emerge with the publication of the panel's second progress report.[2]

Unsurprisingly, the report touches several key problems in the global governance of covid-19: WHO's position, structure, and lack of financing; excessive focus on metrics to the detriment of political analysis; a lack of coordinated and sufficient financing for pandemic preparedness and response; global vaccine inequities; and the role of the broader global health architecture.

Almost every section of the report points to the extent to which politics has driven the trajectory of the pandemic—establishing that governments' policies reflect deeper political agendas and that the tension between the economy and public heath is a false dichotomy. Those governments willing to take the political and economic hit of harsh restrictions early in 2020 now benefit from freedom from population restrictions, and in the case of China and South Korea, thriving economies.

Trying to appease both public health demands and libertarian views has led not only to astronomical death tolls, such as in the US, UK, and Brazil, but to flailing economies. Compromises do not work in response to pandemics and have just dragged this one out for all. Frustratingly, for those of us who research the politics of global health security, this was entirely foreseen.[3 4]

The panel's suggestion that protocols within the International Health Regulations (IHR)—WHO's legal framework for preventing, detecting, and responding to emerging pathogens—are from an analogue era and need to be digitalised are misconstrued. It was through digital systems such as HealthMap, ProMED-Mail, and WHO's Global Outbreak and Alert Response Network that the world first came to know about Ebola, Zika, and SARS-CoV-2. All these mechanisms are permitted under article 9 of the IHR.[5]

The system we have established for global health security cannot respond adequately to a health emergency

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Act on the lessons

The panel identifies 12 previous commissions and panels that made similar recommendations on how to improve global health security. The lessons in this report repeat much of what was said in the others. However, real progress can occur only if the effort devoted to convening new panels is diverted instead to implementing their recommendations. We need to move on from reviews and prioritise action to fix the identified weaknesses.

The report's overwhelming subtext is that the system we have established for global health security cannot respond adequately to a health emergency. Global health security remains too focused on prevention and detection—improving surveillance, laboratory capacity, and the resilience of health systems—with too little attention paid to a managed response. Going forward, the mechanisms for managing health emergencies must rapidly scale up the response element of pandemic preparedness plans, including learning from clear evidence.[6]

However, given the politicisation of responses, efforts to develop a standardised response to health emergencies will have to overcome serious challenges to gain agreement among all member states. Full agreement and adherence are unlikely without WHO building the trust of members and gaining greater authority in global disease governance.[7]

An alternative proposal from the EU is to create political buy-in through a new treaty for pandemic preparedness.[8] However, treaties work only if they are ratified by states. The Framework Convention for Tobacco Control, for example, is often hailed a success but has not been ratified by several countries.[9]

The UK's leadership of G7 is set to champion global health security, including review and reform of WHO.[10] As the independent panel highlights, global health security has to start with an empowered WHO with the mandate, authority, and financing to execute what is expected of it. To do this, WHO must confront the geopolitical tensions it has experienced, such as between the US and China, to reassert its leadership and hold governments to account for flagrant departure from its guidance. This includes considering whether China could have done more earlier in the pandemic, which a WHO panel is investigating.[11] Would governments have acted differently had they known about the pathogen sooner?

We need to make sure accountability is not just focused on China but on the states that delayed preparedness and response efforts. The panel highlights that "it is clear the volume of infections in the early period of the epidemic in all countries was higher than reported."[2] We need a review that names and shames governments, rather than obscuring them with generalisations.

I look forward to bolder reports from the independent panel that consider not only the economic and social effect of the pandemic but the failure of Western governments too.

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A mortal betrayal of the world's health workers

We must do more to protect staff from harm

The pandemic is taking a harsh toll on healthcare workers. More than 850 in the UK are thought to have died of covid between last March and December; at least 3000 have died in the US. Worldwide, the death toll and the impact on the physical and mental health of healthcare workers are staggering.

But some countries, mainly in Asia, have been able to manage covid outbreaks without sustaining any healthcare worker infections at all. The means to do so are now widely recognised. They are costly and inconvenient, and require an acceptance of the predominance of aerosol transmission of this virus and a rigorous infection control system. But it can be done.

Much has been written about why and how healthcare workers are not being protected. Words like groupthink, hubris, inertia, lack of strategic vision, and psychopathy (my preferred descriptor) all feature in the debate on the failings in 2020 and more generally. However, I am going to turn to a parallel question: how is it possible that healthcare workers continue to allow themselves to be "shuffled," with so little active resistance, "up the line to death," as the title of Brian Gardner's anthology of first world war poetry so aptly put it?

