We live in the age of information overload. Once you factor in the unregulated world of social media and self-appointed experts, as well as the urge for people to jump in with their two pennies’ worth and a disregard for real experts, it becomes quite difficult to find sources you can trust. Then covid-19 appears, and the information world looks like a maze full of pitfalls for anyone trying to ascertain the correct information.

Understandable worries abound, and recent times have also shown the impact that healthcare professionals can have, in positive and negative ways. Huge social media followings don’t necessarily mean that account holders have expertise, yet their views are seen and taken on board by large numbers of people, many of whom will be isolating themselves from their usual, face-to-face social networks.

Misinformation is spreading along with the virus. Polarised political views, and the scars of the Brexit debate, have perhaps made some people forget the importance of working together as a nation, and being kind to others in these difficult times.

When a healthcare professional, or anyone else, tweets something along the lines of “Many will die—especially the elderly,” they need to think about the effect this has on older people and those who are vulnerable or whose relatives are. We know that fear will exacerbate many mental and physical health issues, but somewhere this knowledge seems to have been lost by some fellow healthcare professionals. In an effort to make a political point, is the ethos of “be kind” getting lost?

People with diabetes are at increased risk of illness if they contract covid-19. Thankfully, there is some reliable information around. If you’re a healthcare professional and you’d like to direct your patient to a reliable source, it’s worth looking at the information from Diabetes UK and the Juvenile Diabetes Research Foundation (JDRF UK), which has been developed in conjunction with NHS England and Public Health England.

In short, as a healthcare professional, ensure that you’ve given any patients with diabetes the appropriate number of testing strips; ensure that they have access to telephone support for queries and that they know what to do when ill; and reinforce the basics of hand hygiene and social distancing, as advocated by Public Health England. As things stand, it doesn’t matter what your age is, what your type is, what your control is if you have diabetes. If it isn’t essential work or travel, stay at home.

These are extraordinary times, and we need to have faith in the people leading us, from a healthcare point of view. It’s perhaps not very modern to say so—but trust the experts. My parents are both in high risk groups, and they’re here visiting the UK as part of their golden wedding anniversary. With those high stakes, I place my faith in Chris Whitty, England’s chief medical officer and his team.

It’s time we all adhered to that principle and let the team do their job. There’s a time when we all need to learn to follow. This would be it.

Partha Kar, consultant in diabetes and endocrinology, Portsmouth Hospitals NHS Trust
drparthakar@gmail.com
Twitter @parthaskar
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Social media misinformation is spreading along with the virus
Don’t forget covid-19’s impact on US primary care

There are twice as many family doctors in America as in emergency departments, yet they have received little to no guidance

Douglas Kamerow

YANKEE DOODLING

The most important thing to understand about systematic changes in US healthcare delivery is, of course, that we have no single healthcare system. A primary care medical practice may be a small, self-owned group, part of a larger hospital system, owned by the state or federal government, or a community owned non-profit corporation.

Family doctors, for example, may own their practice with full authority to set and change practice policies or they may be salaried employees who lead the clinical team but have little or no say in management. This means that there are dramatic differences in how practices have reacted to the coronavirus epidemic and in what their doctors think about those changes.

Constantly changing guidance

Every doctor I spoke to reported feeling bewildered by constantly changing guidance from experts and regulators about coronavirus testing and triage policies.

They were often confused by changing recommendations from trusted sources, as well as conflicting recommendations from local, state, medical specialty, and federal authorities. They have reacted in different ways, some suspending routine well-patient visits in favour of treating only urgent and symptomatic patients. Others with larger, multi-site practices have routed high risk patients to one specific location, trying to maintain chronic care visits for the rest of their patients.

Once policies for testing and triage are set, practices’ size and ownership affect implementation of patient communication and triage. Doctors in small, independent practices report difficulty reaching all patients and triage. Doctors in larger, multi-site practices have routes high risk symptomatic patients. Others with larger, more resources have outreach workers who can guide patients. Some doctors have ample supplies of the personal protective equipment that enable them to see high risk patients, while others report shortages.

