comment

"Disciplining staff for speaking out is a spectacular own goal" **DAVID OLIVER**
"Providing ordinary care in extraordinary times" **HELEN SALISBURY**
PLUS Prehabilitation during a pandemic; no one life is worth less than another

TAKING STOCK Rammya Mathew

Professionalism in a time of crisis

In recent years doctors have been accused of lacking professionalism, and many of us have suffered with self-doubt as a result. Now, however, the NHS is witnessing a pandemic on a scale we haven't experienced before. We've had to plan at length, reorganise structures, and redeploy staff to ensure we're as prepared as we can be for the coming weeks and months.

None of this has happened without effort. I see colleagues all around me giving everything they've got, often working 20 hour days and making many personal sacrifices to make this happen. But it's not just our leaders that have stepped up: at every level, all NHS staff have responded admirably to this crisis.

Overnight, medical and nursing students have been parachuted onto the front line, starting their careers in extraordinary circumstances. Our junior doctors have had to adapt to new working environments: many have been moved into unfamiliar specialties and are in the process of rapidly expanding their skill set so they can work safely and effectively in their new teams. As junior doctors are redeployed, consultants are taking on "first on call" responsibilities for what could be an indefinite period.

My GP colleagues have been working around the clock—redesigning clinical care pathways, reading and writing umpteen guidelines, and doing what they can to keep people out of hospital, as well as supporting their communities' most vulnerable people. We couldn't have done this without the help of allied health professionals, especially pharmacists, paramedics, link workers, and support staff.

Perhaps most notably, tens of thousands of retired nurses and doctors are joining us, voluntarily stepping out of retirement to help us in this fight. It must have been all too tempting to watch this situation unfold from the comfort of their own homes, but clearly a sense of vocation is overtaking us all.

This is all happening despite much uncertainty around personal protective equipment and the frightening international statistics showing that a disproportionate number of health professionals have died from covid-19. It's heart breaking to hear that some have even written letters to loved ones, in case they don't make it to the other side of this.

I'm humbled to be a tiny cog in this truly outstanding NHS response. We have so much to be proud of. I hope that this chapter in our careers (however awful it may be) firmly draws a line under any accusations of lacking professionalism or any feelings of self-doubt—and that it restores our self-belief, as it's never been clearer that our healthcare workforce will rise to the challenge ahead. In my mind, there can be no greater demonstration of professionalism.

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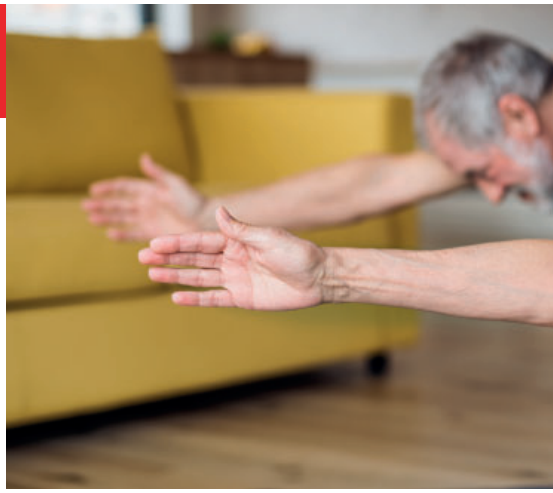
I'm humbled to be a tiny cog in this truly outstanding NHS response



PERSONAL VIEW Julie K Silver

Prehabilitation could save lives in a pandemic

Let's use best practice interventions to improve patients' health to help them fight future infection

Prehabilitation involves interventions aimed at improving patients' health before an anticipated upcoming physiologic stressor so that they are better able to withstand that stress. Prehabilitation emerged as a way to prepare soldiers for battle in the second world war. A study published in *The BMJ* in 1946, entitled "Prehabilitation, rehabilitation, and revocation in the army", described an experiment in which "good food, lodging, hygiene, and recreation combined with controlled physical training and education" for a period of around two months was found to improve the health ratings of 85% of the 12 000 men who participated. The report stated that the participants' outlook on life also improved, and that these physical and psychological changes were "astonishingly easy" to accomplish. Modern day military training continues to use similar interventions.

Although the covid-19 pandemic is not a literal war, many people will have to "fight" a future infection, and what science has taught us since that study was published could be vital to helping affected patients to survive.

