Just as I hoped that public understanding of the covid crisis was improving, and I felt my faith in humanity being restored, I received an email asking how to arrange preferential medical treatment for celebrities.

I wrote several draft replies, some only a few words long. A former colleague suggested phrases such as “I’m a celebrity, get me remdesivir” or “Celebrity come proning.” As I’ve said before, I strongly believe that there are few bad people in the world—just many bad ideas and incentives. I’m sure that many companies supporting high worth individuals have asked similar questions to that email request, and the company that contacted me on this occasion has since apologised and clarified any “misunderstanding.” But it did lead me to wonder why it is that some people believe they deserve preferential treatment.

On an afternoon dog walk that day with my 8 year old daughter, I asked her what she thought of people with more money having better medical treatment. “That’s not fair,” she said. “They should have worse treatments, as they are fit and healthy. The poor people who are dying should get the best treatment.”

A proud dad moment. When we’re faced with a postcode lottery for health inequalities, and death rates from covid almost doubling in the most deprived communities, perhaps we should have an inverse postcode lottery for access to healthcare. The best and brightest centres of excellence should be built in Merthyr and Blackpool, not Cardiff and Oxford.

Yet my warm glow of altruism didn’t last long. The World Health Organization reports that, of the countries rolling out vaccines so far, the vast majority are high income with a few middle income but no low income states have yet started. If we view global health through the lens of poverty, we’re all high net worth celebrities.

The cleaners in our NHS are richer than 95% of the world’s population, the consultants richer than 99%. So, while I scoff at an outrageous email promoting special access for the rich, I really am blinded by my own privilege, living in a nation that’s one of the safest, most secure, richest, and privileged in the world.

Just as we should collectively condemn the concept of “I’m a celebrity, get me remdesivir,” we should equally rally against the global inequality for access to vaccination. A pandemic isn’t over until it’s over everywhere, for rich and poor alike.

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I thank Jill Gildersleeve for the phrase “I’m a celebrity, get me remdesivir”!

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We should rally against the global inequality for access to vaccination
PERSONAL VIEW Chris Ham

UK’s record on covid is a failure of policy learning

Governance weakness led to avoidable mistakes and 100000 deaths

The UK’s response to covid-19 compares poorly with that of other countries. The reasons are to be found in an inability to learn from what was known about the virus. Mistakes could have been avoided if the government had listened to leaders outside Westminster and Whitehall, drawn on a wider range of expertise, and been curious about experience in other countries.

Not everything went wrong. Notable successes included research led by University College London into treatments and work to develop a vaccine at Oxford University. The support for businesses through the furlough scheme and business rates relief can also be counted as timely interventions. As do increases in universal credit payments.

Set against these successes is a litany of errors that could have been avoided. Delays in introducing a lockdown in March are thought to have been responsible for around 20000 deaths and were compounded by further delays in imposing restrictions in September and again in December when evidence of the benefits of early action was clear. Reluctance to impose border controls and quarantining arrangements has been equally consequential.

Educational policy was found wanting in the failure to provide free school meals during holidays, serial inconsistencies in decisions on opening and closing schools, and botched arrangements for exams. The intervention of Marcus Rashford resulted in a U turn on school meals in the summer and again in November in one of the clearest examples of an unwillingness to learn from experience.

Test and trace
Community testing and contact tracing were suspended early in March as the number of cases exceeded available capacity. Substantial sums were then invested in expanding capacity, mainly through the private sector, but initially the government ignored local expertise despite public health directors being well placed to undertake contact tracing. It was also slow to provide information and resources they needed to control outbreaks.

Support for people asked to self-isolate fell well short of what was needed. The main problem was the failure to provide adequate financial support for people on low incomes to enable them to take time off work when they tested positive. Reports indicate that the government is considering a range of measures to tackle this challenge—a year since the first case of covid-19 was detected in the UK and with deaths exceeding 100000.

Locking down sooner when infection rates were rising could have saved lives and reduced the economic impact of the pandemic. A well designed test, trace, and isolate programme could have slowed the spread of the virus and mitigated its long term impact. A well informed educational policy could have reduced harm to children. Policies targeted at groups in the population most at risk might have been effective in moderating the stark inequalities in outcomes that have occurred.

Overcentralised management was undoubtedly a factor in the failure to learn more effectively. Boris Johnson and a small number of Cabinet members were visible in their leadership and appeared reluctant to draw on the expertise of local and devolved government leaders. Opportunities for learning were lost, mistakes were made.