Popular enthusiasm for healthcare workers boomed in Britain in the early months of the pandemic. From the "clap for carers" (shame on you if you didn't join in), to the telethon-adjacent mania of "Captain Tom's 100th walk for the NHS," which raised more than £30m for NHS charities and culminated in a promotion and a knighthood for him in July, there was an outpouring of mass emotion.

Over time, that effusive outpouring has waned, but there continues a near religious expression of "love for the NHS" and for the "healthcare heroes," so hyperbolic that it is arguably blatant manipulation. The implication is that if we keep telling you you're wonderful, then you'll have to keep putting yourself in harm's way to look after us.

DOMINIC LIPINSKI/PA

In July 2020, I called for an immediate end in Australia to the rhetoric of "healthcare workers as heroes," identifying it as a damaging distraction from the legal and moral imperative to accord them the same standards of occupational safety enjoyed by workers in other industries. That rhetoric has now largely abated in Australia, helped by the extreme paucity of covid cases since October, though we are no nearer achieving a safe workplace for healthcare workers.

In the UK, the sanguine acceptance of healthcare worker harm by the public, the NHS, the government, and also, it must be said, healthcare workers themselves, has been an awesome sight to behold. But effusive rhetoric, the corollary to which is a fear of being found wanting, is surely only part of the story.

The near religious expression of "love for the NHS" is so hyperbolic that it is arguably blatant manipulation

Rigid, unkind bureaucracies

Let us speak plainly now, not just about the NHS, but about healthcare systems all over the world. They are top-down "command and control" bureaucracies. Though they brim over with fine words and caring mission statements, we all know they are rigid, unkind bureaucracies, and the main purpose of their management subunits is to take and hold organisational territory. In such authoritarian, often bullying regimes, the pressure to conform need only be explicit occasionally. Fear of censure, and of letting others down, will do the rest.

The "new abnormal" is to believe that it is entirely reasonable for workers to go to work with the expectation they will eventually contract a life threatening illness. Almost everyone, including the workers, believes this. And why not? The self-serving organism of the NHS, with the connivance of the government, has engineered this torrent of sacrifice, ostensibly for the collective good.

As long as the implication is generally accepted that healthcare workers have an unequivocal moral obligation to treat patients, irrespective of any risk to themselves, then governments are released from the obligation to provide a safe workplace. In law, however, employees are not compelled to work in an unsafe workplace. Neither are they ethically obliged to do so.

Shall we persist in manipulating healthcare workers "up the line to death," or shall we pay them the respect they deserve and do whatever it takes to accord them a safe, dignified, caring workplace? To begin, governments must immediately proclaim a target of zero occupationally acquired covid infections in health and social care workers.

To meet this entirely achievable goal requires us to shed the nihilism. It is not "inevitable" that a healthcare worker should catch covid at work. It is not "prohibitively expensive" or "completely impossible" to carry out the required structural improvements to ventilation systems and buildings and to provide personal protective equipment against airborne transmission within a rigorously policed infection control system. It is the will alone that fails to deliver these prerequisites of a safe workplace.

The moral injury of avoidable harm to health and social care workers cuts deep and the scars will persist. Reflect on that when you are next tempted to prod "healthcare heroes" into harm's way with your self-serving cheers.

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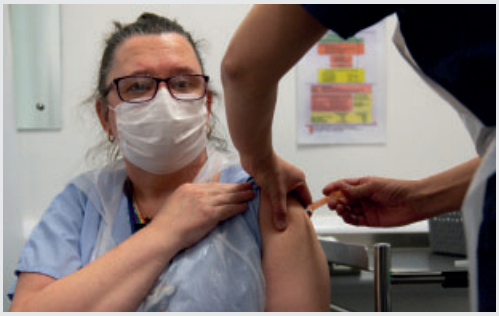
LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Physician, heal thyself?



JACOB KING/PA

We read the reports from Israel suggesting that one dose of Pfizer vaccine could be less effective than expected with disquiet (News Online, 22 January). NHS staff are being vaccinated for covid-19 with a single dose, as if they were members of the ordinary population rather than uniquely exposed to the virus. This approach is out of step with practice abroad and unsupported by evidence. Healthcare workers might die as a result.

Several professional bodies have already raised concern over the scientific basis for modifying dosage schedules. But there is another aspect to this, which carries with it both moral and practical imperatives for the government.