Crucial to understanding why prehabilitation may be valuable during a pandemic is to recognise that strategies that might help slow the spread of disease and perhaps reduce its overall incidence—such as social distancing and staying at home—could have the unintentional effect of decreasing physical activity and contributing to cardiopulmonary deconditioning. In particular, the elderly, who are most vulnerable to pulmonary complications from coronavirus, may show a decrease in their baseline cardiac and pulmonary fitness that could increase morbidity and mortality.

Window of opportunity

Prehabilitation has not yet been evaluated in the setting of an infectious pandemic disease. There is currently a window of opportunity that exists, however, whereby physicians can recommend a best practice approach (based on the evidence from other diagnostic conditions) and advise patients and the public about how to maintain and optimise their baseline fitness and nutritional health in the midst of the pandemic. Notably, these

An important goal is to encourage people to maintain at least their baseline activity level

recommendations can be followed while also adhering to social distancing and staying at home; they are not mutually exclusive.

In presurgical protocols, prehabilitation involves a combination of exercise, nutrition, smoking cessation, and stress reduction. Regarding exercise, there is a large body of research showing that muscle wasting and cardiopulmonary deconditioning occur rapidly during reduction in physical activity (such as bed rest). Thus, an important goal is to encourage people to maintain at least their baseline activity level.

Small changes in cardiopulmonary fitness may have a large impact on patients who are frail, including elderly patients with multiple comorbidities. As such, prehabilitation may have the greatest positive effect on those who are most vulnerable. All healthcare professionals should follow established exercise guidelines when giving advice about increasing activity levels. In older people or

BMJ OPINION Daniel Baker

Assumptions should never be made about quality of life

I am 45 years old and have Duchenne muscular dystrophy (DMD). When I saw the recent NICE guidance on critical care for patients with confirmed covid-19 I was concerned. On further reading that concern became fear. If I were admitted to hospital with covid-19, would I be left to die? Would my current medical equipment just be turned off? Am I of that little value to society? These were a few of my worries.

The critical care algorithm, released on 20 March, stated that if your frailty index was 5 or above then doctors should not provide critical care, patients should be put straight on the end of life pathway. A frailty index of 5 is actually pretty low and includes anyone needing help with outside activities. This could be applied to people with learning disabilities or many conditions people would consider minor.

Guidance that suggests one life is worth less than others isn't the answer

Those of us with DMD would probably be considered 7, or even higher on the frailty index. DMD still has a life expectancy of below 30. Are patients above, or even near, this age considered terminal? Doctors and nurses are currently under a great deal of stress, they have little time to do full assessments and have long chats with patients. Looking at the diagnosis "Duchenne muscular dystrophy, requires 24 hour ventilation" could easily mean a patient would be considered for the end of life pathway, especially as the NICE guidelines appear to suggest you do so.

Many adults with DMD have a good quality of life, some of us have jobs, most contribute to charities or society in some way, we have hobbies, friends, and socialise. We are not

those who are frail, a cautious approach is warranted and exercise recommendations should be carefully tailored to ensure safety and efficacy.

While the benefits of exercise and nutrition are readily appreciated and incorporated in generic prehabilitation protocols before surgery, their application during infectious pandemic disease are also relevant. Once someone becomes symptomatic or is diagnosed with coronavirus, however, then prehabilitation may no longer be appropriate. Since most people who develop pulmonary complications from coronavirus will survive, it is also worth considering who will benefit from conventional rehabilitation post-infection.

For people who remain at risk of infection, now is a good time to consider prehabilitation. Knowledge is power, and there is no better time than a pandemic to empower our patients and the public with information that could decrease morbidity and mortality.

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confined to bed or our homes, portable ventilators allow us to get out to the shops, travel, and do the things that other people do.

I understand that these are difficult times and that health professionals will need to make tough decisions, but giving guidance that suggests that one life is worth less than others isn't the answer. That attitude spreads fear and distrust, many could end up dying at home because they were too scared to call 999.

The NICE critical care algorithm was updated on 27 March, but some damage has been done. I would urge doctors also to consider this: those with long term medical conditions are used to adapting—should our lives be limited more by a treatment we are quite likely still to be able to find ways to continue being productive. Surely giving us all that decision is the most ethical thing to do.

Daniel Baker, trustee, DMD Pathfinders

ACUTE PERSPECTIVE David Oliver

Silencing NHS staff is sheer stupidity

Amid a global pandemic, which is putting our health services and frontline staff under immense strain and personal risk, is it right to suppress their free speech?

On 31 March the media reported on a dossier from the Doctors' Association UK detailing numerous cases of medical and nursing staff being warned, disciplined, threatened, and gagged for speaking out on social or mainstream media. Their concerns included a lack of personal protective equipment and covid-19 testing—putting them, their families, and patients at risk.