These errors were compounded by a lack of diversity among those advising the government. While great store was placed on the Scientific Advisory Group for

BMJ OPINION Chloe Beale

My mental illness does not make me a better doctor

When I became unwell with a mental illness, I was about five years into my job as a consultant psychiatrist. As soon as I decided to take leave from work and seek treatment, I made a point of speaking openly about my illness. Several people called my actions “courageous”; various others suggested I would be a better psychiatrist for this insight I’ve gained into my patients’ experiences. I vehemently disagree with both views.

While those doctors who led the way in speaking openly about their mental health have rightly been applauded for their honesty, we must be realistic about the limits of clinicians’ lived experience—both as a benefit to practice and as a tool for demolishing stigma.

My experience is only mine. Others will

My illness is what it is: neither tragedy nor inspirational success story

have a different view, of course, but I don’t consider my history of mental illness and NHS treatment to mean I have a greater ability to empathise with all my patients. I do not have any firsthand knowledge of many of the social factors that precipitate and perpetuate illness in so many people; I experience illness from a baseline of privilege.

I never feared stigma or job loss secondary to illness because I have very good friends and colleagues around me. My job gave me the financial stability to take long sick leave and to negotiate a very careful return to work. I have a solid support network. I have so much that so many do not.
Emergencies, the advice of social scientists was less prominent. Equally important was the sidelining of public health and social care leaders. The consequences were plain to see in the flawed design of test, trace, and isolate, and in the neglect of social care, resulting in more than 20,000 deaths in care homes.

Another factor was lack of curiosity about the experience of other countries and a willingness to learn. This applies not only to countries in South East Asia, but those closer to home such as Greece and Norway whose responses have been far more effective. A misplaced belief in English exceptionalism, exemplified by the troubled contact tracing app, contributed to this wilful blindness.

These failures reflect a preference for heroic leadership by the few rather than the collective and distributed leadership by the many. It is not too late to improve but only if ministers are willing to act on the best available evidence of what works drawn from different sources and to share leadership with others.

Mental illness is no leveller. It is vastly heterogeneous and I cannot possibly know what it’s like to experience any condition other than my own.

I can’t give the expected, tidy narrative of surviving stronger for having my illness. It is what it is: neither tragedy nor inspirational success story, not a window into my patients’ minds and certainly not the remedy for deeply ingrained stigma.

Having a mental illness does not make me unusual among doctors and I only wish that candour was more commonplace; perhaps then we would be better as a profession at recognition and even prevention.

Chloe Beale, consultant liaison psychiatrist and honorary senior clinical lecturer as well as suicide prevention lead for East London NHS Foundation Trust.

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Politicians have created a landscape which, until 2020, had done little to tackle inequalities

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Social inequity isn’t just for pandemics

Health politics are dominated by the power of the immediate. Future health gains through long term policies are easier to ignore than what happens now. The truism that we need to rebalance priorities away from reacting to sickness towards preventing ill health, tackling inequalities, maximising wellbeing has become an orthodoxy. But the rhetoric is rarely matched by policy levers and investment big enough for the job.

Rapid access to urgent and emergency care, responsive primary care services for patients, and shorter waits for planned investigations and procedures always seem to dominate headlines. Political efforts to improve these are more likely to deliver measurable improvements within the lifespan of a parliament or politician. Bad publicity and scandals are more likely to follow when they’re not delivered.

Pandemic lockdowns and behavioural restrictions bucked the trend by getting politicians, lobbyists, and the media to discuss the impact of these policies on people’s mental and physical health. We saw a surge of interest in poverty, domestic violence, alcohol dependence, housing, early years services, and their impact on health. Suddenly covid put a spotlight on social care and unpaid family carers.

The evidence for socioeconomic and health inequalities gained new momentum as data emerged on the profoundly unequal harms and risks from covid-19.

This attention is, we might think, overdue and welcome. But let’s face it: some of the lobbyists, think tanks, and politiciansflagging the risks to jobs and the wider determinants of health from lockdown had happily colluded in creating a landscape which, until 2020, had done little to tackle prevention, wider health determinants, or inequalities and had often worsened them.

Since 2010 we’ve had austerity, flat funding, real terms NHS pay cuts, and sustained cuts to local government, social care services, and public health. We’ve had underinvestment and real terms funding cuts to schools, as well as cuts to alcohol and drug services and to legal aid, courts, and probation services—none of which can have helped stem the rise in domestic abuse reported by the Office for National Statistics.

Socioeconomic inequalities have become entrenched. Not enough investment has gone into affordable social housing or rent control. And workforce as well as immigration policy has made it harder to recruit and retain staff.