One doctor told me they were switching from 90% in-person visits and 10% online to 20% in-person visits and 80% online. They are planning to do 90% tele-medicine visits and 10% in-person visits.

There are dramatic differences in how practices have reacted to the coronavirus epidemic.

In the exponential growth of covid-19 in parts of the US, we have heard a great deal about brave, exhausted emergency room doctors and staff. Very little that I have seen, however, has focused on a much larger group of doctors who are also on the front lines: those who deliver primary care.

In the US there are more than twice as many family doctors as ER doctors and almost three times as many paediatricians, most of whom work exclusively in primary care. Altogether there are more than five times more primary care doctors than ER doctors, and that is not counting general internists, many of whom in the US are also primary care doctors.

What is going on in primary care? I spoke to friends and colleagues to find out, and I heard three main points. Dramatic changes in practice have come very quickly, without much prior preparation. Little assistance, or even clear guidance, has come from authorities. And the resulting changes vary widely by practice organisational structure.

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virtual visits to the opposite, reducing their in-person visits to 10% of their patient encounters. Smaller practices had fewer resources to even attempt such a dramatic change.

Also, salaried doctors in practices backed by large organisations were not worried about how they were going to be paid for these virtual visits or whether they could afford to keep their practice staff on payroll with dramatically declining fee-for-service income. Not so with a private practice paediatrician who was very concerned at whether they were being reimbursed for telemedicine visits and worried whether they could continue to make staff payroll.

It is a very tough time for primary care medicine. It would be helped by clear policy guidance and financial assistance to enable delivery of the appropriate, safe care that all patients need and expect.

Douglas Kamerow, senior scholar, Robert Graham Center for policy studies in primary care, professor of family medicine at Georgetown University, and associate editor, The BMJ

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Some activities may never return

As the saying goes, “necessity is the mother of invention.” In the pandemic, we’re seeing scientific evidence evolve quickly, technologies develop, and real time, ever changing plans for epidemiology, public protection, and ensuring that health services remain viable.

When we’re through this crisis and have time to reflect, no doubt some practices will see a change for the better. Our planning, preparedness, and understanding of transmission, protection, and treatment will have to change. But what of the things we stop doing? Will we return to our old ways or be grateful for what we’ve learnt?

In acute hospitals, we’re already moving to stop most non-urgent outpatient activities. Many more consultations are moving online or to the telephone. Clearly, we don’t want this war footing to become the new norm. Patients in many cases rely on such work and have their lives saved or transformed. Clinicians get valuable training in those settings. However, organisations such as the Health Foundation and the Royal College of Physicians have argued for some time that outpatient appointments need reform, as have the NHS 10 year plan and the Getting it Right First Time programme. This may help accelerate the process of focusing on value.

Perhaps we need more one stop, rapid access clinics for new patients and more self-directed follow-up—often with advice and remote consultation rather than physical trips to clinic suites, which are especially burdensome for patients with multiple conditions seeing several teams. Hospitals are also redeploying specialist clinicians to allow more fast-track access to their skills, away from overcrowded and pressurised emergency departments. This is overdue.

A recent letter sent by the NHS’s chief executive, Simon Stevens, and chief operating officer, Amanda Pritchard, included a provision to move away from “payment by results” tariffs towards block contracts, removing some financial penalties for trusts in deficit. This purchaser-provider split has always been fraught. Apart from the bureaucracy, transaction costs, and incentives to focus on the “business model,” the tariff paid to acute hospitals for urgent activity doesn’t reflect its true cost—but it allows us to make a margin on outpatient and elective work, effectively cross subsidising unscheduled care. This creates all kinds of perverse incentives, when we may be better collaborating to plan care for a local population.

For now, hospitals seem to be suspending the annual consultant job planning cycle. The process has its virtues, but how much would we miss it? As for the paperwork involved in revalidation, appraisal, and a whole raft of mandatory training, perhaps we’ll learn that it can be slimmed down—as it will have to be if we’re to welcome recent retirees back to work, who might not have retired were it not for the paperwork.

I suspect the crisis will reveal which staff groups are critical to the healthcare business—and which individuals, quangos, or consulting firms won’t be missed.