There's a long history of NHS executives and managers being leant on to prevent them speaking out publicly on other issues, such as serious overcrowding and bed pressures in winter. Speaking to the *Guardian* about the report, an NHS England spokesperson emphasised the importance of consistent, clear, centralised communication during a major incident but said that staff members remained free to speak out in a personal capacity.

So, what are the rights and wrongs here? Clinical staff should generally adhere to the social media guidance set out by organisations such as the GMC or the BMA. Compromising patient confidentiality, abusive comments towards colleagues, incitement of hatred or bullying, or inappropriate online interactions with patients are all clearly liable to sanction, with good reason.

NHS contracts often contain clauses about communications that may compromise or threaten the reputation of the employing organisation. Here, however, we're talking about staff putting their safety on the line every day, while worrying about their own and their families' health. Many have signed up for a much heavier shift pattern or radical changes to their job—often involving work in unfamiliar disciplines or situations, enhancing their fear and vulnerability.

They're also coping with staffing gaps, as the Royal College of Physicians highlighted recently when it found that around one in four doctors was off sick or in self-isolation. Clinical staff may experience moral distress from the change in care standards or visiting arrangements or from the number of sick and dying people around them.

Added to that mix is a lack of trust in the ability of central agencies to deliver PPE and testing kits, and a huge mismatch between reality and the official lines being set out. Clearly, staff will speak out. Of course, we should always get our facts straight, and understand local and national guidance. We want consistent, evidence based messaging, and we shouldn't mis-represent plans or needlessly scare the public.

But we should surely have learnt by now from serial scandals of silenced, threatened, and ruined whistleblowers. And we should be mindful of the statutory duty set out by regulators: openness, transparency, and candour. Threatening, disciplining, demoralising, or suspending the very staff we need most is a spectacular own goal and reputationally disastrous. It must stop.

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We should have learnt from serial scandals of silenced, threatened, and ruined whistleblowers

PRIMARY COLOUR Helen Salisbury

Planning for the peak

This week we've been climbing a very steep learning curve about coronavirus infection. With so many unknowns I feel up in the air, as though my toes are barely touching the safe ground of my medical training. I'm experienced, fairly confident, and—until this week—not in the habit of taking home worries about my patients. Now, the more I read, the less certain I feel about some of my advice. When "outdated" refers to guidance based on China's experience and published a month ago, being up to date takes on a whole new meaning.

Although a few patients call us for advice at the first sign of symptoms, many try hard to manage at home. Some ring us a week or more into their illness when they're over the worst, and I try to be reassuring about prognosis. "Safety netting" has never been more important, particularly the instruction to call for help if they feel more unwell or breathless. Then, having read about late deteriorations or about low oxygen levels manifesting as confusion with no sensation of breathlessness, I worry anew.

We've set up a system to proactively contact all patients we're concerned about, at 24 or 48 hour intervals. I'm trying to source more oxygen saturation probes so that we can lend them out for home monitoring. Questions remain about decontamination (although it seems that readings are accurate through a latex glove), but I hope that we'll have solved them by the time you read this.

Changes are happening quickly, all over the NHS. One of the most heartening is the melting of ego and the overturning of hospital hierarchies. Surgeons, relieved of their elective lists, volunteer for nursing shifts in intensive care, and consultants slide back down the career ladder to become juniors in unfamiliar acute specialties. When this is all over, will we have learnt a kinder and more flexible way of working together?

In general practice, some of us are experiencing impostor syndrome: the real doctors are at the front line in the hospital, or they're at "hot hubs" and palliative care visiting services in the community. Reading gruelling accounts of 12 hour shifts in intensive care makes me grateful for the relative safety of my surgery.

This may all change, but for now we're continuing to provide ordinary care in extraordinary times. People still need treatment for asthma, diabetes, depression, and hypertension. They still need diagnosis and speedy referral to exclude cancer. More than ever, patients need reassurance and continuity from their GP surgery and to hear us say, "We're still here, we will still care for you, and we'll make sure your medicines reach you. We've got this—just stay home."

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When "outdated" refers to guidance published a month ago, being up to date takes on a whole new meaning

LATEST PODCAST

Organisational kindness during the pandemic

With healthcare services facing extreme pressures, what can organisations do to protect their staff's wellbeing? In this podcast, Michael West, professor of organisational psychology at Lancaster University, joined us to talk about creating a culture of compassion in health teams and how it's up to leaders to spearhead this.