In Iraq and Afghanistan, British soldiers were expected to make do with second rate kit, including not enough helicopters, poor communications gear, and under-armoured vehicles. Only the professionalism and dedication of our service people, and an outcry at home that pushed the Ministry of Defence to rush through new procurement, maintained high standards of performance and prevented serious morale problems. Soldiers fight better if they know they and their mates will be protected and looked after if wounded. But individual courage should not have to make up for substandard materiel.

To ask NHS workers to potentially risk their health and that of their families and patients by under-immunising them is similar. Like soldiers in wartime, they accept the risk of injury or death, but they have a right to expect to be given the best protection and weaponry available.

"Physician, heal thyself" is generally seen as a warning from Jesus against hypocrisy. But when it comes to covid-19, leaving the healers at risk is both practically and morally unacceptable. NHS workers should not have to make do with modified vaccination. Their loyalty and ability to perform to their best is being unfairly tested.

Gordon Muir, consultant urologist, London; Jonathan Boff, reader in the history of warfare, Birmingham

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ELIMINATION OF COVID-19

A practical roadmap by segmentation

We agree with Baker and colleagues that eliminating covid-19 should be the goal (Analysis, 16 January). The "hammer and dance suppression strategy" did not suppress the epidemic enough to give an opportunity to "dance." Rather, the dance period induced a larger resurgence of the epidemic, ending up with fatigue and complacency among citizens.

The elimination strategy is scientifically sound but is likely to be dismissed in the real world. We propose an additional strategy—segmentation. Eliminating SARS-CoV-2 is harder when we want to achieve it in large, densely populated areas, so it should be implemented in a smaller area first and then scaled up. By gradually increasing (and expanding) the covid-free areas, people are more likely to follow the same steps.

Historically, elimination strategies were laughed at. But obstacles are hurdles to overcome, not reasons to give up. We need to be logically optimistic to progress.

Kentaro Iwata, professor of infectious diseases, Kobe; Yuki Aoyagi internist, Dunedin

Cite this as: *BMJ* 2021;372:n349

COVID-19: TRENDS IN SUICIDE

Responsible reporting of suicide research

John and colleagues discuss the role of the media in preventing suicide (Editorial, 28 November). Academics must also contribute to responsible reporting through carefully described research findings. We recommend that authors, peer reviewers, university press offices, and journal editors consider the following when publishing information about suicide in the covid-19 pandemic and its aftermath:

- Remove references to methods of suicide from article titles and avoid detailed description of methods
- Avoid descriptions of novel methods of suicide
- Avoid simplistic explanations of suicide, such as single "triggers" or causes. Associating the pandemic with suicidal behaviour carries substantial risk of normalising it as a way of coping
- Avoid sensational language, such as "surge," "crisis," "tsunami," and "epidemic"
- Take special care when describing suicidal behaviour in young people as they are particularly susceptible to suicide contagion.

We must ensure safe and accurate translation of suicide research findings into media reporting that minimises risks to vulnerable people.

Duleeka Knipe, vice chancellor's Elizabeth Blackwell Institute research fellow, Bristol; Keith Hawton, professor of psychiatry, Oxford; Mark Sinyor, associate professor, Toronto; Thomas Niederkrotenthaler, associate professor, Vienna

Cite this as: *BMJ* 2021;372:n351

THE BMJ APPEAL 2020-21

Food poverty should not be allowed to continue

The BMJ Appeal could substantially and immediately improve food insecurity and children's health (16 January).

Healthy eating is a multifaceted and complex public health area, and there are inter-related structural issues that can influence a family's eating habits. These include insecure and low paid employment, insufficient social welfare provision, lack of cooking skills, and a socially unjust food distribution system.

Fiscal measures are needed so that low income and unemployed families can afford food, electricity, and other essentials. They could also be used to subsidise fruit and vegetables and tax less healthy foods.

Foodbanks and free school meals are vital at the present time, but we urgently need a long term national strategy so that these types of initiative become redundant in the future. The UK is one of the world's richest countries, and food poverty should not be allowed to continue. Robust government action is needed immediately.

Michael Craig, Watson trustee; John Lloyd, honorary vice president, Institute of Health Promotion and Education

Cite this as: *BMJ* 2021;372:n343

Subhas Chandra Datta

Community paediatrician (b 1948; q Calcutta Medical College, Kolkata, India, 1970; DCH, FRCP), died from atypical pneumonia after treatment for lung cancer on 27 July 2019

Subhas Chandra Datta was passionate about medicine, sports, and arts and culture. He graduated from Calcutta Medical College, India, in 1970 and then pursued a career in paediatrics. In 1973 he came to the UK for further training. He went back to India for a few years and continued working there as a neonatologist and paediatrician. He returned to the UK and worked as a community paediatrician in the NHS at the Betsi Cadwaladr University Health Board, north Wales, until he retired, a few days before his death. He was well respected and loved by his family, friends, and colleagues alike. He leaves his wife, Purnima; two daughters; and two very young grandchildren.