The Great British Queue will stretch, not only getting longer, but also more spaced out. Expect cartoons and editorials that poke fun at this. Laughing is a way to build community resilience. There is a point to black humour, but let’s not make it cruel.

When it is all over expect an explosion of life and colour. Once again, we will marvel at live theatre, holler for our favourite teams, and share intergenerational Sunday lunches. We will enjoy these things even more, knowing what it is like to do without. In times of crisis, we all get to decide. Courage and kindness or looking out for yourself? The first will sustain us, individually and collectively. Choose decency. Then add a large dose of medicine and science, mix with a dollop of common sense and garnish with courage.

Mary E Black is a public health doctor

Organisations have argued for some time that outpatient appointments need reform

The BMJ | 4 April 2020

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**Fear in the time of covid-19**

While London’s hospitals are nearing the “phony war” stage of this pandemic. Never has so much work been done, so quickly, in so many hospitals. New critical care wards have been created, operating suites repurposed, and emergency departments completely reorganised to try to concentrate infective patients in one place. Changes that would usually have taken years of wrangling about money have happened in the space of a week, with superhuman efforts from healthcare workers and managers alike. I am in awe.

Our academic colleagues are also working in overdrive, rapidly synthesising evidence and getting it out to clinicians who need it. It’s hard to keep up, but every piece of trusted information helps when struggling with an unfamiliar disease.

In general practice, we’ve changed our way of working. We’ve put off everything that can safely be postponed. The doors are locked, and patients set foot in the building only when it’s clear that their problem can’t be solved remotely and that they’re deemed to be low risk.

But what is low risk? As asymptomatic shedding of the virus in the early stages seems to be the norm, and some people have only very mild symptoms for their entire illness, we can’t be sure. From NHS supplies, we’ve received a delivery of 150 fluid resistant surgical masks and plastic aprons and gloves, which won’t last long if we use them for every contact. Like many other practices we’ve been sourcing our own—scouring the internet for scrubs, masks, goggles, and gowns—but supplies are drying up.

Most regions have plans to set up “hot hubs,” where patients who need to be assessed face to face in primary care can be seen by a dedicated team. It’s still not clear how these will operate, who will work there, or what will be done to minimise the risk to staff. The learning curve will be steep. A serology test that could tell us who has already been infected and is therefore relatively immune would be hugely useful.

The emotional rollercoaster is a hard ride. Pride in our colleagues is matched by anger at the government’s failure to prioritise the testing, personal protective equipment, and ventilators we need. Many of us, knowing hospital colleagues have no choice, are feeling cowardly that we haven’t yet volunteered for the hubs. Fear is all around—for ourselves, for our families, and for our patients. We know some will die from covid-19 despite the best that modern medicine can offer. The bigger fear is hospitals will be overwhelmed, as in Italy, bringing many more preventable deaths. I’m still holding on to the hope that the capacity increases, combined with reduced transmission from social distancing, will be enough.

Cite this as: BMJ 2020;368:m1286

**The crisis in global politics**

Covid-19 is a pandemic. It is also a diagnostic for understanding and evaluating the ongoing crisis of international politics.

Throughout this pandemic, covid-19 has exposed and emphasised the ways in which populations access, perceive, and respond to changes in their communities, political structures, and societies. Widespread smartphone use and real time social media access have been central to the proliferation of viral misinformation.

The pandemic has also exacerbated underlying tensions between global powers. We have seen this in Donald Trump’s referencing of the “Chinese virus,” China’s expulsion of US journalists, and concerns over Russian misinformation campaigns impacting on global responses. Covid-19 has become the most recent arena where competing practices, politics, and ideologies play out across an international backdrop of rising state-centric populism, antiglobalisation, and authoritarianism.

The spread of covid-19 has further propagated the rise of social malaises including racism and xenophobia. Yet discussing the rise solely in this context misses a larger and critical picture. Deeply troubling expressions of racism were also witnessed during previous health emergencies including HIV/AIDS, SARS, and Ebola. While covid-19 has given rise to new channels in which racism can be more openly expressed, its persistence as a long standing global ill speaks first to the complacency or failure of many states to counter and eliminate expressions and practices of racism in non-outbreak settings.