"Compassionate leadership is more important now than ever. That means leaders paying attention to all staff, listening to them, hearing their voices, being present with them; understanding the challenges they face (truly understanding rather than seeking to impose) and empathising with them; feeling their fears, stresses, uncertainties, anxieties, and exhaustion. That should give leaders the motivation to always ask the question, "how can we help you?" And that's the most important task of leadership now as we go forward in this crisis situation. Compassion is critical and compassionate leadership is the means by which I think our leaders can respond most effectively."

Talk Evidence: covid-19 update

Hosts Helen Macdonald, Carl Heneghan, and Duncan Jarvies discuss the many covid-19 uncertainties, from the symptoms, to the fatality rate and treatment options. Their guest John Ioannidis, a professor in disease prevention at Stanford University, talks about why the more data we have, the better.

"Practically, when you have an outbreak you see the worst cases, those that have the severe symptoms, the worst outcomes. Usually, there is far more that is going on in terms of infectious load in the community. And the question is, how much more is the part that you're missing? So far, testing has been extremely limited almost all over the world."

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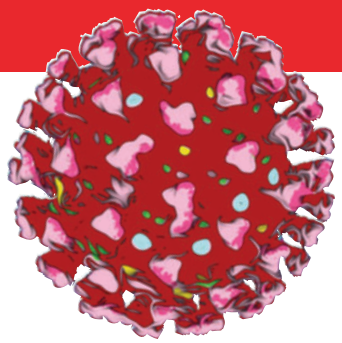
Edited by Kelly Brendel, deputy digital content editor, *The BMJ*

Covid-19 on bmj.com



The BMJ has published a wealth of material on covid-19. Here we highlight some of the best of the content to be discovered online at bmj.com/coronavirus

An intensive care doctor's message from Wuhan

Intensive care doctor Peng Ji shares her initial experiences of dealing with covid-19 in Wuhan in a BMJ Opinion piece. She volunteered in early February to join the efforts to manage the outbreak, and describes her experiences in the first few days after her arrival in the city, as well as her optimism.

PPE guidance is only any good if the kit now follows

Derek Alderson, president of the Royal College of Surgeons of England, says in a BMJ Opinion piece that it is critical that NHS staff are protected through this crisis, but that guidance in itself doesn't protect anyone. He says that staff need the resources to implement Public Health England's updated guidance on personal protective equipment.

Adapting palliative care in Italy

Raffaella Bertè and colleagues recount in a BMJ Opinion piece their experience of managing the covid-19 outbreak in a small town in Italy. They describe how the role of palliative care had to be adapted to manage this "ultra-emergency."

Additional funding for public services

The first budget from Rishi Sunak, the chancellor of the exchequer, promised an extra £5bn for public services to help deal with covid-19. Richard Murray, chief executive of the King's Fund, argues in an editorial that, as we enter the most difficult weeks of the epidemic, there is a strong case for spending judiciously on capturing the learning and experience currently being gained at such cost.

How to avoid touching mouth, nose, and eyes

Robert West, professor of health psychology at University College London, and colleagues discuss the challenges around trying to avoid touching the mouth, nose, and eyes—the area known as the t zone. "To promote effective behavioural control requires a sound understanding of the capability, opportunity, and motivational factors involved and not just an appeal to common sense understanding," they say.

Helping people with poor mental health

Lorna Collins, a peer support worker with Oxford Health NHS Foundation Trust, artist, and writer, discusses in a BMJ Opinion piece how covid-19 is having drastic effects on our mental health. "Here I am, trapped in my home, surrounded by things I would rather avoid: hallucinations, boredom, stillness, uncertainty, my body," she writes. "It's difficult when the things that I usually do to keep myself safe and happy are so abrupted."

Keeping calm in self-isolation

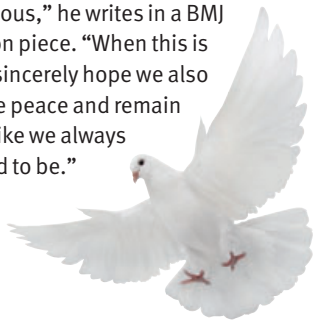
On top of the stress of work, there are now additional pressures to deal with at home, especially if you are self-isolating. In this Careers article, Adam Dobson, a head of early years foundation stage education; Jon Bailey, an autonomous underwater vehicle operations engineer; and Scarlett McNally, a consultant orthopaedic surgeon and deputy director for the centre for perioperative care, discuss how best to manage these pressures.