Successive parliaments have ducked decisions on obesity and alcohol policy that might make a dent in the prevalence of potentially preventable, noncommunicable diseases. Despite rhetoric about giving mental health services “parity of esteem” with physical health problems the two have remained poor relations in terms of access, staffing, and capacity.

Once we’re through with this pandemic will we all still be so interested, outside the professional communities and advocates who always have been? I’m not holding my breath.
Family doctor” might be an old fashioned way of describing a general practitioner, but it has some useful connotations. It indicates a relationship that stretches from postnatal checks and childhood illnesses, through pregnancies and long term conditions, to palliative and end-of-life care. I might consult several members of the same family in the space of a week and sometimes have to listen carefully to multiple versions of the same events. A core skill of being a GP is remembering who told you what and being careful not to betray a confidence by responding: “Yes, I know.”

The family doctor conjures an image of someone known and trusted, with a relationship not just to an individual but to several generations of the same family. These kinds of credentials might be easier to establish in rural areas, and the role can have its downsides: too much closeness can feel claustrophobic, and younger patients might respond by seeking someone new, especially in their teenage years, although in practice many do choose to stick with a familiar face.

Shortages have been part of this pandemic—beginning with a run on hand gel, loo roll, and pasta and reaching a frightening peak with the scrabble of protective equipment. Our current efforts to get them vaccinated.

Thanks to combined efforts to get them vaccinated, oldest family members remain well enough syringes. But an even more important thing needed for the successful handling of a pandemic is trust—and this too has been in short supply.

Poor decisions at a national level have led to the worst death rate in the world, making a general absence of trust understandable. But doctors rate highly (second only to nurses) in the public perception of trustworthiness. In December, we invited our first cohort of patients for vaccination. At that stage, we had no access to the more portable Oxford-AstraZeneca vaccine and no information about when we would be able to use it for home visits. Some of my oldest patients live in multigenerational households, and many were brought to the surgery by younger family members. Six weeks on, with high levels of infection in our city, covid is affecting younger members of these households, but the oldest remain well, almost certainly owing to combined efforts to get them vaccinated.

Most patients will rush to have the vaccine, but a minority will feel anxious and unsure, and this is where we can make a difference. Family doctors across the country are using the relationships of trust they have built up with their patients to save lives one at a time. We do this by looking at our lists of vulnerable patients still not vaccinated and picking up the phone.

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LATEST PODCASTS

Long covid

It’s estimated that about 10% of people who get covid-19 are still having symptoms a month later. How can GPs be ready to help these patients? In a new episode of our Deep Breath In podcast, respiratory consultant Melissa Heightman emphasises the complexity of knowing when to refer patients on:

“It’s incredibly difficult for GPs because this is a disease that we do not understand the mechanisms of. While it’s easy to over-investigate people, I also think it’s wrong to under-investigate them, and finding that balance is something that we need to learn rapidly. What’s key at the moment is that GPs are able to get good quality advice—because I am learning stuff about this every week. I wouldn’t want any patient to be denied a quality assessment just because of a pathway that we guess at being the right answer when we just don’t know.”

Being present at a birth

In the latest episode of Sharp Scratch, Lucy Chappell, a consultant obstetrician, joined the panel to share her reflections on a career helping people during pregnancy and birth. Here she explains how she still feels a sense of wonder during every birth, and why it’s important to retain that:

“It’s incredibly difficult for GPs because this is a disease that we do not understand the mechanisms of. While it’s easy to over-investigate people, I also think it’s wrong to under-investigate them, and finding that balance is something that we need to learn rapidly. What’s key at the moment is that GPs are able to get good quality advice—because I am learning stuff about this every week. I wouldn’t want any patient to be denied a quality assessment just because of a pathway that we guess at being the right answer when we just don’t know.”

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Put to the test: use of rapid testing technologies for covid-19 detection

Alex Crozier and colleagues look at how new processes can be most appropriately used to support different public health strategies and examine the benefits and risks.

Governments have invested enormous resources in scaling up testing capacity in their responses to covid-19. Real-time reverse transcription polymerase chain reaction (PCR) was the first, and still the most widely used, test. However, several days can elapse between requesting a test and getting and acting on a result, leaving a window in which infection may spread. A further problem is that people may transmit infection before recognising symptoms. In addition, some asymptomatic people have a similar viral load to those who do develop symptoms and may also contribute to spread, although the extent of this is unclear.