Covid-19 has exposed resource inequities. This has been most widely witnessed in the amassing of food, drugs, and medical products seen as essential by populations with the ability to pay. These behaviour trends have led to claims that covid-19 prevention practices are far more accessible for financially secure groups. The pandemic has not produced these chasms in resource inequities, but it has accentuated and deepened them.

These pre-existent challenges mean the study of politics and the cognate social sciences within global pandemics has never been more vital.

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Pride in our colleagues is matched by anger at government failure to prioritise testing, PPE, and ventilators

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

Stephen L Roberts

Cite this as: BMJ 2020;368:m1286

BMJ OPINION

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

Stephen L Roberts, LSE fellow in global health policy, London School of Economics
LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Medicine, so far from an exact science

McCormack and Holmes’s article clearly shows how far the practice of medicine is from an exact science, how much it is still an art dependent on the performer (Practice Pointer, 22 February).

In medical school we are taught to treat not the test but the patient, but test results, even repeated, might simply show physiological variation and not a trend indicating the need for treatment.

The other part of the patient record—non-numerical data—can be even less helpful. Clinicians are infrequent coders, and electronic health records contain abundant free text without a mechanism for processing and comparing data, analysing trends, auditing, or implementing supportive diagnostic tools.

Defensive medicine is now becoming a process of collecting data, many of them unnecessary and stored in an oversized, shared electronic health record. The outcome of this information management is the dismissal of most of the available data and the collection of more facts. The result is not knowledge but confusion. There is too much talk about improving outcomes and population health management, but the lack of adequate data and the misinterpretation of information lead only to ignorance.

Medical professionals are not managing the vast amount of patient data available. They are failing to use the information at their disposal adequately, to find the knowledge that could change their diagnosis and management plans, and to acquire the wisdom that could make medical practice safer. In consequence, they are failing to improve the outcome for patients.

Information is power, and as medicine cannot control its vast collection of data, it is becoming powerless, incapable of progressing or harnessing the benefits other sciences, such as informatics, can provide.

Pablo Millares-Martin, GP, Leeds
Cite this as: BMJ 2020;368:m1188

NURSES’ JUDGMENT

Medicine has lost its way

The loss of a valuable nurse because of an irrational decision by the Nursing and Midwifery Council will damage nurses’ confidence in the council and increase the number of inappropriate cardiopulmonary resuscitation (CPR) attempts (David Oliver, 22 February).

Inflicting CPR on a dying person is not sensible or dignified. We need appropriate care for people according to their stage of life; one of them is dying, which cannot be reversed.

The quality of our death is important for us and our families, and how it is managed can ease grief. A caring nurse using their professional judgment can help, and this should be the primary obligation.

Modern medicine, for all its brilliant achievements, has lost its caring, its balance, and professional judgment. Restoring this is urgent. It needs to be part of a wider debate on the direction of medicine and the irrational and unrealistic expectations of it.

David Reilly, retired surgeon, Llandudno
Cite this as: BMJ 2020;368:m1191

HIP REPLACEMENT OUTCOMES

Understanding patient flow

Complications after total hip replacement often present to an NHS hospital, even when the primary procedure was undertaken in the private sector. Overall patient reported outcome measures are skewed by this, and outcome metrics reported by private hospitals might be misleading if they fail to take this into account.

Appleby reports very few outliers after adjustment for case mix as described by NHS England. Adding body mass index and ASA grade to the adjustment might reduce the number of outliers further. Multilevel modelling is another approach to measuring variation between hospitals that helps determine the relative importance of patient, surgeon, and hospital factors.

Adam M Ali, Frank Knox fellow, Cambridge, MA
Alex Bottle, professor of medical statistics, London
Cite this as: BMJ 2020;368:m1161

YOUR RESULTS MAY VARY

Don’t blame the tools

McCormack and Holmes discuss the imprecision of medical measurements (Practice Pointer, 22 February).