Drugs and the renin-angiotensin system in covid-19

Jeffrey K Aronson, a clinical pharmacologist, and Robin E Ferner, honorary professor of clinical pharmacology, argue in an editorial that, as clinical effects in covid-19 are unpredictable, treatment decisions must be tailored and pragmatic. They present some recommendations intended to help doctors advise patients with covid-19 on appropriate treatment.

Winning the peace

Peter Brindley, professor of critical care medicine, medical ethics, and anesthesiology at University of Alberta, Canada, believes that, although healthcare workers are scared, they are, in some ways, also lucky. "We have the best chance to relearn that human contact is lovely, that caring for others matters, and that finding humour in the everyday is glorious," he writes in a BMJ Opinion piece. "When this is over I sincerely hope we also win the peace and remain more like we always wanted to be."



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All content from across the *BMJ*'s journals and learning resources that relates to covid-19 is freely available and collected on our covid-19 page at bmj.com/coronavirus

EDITORIAL

How a virus is turning the world upside down

We may emerge from this crisis with a much healthier respect for our environment and common humanity

This pandemic, once it has passed, might force us to turn our united and undivided attention as a global community to jointly address global health, climate change, and the widespread egregious disparities that leave our existence at risk

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Zulfiqar A Bhutta, co-director, Centre for Global Child Health, Hospital for Sick Children, Toronto

Malebona Precious Matsoso, director of health regulatory science platform, University of Witwatersrand, Johannesburg

Chikwe Ihekweazu, director general, Nigeria Centre for Disease Control, Abuja

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

The covid-19 pandemic is the biggest threat in living memory to health and wellbeing, social welfare, and the global economy. In a world shaped by neoliberalism the economy has always come first, but many leaders of rich countries are now explicitly prioritising people's health over the economy. On 26 March, G20 leaders held an extraordinary summit on health, focusing on covid-19. In the face of the severe economic impact of necessary public health actions, financial rules that were considered sacrosanct are being bent with startling speed and force.

Germany's chancellor, Angela Merkel, promised, "We will do what is necessary." Germany has enough financial reserves and emergency instruments to release funds and maintain economic life.[1] France is engaged in an economic war, according to its finance minister: "This war will be long, it will be violent, and we must mobilise all our national, European, and G7 forces."[2] President Cyril Ramaphosa of South Africa believes that, "What we are witnessing is social solidarity in action, a defining feature of our nationhood."[3]

Health before wealth

The global economy is braced for at least $2.7tn (£2tn) in lost output, equivalent to the annual gross domestic product of the UK.[4] Projections indicate that many economies will be crippled and unable to recover quickly, especially in the global south.[5] The Organisation for Economic Cooperation and Development, created to implement the Marshall plan after the second world war, is calling for a global new deal.[6] If economies and social order collapse in South Asia, Africa, or Latin America, no border, wall, or boundary will be enough to contain the consequences. At its emergency summit, the G20 committed "to do whatever it takes to overcome the pandemic," including injecting over $5tn into the global economy.[7]

In contrast to the financial crisis of 2008, when the focus was on saving banks and capitalism, political declarations and economic programmes now also seek to protect the most vulnerable people, nationally and globally. Hundreds of billions of dollars are available in the global north to finance rescue measures such as tax cuts, extended unemployment benefits, mortgage holidays, and liquidity for small and medium sized businesses.

Even countries that were initially willing to allow some older people to die, such as the UK and US, are bowing to pressure to follow a similar playbook.[8] The US congress has agreed to a bipartisan $2.2tn covid-19 rescue bill, and despite substantial corporate handouts

there is tacit agreement across the political divide to include direct payments to the most disadvantaged citizens.[9]

The World Bank announced up to $12bn of immediate support for country responses to covid-19.[10] The International Monetary Fund belatedly said it might relax structural adjustment measures to allow countries to invest in prevention and treatment of covid-19.[11] The EU is fighting over a common eurozone debt instrument called "corona bonds" to bolster economies.[12] More urgent and decisive initiative is required from the World Bank and IMF, such as writing off debt; this may follow the G20 statement, which calls for an action plan to safeguard the global economy in response to covid-19.

For ordinary citizens, coming through experiences of austerity and seeing national infrastructure and public services starved of investment, the sums of money that are suddenly available are bewildering. Politicians who came to power with plans to weaken government, dismantle the nanny state, and privatise government functions are now discussing how to nationalise major strategic sectors.[13]

The strong state is back, but there is no way to predict which political agenda, left or right, or which type of leader this development will support in the end.