Given the importance of presymptomatic or paucisymptomatic transmission, measures that shorten the time between testing and results are essential to minimise onward transmission. It is difficult to achieve this with large scale PCR testing.

Rapid antigen lateral flow tests offer an alternative. They provide rapid results but are less able to detect infections. They are being purchased in large quantities by governments, with some seeing a single test as a way to free a person from quarantine, a view not supported by the World Health Organization. However, repeated lateral flow testing may have value in combination with other measures. In Liverpool, for example, authorities are examining test-to-protect, test-to-release (from quarantine), and test-to-enable (safer return to restricted activities) regimens, alongside outbreak response and open access to lateral flow testing. Such real world evaluations are needed to understand how these models work in different populations and settings, how they influence behaviour, and the test’s contribution to overall strategies.

Interpreting test results

Meaningful interpretation of any test requires knowledge of its sensitivity (proportion of infected people who test positive), specificity (proportion of non-infected people who test negative), and pre-test probability that an individual is infected, reflecting population prevalence and the individual’s circumstances.

Although controls within assays minimise errors, technical problems during sample collection, processing, or reporting can give false results. Lateral flow tests produce very few false positive results, and in a low prevalence setting these can be detected by confirmatory PCR testing. False negative results are more concerning. Besides technical errors, they can arise in people tested during the 5-7 day incubation period before the viral antigen shed in the nose and throat is sufficient to be detected, usually 1-2 days before symptom onset. Taking swabs requires skill, and swabs taken by untrained individuals are more likely to give false negative results. False negatives might create a false sense of security, paradoxically increasing transmission risk.

Conversely, PCR testing is overly sensitive, detecting viral shedding long after the infectious period (about 9 days), with people continuing to test positive for a mean of 17 days. Although such positive results are technically correct, these people are not infectious and should not be quarantined. Moreover, any test is just a snapshot of the moment the sample was taken.

A shared understanding of the utility and uncertainties of these tests is key to using them well (see bmj.com for a full analysis). Effective communication of what results mean is paramount.

KEY MESSAGES

- Strategies for use of covid-19 tests vary widely between countries
- Rapid tests provide opportunities for early detection and isolation but must be integrated into wider strategies to control transmission
- Assessment of the benefits and risks of strategies suggests how novel tests can be used in public health to improve resilience and recovery

Novel tests

Several novel techniques, such as loop mediated isothermal amplification, next generation sequencing (LamPORE), point-of-care PCR, and lateral flow tests are in different stages of development, validation, approval, and implementation. Lateral flow tests aim to detect only infectious cases, can be scaled up quickly for decentralised testing, are relatively cheap, do not require laboratories, and provide results rapidly. Lateral flow tests are less sensitive than nucleic acid amplification tests such as PCR, generating more false negative results if used as a test of infection rather than infectiousness, and they are particularly susceptible to sampling quality (table).

The window for using lateral flow tests to detect infectious cases is narrow. They are most suitable when testing is frequent, and the goal is detection of cases with high viral shedding immediately before and after symptom onset (figure).

Although lateral flow tests have a higher risk of false negative results, in theory the rapid increase in viral shedding after the incubation period leaves only a short period when there will be a substantial difference between the point when you get a first
positive result on a highly sensitive test (PCR) compared with a lower sensitivity test (lateral flow). Importantly, modelling suggests more frequent testing with lower sensitivity tests can achieve the same probability of detecting a case as less frequent testing with higher sensitivity tests. Under laboratory conditions, the detection limit of lateral flow tests largely aligns with the quantities of viral shedding and ability to culture virus typically observed at the end of the first week of symptoms, after which most patients cease being infectious.

As detected viral antigen and cell culture infectivity are proxies and not direct indicators of infectiousness, caveats remain, but the point when lateral flow test results change from negative to positive, and vice versa, mostly coincides with the beginning and end of infectiousness of most symptomatic cases, and potentially also in asymptomatic cases. Furthermore, analysis of national PCR and contact tracing data showed that cases with high viral load are the most infectious (infected more of their contacts) and that, under laboratory conditions, the best performing lateral flow tests detect 91% of cases that lead to onward transmission. Thus, despite lower sensitivity, lateral flow tests may be a useful indicator of infectivity and less likely than PCR to detect post-infectious shedders.

Test sensitivity is operator dependent, and self-swabbing in real-world conditions is likely to miss more infections than in controlled conditions. In the Liverpool community testing pilot, samples were obtained by self-swabbing under supervision of soldiers, and lateral flow tests missed 60% of PCR positive cases. However, over half of those with positive PCR results were likely to be post-infectious shedders, consistent with the low and falling prevalence in the city at the time.