If a perfect laboratory test existed, patients could cut out the intermediary and do a direct-to-consumer diagnostic test. They might be imperfect, but laboratory tests complement other clinical information. Results must be interpreted in the context of patient symptoms, medical history, clinical findings, and radiology.

Take prostate specific antigen levels as an example. A low normal PSA of 2.0 ng/mL does not rule out prostate cancer if digital rectal examination of the prostate is abnormal. An abnormally high PSA level of 100 ng/mL is not concerning if the patient has had bladder retention and prostate biopsy has shown inflammation only.

Busy clinicians already have a plethora of laboratory tests to contend with; adding complexity to existing test results should be done only if high quality evidence indicates improvement in clinical care.

Santhanam Sundar, consultant oncologist, Nottingham
Cite this as: BMJ 2020;368:m1182
Iain Smith Macdonald
Public health medical officer (b 1927; q Glasgow 1950; CB, MD, DPH, FRCP, FFPH, QHP), died from old age on 4 January 2020
Iain Smith Macdonald was born in Greenock. After graduating, he did national service in North Africa, then qualified in public health medicine and did a spell as a lecturer at Glasgow University. After posts as deputy medical officer of health in Lancashire, he joined the Scottish Home and Health Department in 1964, serving as chief medical officer of Scotland from 1985 to 1998. His wartime experience of evacuation to Kingussie kindled an abiding interest in Scottish history and the roots of the family in Glencoe. This led him, in retirement, to undertake research leading to the publication of several scholarly articles and, in 2005, a book, Glencoe and Beyond: The Sheepfarming Years 1780-1830. He leaves Sheila, his wife of 61 years; two children; and two grandchildren.
Angus Macdonald, Morag McQuade

Mohammad Fahim Siddiqui
Chief of surgery and departmental director (b 1941; q Liaquat Medical College 1965; FRCS), died after a sudden cardiac arrest on 22 December 2019
Mohammad Fahim Siddiqui was born in Bareilly, British India, but the family emigrated to Pakistan after partition. He moved to the UK in 1968 and worked for the NHS for 11 years. In 1979 he moved with his family to Saudi Arabia, where he practised for over 40 years. He published Arabic For Hospital Staff to help non-Arab medical personnel communicate with their Arab patients. Fahim specialised in haemorrhoidectomies and worked right until the very last day of his life—the Ministry of Health renewed his licence year after year. He had his funeral prayers with his community in Saudi Arabia and was buried back in England, next to his wife, who had died in February 2019. He leaves four daughters and six grandchildren.
Nasima Siddiqui

John Smith
Consultant anaesthetist (b 1945; q Liverpool 1969; FFARCS, died after a long illness on 30 December 2019
John Smith was appointed as a consultant to Selly Oak Hospital, University Hospitals Birmingham, in 1982. His enthusiasm for his specialty led him to develop an interest in the management of difficult airways. John rapidly became known nationally as a pioneer in the use of fibreoptic laryngoscopes and published numerous papers, presenting his work at many national meetings. Once the technique became established, his research moved on to cover aspects of training in difficult airway management. He developed one of the first fibreoptic training courses and taught both local trainees and those from further afield who were among some of the first “airway fellows.” In retirement he enjoyed spending time with his family and planning the many holidays they enjoyed together. John leaves his wife, Fang, and a daughter.
Nicola Osborn, Tina McLeod

Joseph Charles Stoddart
Consultant anaesthetist and intensivist Newcastle (b 1932; q Durham 1956; MD Newc, FRCA, FRCP Lond), died after a long debilitating illness on 26 October 2019
During his military service Joseph Charles Stoddart (“Joe”) was attached to the aviation medicine department at Farnborough, where he came under the influence of Edgar Pask, famous for the development of survival suits for airmen. Joe returned to Newcastle to work with Pask. The massive flu epidemic in 1969 led to a need for dedicated wards and specialists for intensive care and Stoddart was at the forefront of this, setting up an excellent unit in Newcastle’s Royal Victoria Infirmary. With colleagues he developed the specialty of intensive care medicine and national training programmes, and wrote a standard textbook. He was an avid bibliophile. In 1956 he married Sally; she predeceased him. He leaves four children.
Anna Batchelor, Alan Craft