Poulami Datta

Cite this as: *BMJ* 2020;371:m4658

Gordon Booth Farquharson

General practitioner and adviser (b 1926: q Aberdeen 1950; FRCGP), died from a myocardial infarction on 31 July 2020

Gordon Booth Farquharson worked in a mining practice in Kirkby in Ashfield, Nottinghamshire, before coming to a small practice in Inverness in 1962. By joining with two singlehanded practices, the town's first health centre—Ardlarich—was established, where he remained until he retired in 1988. Gordon was a trainer for many years and was appointed as the first regional adviser in general practice for the Highlands. He was provost in North Scotland Faculty of the Royal College of GPs and a president of the Highland Medical Society. He was a past captain and vice president of the Nairn Golf Club. Gordon's elder son, Alan, a doctor, was killed in an offshore helicopter crash in 1982. His wife, Anne, died in 2011. He leaves two children, four grandchildren, and a great grandson.

Niall A Farquharson

Cite this as: *BMJ* 2020;371:m4657

Peter Tiplady

Public health physician Carlisle (b 1942; q Durham 1965; MRCGP, FFPHM), died from complications of valvular heart disease on 17 June 2020

Peter Tiplady ("Tippers") was born and raised in Gateshead. After house jobs he spent two years in pathology. He trained as a GP on Teesside and was appointed as community health specialist and later director of public health in Carlisle. He relished this role and managed large scale outbreaks of *Escherichia coli* and foot and mouth disease. He appeared regularly in the media. He was the country's longest serving public health doctor when he retired in 2003 and received the BMA medal for services to medicine. Faith was important to him, and he became a non-stipendiary minister in his local church, which enabled him to marry both of his sons. He was known for his riveting sermons, always interspersed with Geordie humour. He leaves his wife, Pauline, and two sons.

Chris Tiplady

Cite this as: *BMJ* 2020;371:m4652

John Alexander Gibson

Consultant physician and gastroenterologist (b 1941; q Cambridge/Barts 1965; MD, FRCP), died from prostate cancer on 18 July 2020

John Alexander Gibson was appointed consultant physician at Stafford Hospital in 1977, where he set up the gastroenterology department, and later the endoscopy unit, which bears his name. He was a founder member of the "Gut Club" and later the "Travelling Gut Club," a board member of the Dinwoodie charity (dedicated to improving medical education), a highly regarded college tutor, and for a while medical director at Stafford. He was chairman of the trustees of the Katharine House Hospice, which repaid him by its superb contribution to his terminal care. John enjoyed classical music, opera, ballet, and theatre. He excelled at sport, in particular rugby football. He enjoyed fishing, shooting, skiing, and his dogs. He leaves Sarah, his wife of 47 years; two children; and four grandchildren.

Tom Gibson

Cite this as: *BMJ* 2020;371:m4656

Mohankumar Adiseshiah

Emeritus consultant vascular surgeon University College London Hospitals NHS Foundation Trust (b 1941; q Westminster Hospital Medical School, London, 1965; MA Camb, MS Lond, FRCP Lond, FRCS), died from covid-19 on 24 April 2020

Mohankumar Adiseshiah ("Mo") trained in the heyday of invasive open aortic surgery for life threatening bleeding. His most enduring legacy is undoubtedly his pioneering role in the early development of minimally invasive endoluminal stent graft repair. He stuck with this new technique through its at times underwhelming "endogloominal" infancy, training, publishing, and participating in defining trials for what is now the global default aortic operative approach. Mo served on the council of the Vascular Society and published widely. After surviving a major stroke in November 2018, he regained some quality of life only for him to be stolen from us by covid-19. Mo leaves his wife, Maria; six children; and three grandchildren.

Obi Agu, Maria Adiseshiah, Michael Jenkins

Cite this as: *BMJ* 2020;371:m4659

Maldwyn Jones Griffith

Consultant orthopaedic surgeon (b 1940; q Liverpool 1963; OBE, FRCS Ed, FRCS Eng, MChOrth), died after a period of ill health and frailty on 11 January 2020

Maldwyn Jones Griffith was the first orthopaedic surgeon to be appointed Hunterian professor by the Royal College of Surgeons for research into adolescent hip disease. He worked at Liverpool Royal Infirmary, Wrightington Hospital, and Alder Hey Children's Hospital; he was also associate professor at the Albert Einstein College of Medicine in New York. He was appointed consultant orthopaedic surgeon at West Wales General Hospital and became director of surgical services for the Carmarthen and District NHS Trust. As a junior doctor, Maldwyn was awarded the Royal Humane Society medal for bravery. In 1998 he was appointed OBE for services to medicine. His book *The Historical Jesus* was published in 2018. Maldwyn leaves his wife, Elizabeth; two sons; and five grandchildren.