Viruses such as SARS-CoV-2 do not recognise nationalities, borders, or political leanings, but they do lend themselves to being politicised

Guided by Asia and Africa

The G20 made it clear the repercussions of this pandemic can only be resolved through global cooperation. But many countries that once claimed leadership in global health have offered little. Indeed, in their hubris, they have taken too long to learn from Asia. Now, every country is asked: why are you not applying successful measures from South Korea, China, Hong Kong, Taiwan, or Singapore? The public health lockdown, initially heavily criticised as typical of China's authoritarianism, has in one form or another become an international norm.

Containment or suppression is a de facto strategy, whether by choice or necessity, based on the success of countries that rapidly "controlled" the outbreak. However, the degree of political repression in some national strategies is still blurred. Hungary, for example, has passed legislation that will allow the government to indefinitely extend its state of emergency.[14] In several countries, armies ensure compliance with lockdowns. Draconian methods, partly based on digital surveillance, that can work for the public good in terms of health create major challenges for Western democracies that profess to uphold individual freedoms.[15] They will also completely change the trading systems in Africa and circulation of goods in the informal business sector.[16]

Physical distancing and lockdowns mean very different things in societies with and without support systems and social safety nets. Strategies to strengthen these may flounder if communities are not engaged. A failure to win over religious and community leaders in South Asia and Africa, for example, will fuel resistance to public health measures. African countries with recent experience of Ebola will probably better understand the value of community involvement than the global north.

Learning from others and from Asia and Africa is becoming essential. Citizens and experts outside the corridors of power are holding governments to account by comparing their response to that of other countries, to the relative success of South Korea or the relative failure of Italy. Everyone is a lay epidemiologist, poring over graphs and analyses produced by experts, institutions, and charlatans. Media coverage is extensive, and social media is buzzing with debate, facts, and fiction. Health literacy is critical as an "infodemic" is competing with the real pandemic. Leaders of public health institutions, virologists, and modellers have rarely been so visible and held so much responsibility.

Paradoxically, at the crest of an isolationist wave, international solidarity and strengthening multilateral institutions have never seemed more vital. Building on its successful handling of the 2018-19 Ebola outbreak, the World Health Organization has improved its performance. It is highly visible, with its director general leading calls for solidarity between people and nations, launching global initiatives, and fundraising.[17]

But WHO's mandate is still too weak and its funding gravely inadequate. It faces problems in some of its regional and country offices, which find it difficult to challenge governments on lack of transparency or inaction and struggle to influence policy. Disappointingly, the UN Security Council has yet to recognise the threat covid-19 poses to international peace and security because of a geopolitical fight over what to call the virus.[18]

International solidarity

In the face of these difficulties, will international solidarity win out? It is, after all, a loathed concept for many countries that have refused more funding for WHO, or those that persist with economic and other sanctions. The US perversely imposed additional sanctions on Iran, denying access to diagnostic kits and protective equipment.[19] One outcome of this is the effect on bordering countries: an estimated 80% of cases of covid-19 seeded to Afghanistan and Pakistan originated from people returning from Iran who were not tested or quarantined.[20]

International solidarity is also soft power, a diplomatic code for gaining geopolitical sway and influence. While the US is fully focused inward and its president blames the "Chinese virus," China is positioning itself as a global health benefactor and showering aid to cope with the pandemic. President Xi described China's mass deployment of medical aid to Europe as an effort to establish a "health silk road," stretching the concept of its belt and road initiative.[21]

The last time the world found courage for true solidarity was after a devastating war in 1945. The enemy now is common but invisible. Viruses such as SARS-CoV-2 do not recognise nationalities, borders, or political leanings, but they do lend themselves to being politicised. As both our health and our economies are threatened, is there a lesson in all of this for those who vehemently oppose globalisation and promote nationalism? Can the world accept that global risks require solutions that engage countries and people as equal partners?

In global health it took the SARS crisis for countries to accept the International Health Regulations as a "cosmopolitan moment."[22] Cosmopolitan moments are points in time when the global community comes together to create institutions and mechanisms that it has not otherwise been willing to introduce. This pandemic, once it has passed, might force us to turn our united and undivided attention as a global community to jointly address global health, climate change, and the widespread egregious disparities that leave our existence at risk.

Covid-19 has taught us that health is the basis of wealth, that global health is no longer defined by Western nations and must also be guided by Africa and Asia, and that international solidarity is an essential response and a superior approach to isolationism. We may emerge from this with a healthier respect for the environment and our common humanity. All citizens, governments, businesses, and organisations must heed these lessons. Covid-19 is the virus that is turning the world upside down. It will destroy the world as we know it; in the process we may learn to hold it together.