**Mass testing**

The effectiveness, feasibility, opportunity costs, and ethics of large-scale asymptomatic testing are fiercely debated. Mass (repeat) testing using PCR in China, Vietnam, and Iceland and lateral flow tests in Slovakia have identified cases that would have gone undetected. However, mass testing poses tremendous logistical challenges, requiring considerable resources and careful planning. In the UK, non-focused mass repeat testing is unlikely to be feasible or cost effective.

**SMART**

Liverpool has developed a focused approach to community testing with lateral flow tests called SMART (systematic meaningful asymptomatic repeated testing). Open access testing of the public is supported by communications and outreach targeting specific groups that are vulnerable to covid-19 or its control measures. SMART comprises a dual strategy of focused reduction in transmission alongside outbreak response and specific test-to-test, test-to-enable, and test-to-release schemes designed to protect key services, reconnect societies, and recover the economy. The benefits and risks of the scheme are monitored through public health, healthcare, and administrative data and continuous qualitative information gathering. Positive lateral flow results are confirmed with PCR and viral genetic sequencing.

Although SMART has strong potential to find asymptomatic or paucisymptomatic cases early and reduce onward transmission, large-scale data is resource intensive and requires effective local engagement. Given the importance of pre-symptomatic and paucisymptomatic transmission, SMART must find more cases in the incubation period to improve on symptomatic testing, while reducing the risks of false negatives. Up to 21 January, 359 606 lateral flow tests had been done on 205 836 Liverpool residents, identifying 4421 people who were likely to be infectious (CIPHER dashboard data, available from authors). These people were then able to self-isolate, breaking chains of transmission.

Although the behavioural responses to large-scale asymptomatic testing in the community are not fully understood, Office for National Statistics data in Liverpool showed most (62%) said a negative result would be unlikely to cause them to change their behaviour. However, some said they were more likely to visit friends (9%) or go to work (7%), emphasising the need to communicate the importance of maintaining covid-safe behaviours.

Although 95% of positive cases in the Liverpool pilot self-isolated and informed relevant contacts immediately, not being able to afford the costs of self-isolation was a substantial barrier, highlighting the need for a holistic public health approach, including effective communication and comprehensive support. Tests alone are not the answer.
The biological, behavioural, ethical, and system implications of complex public health interventions such as SMART must be evaluated, with findings used to develop rigorous standard procedures and protocols that optimise strategies.

Improving outbreak response
It takes 4-5 days for someone infected with SARS-CoV-2 to infect another person so tracing must identify and reach contacts as soon as possible. As many people don’t request a test until 24–48 hours after developing symptoms and PCR can take more than 48 hours to return results (median 38 hours with 14% taking over 72 hours in England29), substantial transmission can occur before contacts are reached and clusters can quickly develop into large outbreaks.

Modelling suggests rapid and frequent testing can help to reduce transmission.19 25 In high risk settings (workplaces, care homes, schools, universities, prisons, and hospitals), repeated and frequent lateral flow tests cut these delays, providing real time results for cases and close exposure contacts, which can identify clusters29 quickly. To mitigate the increased risks of false negatives, people with symptoms could have lateral flow and PCR tests in parallel. Robust communication that a negative lateral flow result does not mean “not infectious” is essential, and symptomatic people must continue to isolate.

Test-to-protect
If implemented carefully, repeated testing in high infection risk settings can protect people who are either clinically vulnerable or vulnerable to infection (and transmission).19 29 Although the high sensitivity of the PCR test favours its use in such settings, it can take days from requesting a swab to getting the result.

The recent policy of bi-weekly testing of vulnerable to infection (and transmission).29 people who are either clinically vulnerable or in high infection risk settings can protect if implemented carefully, repeated testing can compensate for reduced sensitivity. Specific testing strategies may also be focused on protecting groups most susceptible to infection and transmission, such as key workers, enabling continuity of essential services and possibly reducing overall transmission. Again, communication must be clear that a negative result does not necessarily mean a person is non-infectious. Crucially, test-to-protect policies will have limited effect unless workers are supported to self-isolate.20 Weekly point-of-care PCR testing is also being evaluated in some UK care homes.