Owen Griffith

Cite this as: *BMJ* 2020;371:m4655

Nick Foster

Founder member of the East Midlands Immediate Care Scheme

Nicholas John Foster (b 1955; q dentistry, Sheffield, 1978; q medicine, Sheffield, 1984; DCH RCP Lond, DRCOG, FRCGP), died from bowel cancer on 27 September 2020

Nick Foster was born in Leicester in 1955, an only child, and raised in Hong Kong where his father, John, was a Church of England dean. In his youth, Foster adored animals and according to his family was always rescuing "mutts" from the streets in Hong Kong, where he attended a local school.

As a child, he underwent many operations—he was born deaf in his left ear. He returned to England as a boarder at Loughborough Grammar School. He was told he was not bright enough to be a doctor but in time became an exceptional medical practitioner.

Foster initially studied dentistry at Sheffield University and qualified as a dentist in 1978. Afterwards he read medicine. He worked briefly in maxillofacial reconstructive surgery and anaesthetics before opting for general practice. He trained in Nottingham.

Kegworth air disaster

Foster was the first doctor at the scene of the Kegworth air disaster in 1989, when a British Midland Boeing 737 carrying 126 passengers and crew missed the runway and crashed on to the M1 motorway, killing 47 people and severely injuring 74. He had responded to the emergency as a founder member of what is now the East Midlands Immediate Care Scheme (EMICS)—a team of volunteer doctors who respond to emergencies.

From this time and as medical director with EMICS until 2015 he responded to more than 3500 emergency trauma calls, rescuing and treating patients on a voluntary basis and mostly out of hours. His colleague Nigel Cartwright, now his successor as senior partner at the Kegworth Surgery, said, "Nick was ideal for this role because of his passion and energy—and also because of his knowledge and skills in surgery and anaesthetics."

Gillian Wilmot, his wife of 34 years, recalled, "Nick wasn't particularly traumatised by the Kegworth air crash as he had to deal with worse disasters during his career. He thought it was remarkable how many people could survive with prehospital emergency expertise.

"Nick was very brave and once crawled under a train to get someone out and on another occasion went into a building where someone had a knife. He even managed to anaesthetise at the side of the road. He had experience in anaesthetics, as well as surgery, and had excellent motor skills thanks to his dental training. He was precise, neat, and brave."

He was recognised for his work with EMICS by two Queen's medals in 2002 and 2012.

GILLIAN WILMOT

Foster was the first doctor at the scene of the 1989 Kegworth air disaster

Rural general medical practice, teaching, and education

Foster started as a partner at the Orchard Surgery, Kegworth, in 1988 and remained there until his final illness after major surgery for a bowel obstruction in July 2020. From the outset he displayed energy and enthusiasm in all he did.

He was an early adopter and advocate of medical computing, where his path crossed with James Read, who was five miles down the road in Loughborough.

Foster shared an enthusiasm for education and teaching—inherited from his trainer, Dan Hoyte—with his partners; this became a defining characteristic of the practice. He became a trainer in 1992 and was the longest serving trainer in Nottingham.

He was a well liked programme director on the Nottingham GP training scheme for 18 years and from 1999 was an examiner for the Royal College of GPs. He shared his enthusiasm and love of knowledge and skills with many GPs in training across the east Midlands—many of whom remained colleagues and friends.

His colleague, Caroline Anderson, recalled, "For 21 years from 1993, there was exceptional stability and continuity of 'family doctor' medical care with the same four GP partners—myself, Nick Foster, Nigel Cartwright, and Helen Eglitis—serving 8000 patients. Nick's calm and compassionate attitude translated into a life of service, nurturing and supporting the development of excellent general practice through multiple healthcare reorganisations, with a lot of fun along the way. Nick was also an amusing raconteur at GP practice staff fancy dress Christmas parties."

Alongside his partners and team Foster was featured in a magazine article entitled "The Perfect Practice?" The practice continues to maintain a reputation for excellence, education, and stability.

In his later years he became an appraiser and valued mentor to many senior colleagues, described as "kind and genial" and "decent and wise."

Foster leaves his wife and two sons.

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