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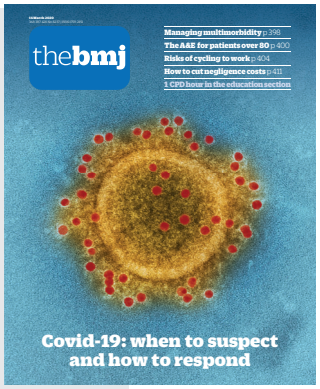
LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

We can and must do better in our approach to covid-19



Accurate and interpretable data are essential in guiding our approach to the covid-19 pandemic. Basic epidemiological principles are currently being flouted. Mostly, as in your article (The Big Picture, 21 March), case numbers are being reported. This number needs to be converted to a proportion, using the population size as the denominator. Otherwise, how can we tell which countries are being affected the most?

When the rate of disease is highly variable by age, as in covid-19, we need to examine age specific mortality and morbidity and case fatality rates. Given the sex differences, these rates also need to be stratified by sex. Age adjustment, by either the direct or indirect method or statistical models, is too crude when the rates are highly variable across age groups, although it is better than the overall or crude rates that we are currently seeing, invariably in the media but also in professional journals.

We are being misled about the potential dangers (or not) by using overall or crude death rates. The Chinese overall mortality proportions, for example, will not apply to countries with older age structures, such as Italy or the UK, where mortality will be higher. The Italian proportions will not apply to much of Africa, where the average age of the population is low. Data should be published in 10 year age groups or, even better, 5 year age groups. The data are likely to be reassuring for parents and young people and the opposite for older people. The results are likely to be much more informative than the widely disseminated and extremely crude estimate of 1-2% mortality or even lower, which is mostly based on China's experience.

We can and must do better.

Raj Bhopal, emeritus professor of public health, Edinburgh

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COVID-19 WORLDWIDE

GPs are the backbone of any country's response

GPs are at the core of the response to covid-19 in European health systems (The Big Picture, 21 March). The coordination of primary care differs across countries; we describe the response in Belgium and the Netherlands.

Initially, central public health authorities developed a national protocol for screening and case finding. In the Netherlands, decentralised public health services were appointed for case finding of patients not needing acute care. Belgium does not have decentralised preventive health services, so healthcare workers implemented the protocol. In both countries, out-of-hours services and GPs were at the centre of local coordination.

Then, both governments scaled up, but the locus of coordination differed. In the Netherlands, most approaches were centralised. In Belgium, in the absence of regional coordination, the pattern seemed more scattered and varied.

The presence of professional GPs, in these and other countries, is the backbone of the health system response.

Josefien van Olmen, tenure track professor; Roy Remmen, professor of general practice; Paul Van Royen, professor of general practice; Hilde Philips, professor of general practice; Veronique Verhoeven, professor of general practice; Sibyl Anthierens, professor, Antwerp

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HEALTH INEQUALITIES

The pandemic and the socioeconomic gradient

Shortage of resources is of grave concern in some countries affected by covid-19, underscoring global health inequalities (Editor's Choice, 29 February).

Many countries are using a household based prevention model, which can be fragile and limited, especially for people who are poor, isolated, and undereducated. The wellbeing of family members can be compromised indirectly. In rural Hubei, a 17 year old boy with cerebral palsy, whose single father was placed in quarantine for possible covid-19, was found dead after six days of being left alone.

The socioeconomic gradient can also be seen in higher socioeconomic groups. A specialist in Hong Kong had to pay to rent a hotel room for self-quarantine to protect his family members; healthcare staff of lower ranking might not be able to afford that.

We need a whole population health prevention strategy that promotes good public hygiene practices. Disease specific health literacy is essential.

Roger Yat-Nork Chung, assistant professor; Dong Dong, research assistant professor; Minnie Ming Li, lecturer, Hong Kong

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HEALTHCARE IN PRISONS

Prisons critical in covid-19 response

Improving prison health services (Health and Justice, 29 February) is critical for dealing with epidemics. On 20 February, more than 500 new covid-19 cases in five prisons ended 16 days of continuous decline in new cases in China (excluding Hubei province).

Prisoners are at much higher risk of infectious diseases because of overcrowding, poor health services, high risk behaviours, security versus public health concerns, and lack of empathy for prisoners.

The UN says that prisoners "shall have access to the health services available in the country without discrimination on the grounds of their legal situation." But burgeoning prison populations and epidemics mean that healthcare services are increasingly strained.