Euan Wallace
General practitioner Petersfield (b 1938; q Cambridge/St Thomas’ 1965; MA Camb, MRCP UK, DObst RCOG), died from pancreatic cancer on 20 December 2019
Euan David Wallace combined rigorous scientific principles with shrewd clinical acumen in all his work, which included roles as a GP trainer, palliative care physician, and clinical assistant in diabetes and dermatology. A colleague described him as “never being interested in status, power or money, but five minutes in his company would just make you feel better about life.” Having survived two different cancers, he described himself as a “hardy perennial, the longest surviving medical wreck around.” In retirement he enjoyed playing the piano, choir singing, playing tennis, travelling for ornithology and photography, but above all he loved walking. Predeceased by his wife, Jill, and his son, he leaves three daughters and seven grandchildren.
David H Jones

Charles Arthur Veys
Chief medical officer Michelin, Stoke-on-Trent; honorary senior research fellow, Primary Care Research Centre, Keele University (b 1933; Liverpool 1956; OBE, FFOM, MD, MIOH, DPH, DIH), died after a long battle with progressive supranuclear palsy on 30 November 2019
Charles Arthur Veys was born in Antwerp, but his family moved to Sheffield in 1935. In 1962, he started his career in occupational medicine through postgraduate studies in public and industrial health at Liverpool University. He worked at Pilkington glass manufacturers before moving to the Michelin tyre company in Stoke-on-Trent. He also conducted epidemiological studies into cancer rates in the area. In 1979 he joined the new industrial and community health research centre, linked to Keele University, as a base for his academic activities. He leaves his wife, Sally; five children; and 13 grandchildren (including five now in the medical profession).
Peter Croft, Jane Veys, Paul Veys

Nicola Osborn, Tina McLeod

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David H Jones
Medical epidemiologist Peter Salama, a leading figure in the World Health Organization and Unicef, shook up global efforts to tackle major disease emergencies such as Ebola. He is credited with helping to rebuild WHO’s reputation after experts criticised its slow and disorganised response to the Ebola outbreak in west Africa (2013-16). His sudden death has shocked the global health community.

Jeremy Farrar, director of the Wellcome Trust, says Salama’s influence can be found in a more proactive and research based approach to tackling epidemics. His “energy and drive” at WHO were important in supporting the development of an Ebola vaccine and its use “as a public health tool which has had a dramatic impact,” says Farrar.

### Ebola response

**More than 11 000 people died in the Ebola outbreak that wrecked economies in Guinea, Liberia, and Sierra Leone from 2013 to 2016. During 2014-15, Salama led Unicef’s global response to the crisis and developed community based approaches to care and support that helped "substantially" to control the outbreak, say colleagues.**

David Nabarro, professor of global health at Imperial College London, says, “Pete consistently made the point that establishing trusted relationships between communities and responders is at the heart of effective responses to disease outbreaks.” UN agencies and others were determined to prevent repeat catastrophes.

From 2016, Salama, as WHO executive director for emergency preparedness and response, led 1000 staff in implementing reforms. He said in 2016, “It’s not just about sending the infectious disease experts in. They have to have access. They have to be protected from a security point of view. That confluence is going to challenge us more and more.”

Salama sought to build up capacity after a damaging cycle of budget cuts and ensure closer working with technical experts and other partners.

Rick Brennan, regional emergency director for WHO’s Eastern Mediterranean region, says Salama provided “clear vision and leadership,” recruited well, and engaged organisation-wide support to prioritise WHO’s emergency work. The way a subsequent Ebola outbreak, in Democratic Republic of Congo’s Equateur province in 2018, was quickly controlled “demonstrated WHO’s strengthened operational capacities and improved ability to partner with key agencies,” says Brennan.

However, a subsequent Ebola outbreak in DRC’s North Kivu province, has proved harder to defeat. It has claimed more lives and some experts have criticised the global health community’s response. Whitworth says responders have faced a “perfect storm” of challenges in a highly volatile region with warring militias, difficult logistics, and communities distrustful of outside agencies. He says that while the outbreak has not been eliminated “it’s not been allowed to expand,” thanks in part to the benefits of vaccination.