Health education for inmates and prison staff must be intensified, and better treatment and prevention measures require increased funding. More non-custodial sentences would decongest prisons, reducing the potential for outbreaks. Links between prison and national health services should be strengthened.

Hong Yang, lecturer, Reading; Julian R Thompson, professor, London

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TESTING AND TRACING

End hostile environment now

For contact tracing to be viable, all sections of the community must be willing to be contacted by the NHS or public health staff (Editorial, 4 April). The community includes "overseas visitors" on the receiving end of the government's "hostile environment" policy, who might fear that any contact will incur NHS charges or lead to their being reported to the Home Office.

The Irish government has declared that all people—documented or undocumented—can now access healthcare and social services without fear. Undocumented immigrants and asylum seekers in Portugal have been granted the same rights as residents, including access to medical care, in the current state of emergency. In South Korea, undocumented immigrants can be tested without risk of deportation.

To tackle this epidemic and protect everyone's health, all barriers to accessing NHS treatment—including charges and reporting of debt to the Home Office—should be suspended immediately.

Greg Dropkin, retired NHS administration worker, Liverpool

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CLINICAL TRIALS IN COVID-19

Ethical review of coronavirus clinical trials

We urgently need more effective drugs and diagnostic strategies for covid-19 (This Week, 21 March). Despite the urgency, we shouldn't conduct clinical trials without supervision. The safety and quality of clinical trials must be guaranteed.

On 24 March, the Chinese Clinical Trial Register had 471 registered items related to covid-19 and ClinicalTrials.gov had 143. If ethics committees cannot review this number of clinical trials to a high standard, many high risk and low benefit drugs will be used on patients and meaningful research might miss out on resources. At one hospital in China covid-19 studies were reviewed by emergency video conference to ensure timely implementation of important research.

Ethics committees have a vital role in reviewing covid-19 studies, especially intervention studies that might cause physical injury to patients. Ethics committees need not only to improve the review efficiency, but also to make sure the standard of ethical review is not relaxed.

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COVID-19: SOCIAL DISTANCING

Protecting mental health

The government has enforced "social distancing" to curb transmission of covid-19, protect the vulnerable, and prevent saturation of the NHS (This Week, 21 March).

Depression and anxiety are likely to rise as confined people are detached from their loved ones, deprived of personal liberties, and devoid of purpose owing to altered routine and livelihood. Those with pre-existing mental illness might suffer from limiting the interpersonal interactions that are central to their management and reduced access to "non-essential" psychiatric services.

Mitigating these effects requires a concerted effort from the public, policy makers, and healthcare professionals. For the public, daily routines incorporating a healthy lifestyle, hobbies, virtual social interactions, and mindfulness are recommended. Government, media, and healthcare professionals should communicate clear and accurate public health guidance. Care workers could remotely monitor people at risk to provide additional support. The challenges of society returning to normalcy after social distancing remain to be explored.

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COVID-19 PANDEMIC

Opportunity for social transformation

Covid-19 is the first major pandemic of our generation (Practice Pointer, 14 March), and we must seek opportunities to reflect and react as a global society.

Covid-19 is challenging our position in the world because we realise our connectedness to those around us regardless of geographic distance, yet we are deeply aware of our individuality because the illness is a threat to our physical and mental wellbeing. Our concepts, language, and understandings of ourself and the world are merely semantics. We become our bodies through our experiences of illness.

By merging public health with mental health, the ways that covid-19 are changing the world could be for better rather than worse. As mental healthcare professionals, we must ensure that the ways we prescribe the meaning of covid-19 to our own selves and the world enhances our mental health rather than limits what we can transform individually and globally.

Ayesha Ahmad, lecturer in global health; Christoph Mueller, academic clinical lecturer in old age psychiatry; Konstantinos Tsamakis, consultant psychiatrist, London

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PUBLIC COMMUNICATIONS

Covid-19 and the rise of racism

Covid-19 has dramatically changed how we live. The media and the government have rightly been concerned with the global health and economic implications (Medicine and the Media, 14 March), but they have neglected to acknowledge the spread of prejudice and xenophobia.

Fear leads to the desire to understand and control situations. We have seen a surge of discrimination, prescribing an "otherness" to disease to feel protected and ascribing blame to justify prejudicial rhetoric.

We cannot afford to isolate people even more through stigma and xenophobia; we each have a responsibility to support each other and advocate for a better society. The government and media must condemn these actions. They have a duty to educate the public, protect the vulnerable, and hold people accountable for prejudice and discrimination. By staying silent we let xenophobic narratives and racist attacks damage our society, the repercussions of which will likely persist beyond the pandemic.

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