Salama left his wife, Matt Limb, Croydon

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**Salama “embodied everything that is best about WHO and the UN—professionalism, commitment, and compassion”**

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**Life and career**

Salama’s family had migrated to Australia, his birthplace. His mother was a refugee from Palestine, and his father an accountant from Egypt. After his medical studies at Melbourne University, Salama obtained a master of public health at Harvard University, where he was a Harkness and Fulbright scholar in public policy. He completed the Epidemic Intelligence Service programme at the US Centers for Disease Control in Atlanta, US, in 2001, and worked as a medical officer with Concern and Médecins Sans Frontières.

He joined Unicef in 2002 and supported the design of the post-Taliban health system in Afghanistan (2002-04). Between 2004 and 2009 he was chief of immunisation, principal adviser for HIV/AIDS, and chief for global health for Unicef in New York. He later became Unicef’s country representative in Zimbabwe and Ethiopia (2009-15). From 2015 he was Unicef’s regional director for the Middle East and North Africa, based in Jordan.

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**OBITUARIES**

### Peter Salama

Medical epidemiologist who transformed global efforts to tackle major disease emergencies

Peter Salama (b 1968; q Melbourne University, Australia, 1993), died from a suspected heart attack on 23 January 2020

Peter Salama, a leading figure in the World Health Organization and Unicef, shook up global efforts to tackle major disease emergencies such as Ebola. He is credited with helping to rebuild WHO’s reputation after experts criticised its slow and disorganised response to the Ebola outbreak in west Africa (2013-16). His sudden death has shocked the global health community.

Jeremy Farrar, director of the Wellcome Trust, says Salama’s influence can be found in a more proactive and research based approach to tackling epidemics. His “energy and drive” at WHO were important in supporting the development of an Ebola vaccine and its use “as a public health tool which has had a dramatic impact,” says Farrar.

### Ebola response

More than 11 000 people died in the Ebola outbreak that wrecked economies in Guinea, Liberia, and Sierra Leone from 2013 to 2016. During 2014-15, Salama led Unicef’s global response to the crisis and developed community based approaches to care and support that helped “substantially” to control the outbreak, say colleagues.

David Nabarro, professor of global health at Imperial College London, says, “Pete consistently made the point that establishing trusted relationships between communities and responders is at the heart of effective responses to disease outbreaks.” UN agencies and others were determined to prevent repeat catastrophes.

From 2016, Salama, as WHO executive director for emergency preparedness and response, led 1000 staff in implementing reforms. He said in 2016, “It’s not just about sending the infectious disease experts in. They have to have access. They have to be protected from a security point of view. That confluence is going to challenge us more and more.”

Salama sought to build up capacity after a damaging cycle of budget cuts and ensure closer working with technical experts and other partners.

Rick Brennan, regional emergency director for WHO’s Eastern Mediterranean region, says Salama provided “clear vision and leadership,” recruited well, and engaged organisation-wide support to prioritise WHO’s emergency work. The way a subsequent Ebola outbreak, in Democratic Republic of Congo’s Equateur province in 2018, was quickly controlled “demonstrated WHO’s strengthened operational capacities and improved ability to partner with key agencies,” says Brennan.

However, a subsequent Ebola outbreak in DRC’s North Kivu province, has proved harder to defeat. It has claimed more than 2000 lives and some experts have criticised the global health community’s response. Whitworth says responders have faced a “perfect storm” of challenges in a highly volatile region with warring militias, difficult logistics, and communities distrustful of outside agencies. He says that while the outbreak has not been eliminated “it’s not been allowed to expand,” thanks in part to the benefits of vaccination.

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Salama worked in many countries in Africa, Asia, and the Middle East, and at local through to executive levels, accumulating extensive knowledge of how to meet health needs. He also led research and published extensively on maternal and neonatal health, vaccine preventable diseases, HIV, nutrition, war related mortality and violence, and refugee and emergency health.

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