Test-to-release
Test-to-release models use repeated tests to reduce unnecessary quarantine of non-infectious people, focusing isolation decisions on presumed infectivity rather than on infection. PCR testing has been used as a way to shorten unnecessary quarantine of non-infectious contacts, while daily lateral flow testing is being piloted as a way to end unnecessary quarantine of non-infectious contacts. However, PCR has a median false negative rate of 38% five days after exposure and 20% on day 8 (although some assays showed near 100% detection at day 7).33 Although one study showed PCR testing on day 7 reduced quarantine time and resulted in no post-quarantine transmission,34 an evaluation of test-to-release of household contacts showed that 19% experienced symptoms or received a positive PCR test result after testing negative seven days after the index case developed symptoms,35 suggesting this strategy is not without risk.

Any test-to-release policy must account for the incubation period,32 mitigate the risks of premature return or hazardous behaviours, and be shown to be cost effective. Ultimately, no test can replace comprehensive support, both practical and financial,10 16 as a means of tackling low rates of self-isolation, particularly in disadvantaged communities.

Test-to-enable
Test-to-enable policies seek to lift restrictions on social contact that are causing wider public health and economic harms in a way that minimises risk. Focused regular testing is more logical than single tests for entry, which are unlikely to confer population wide benefits.11 Context is key: disadvantaged areas with greater mounting harms from control measures could get most benefit from locally sensitive responses. Again, however, practicalities and false negative results are concerns, and we must await quality pilot data before any large scale rollout.

Conclusion
Rapid tests provide opportunities to find and isolate cases and contacts early in the infection. However, implementing such tests in local health systems is complex. Continued formative evaluation is needed if such testing is to simultaneously reduce transmission and alleviate harms from control measures. SMART pilots provide evidence of large scale, targeted use of lateral flow tests. Successful approaches to control covid-19 must facilitate earlier and better targeted isolation of the most infectious people and their close contacts while releasing non-infectious contacts sooner from unnecessary quarantine. This requires testing to be integrated into a comprehensive programme, created with local leaders and communities, including effective contact tracing, appropriate support and incentives for those isolating, and strategic testing as part of ongoing surveillance of vaccine effectiveness. A holistic public health approach, joined up across towns, cities, and regions, is key to sustainable recovery from the pandemic.

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FEATURE, p 186
LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Behavioural responses to chaotic decision making

“Chaotic decision making,” as well as undermining the government’s response to the pandemic (Seven Days in Medicine, 9 January), also lowers behavioural adherence to lockdown restrictions.

Lockdown adherence can be compromised by comparative optimism fuelled beliefs, such as “covid will affect others, but not me” and “if it has not happened yet, it is unlikely to happen now.” This comparative optimism is an ongoing threat to lockdown adherence, potentially augmented by the knowledge that a vaccine is imminent.

Second, an intention to change behaviour to protect oneself from health threats is more likely if people perceive that their change in behaviour will effectively limit the threat. People entering their third UK lockdown are thus likely to question the efficacy of adhering to lockdown messages, as previous adherence has clearly not protected them from threat.

Third, adherence to behaviour change instructions is influenced by source credibility. “A source that is perceived as more credible is found to increase message compliance by increasing both the perceived message threat and efficacy.” The UK government has made several U-turns in its handling of covid-19—insisting schools were safe on one day, only to close them the next, for example. They described the prospect of a third lockdown as “a catastrophe,” weeks before instructing said lockdown. The U-turn on Christmas remains at the forefront of people’s memories.

U-turns in messaging might be tolerated in politics, but in behavioural science we know that, to be perceived as credible, a source must be competent, trustworthy, and caring. The UK prime minister was recently judged “competent” by 34% of the UK population and “trustworthy” by 26%. Behavioural science evidence indicates that, although attitudes towards this lockdown might be supportive, actual behavioural adherence is likely to fall short.

Koula Asimakopoulou, reader in health psychology, London; Neil Coulson, professor in health psychology, Nottingham; Dave Gilbert, distance learning coordinator, London; Sasha Scambler, reader in sociology, London

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VACCINATION VOLUNTEERS

Volunteers cannot be outsourced

A spokesperson from the Department of Health and Social Care said that there were no delays in accrediting volunteers for the covid-19 vaccination programme (This Week, 9 January). Evidently NHS staff have time to vaccinate 30 million people in a few weeks without our help. Is the real reason for the stonewalling that unpaid volunteers cannot be outsourced to private companies?

Volunteers must be competent, but much of the red tape is avoidable and probably generated by the perceived need to give volunteers a paid contract. I doubt I am alone in feeling more willing to help if I were not being paid.

The UK has an opportunity to show the world how a scientifically based, professionally led NHS, supported by massive voluntary effort and public goodwill, can meet this huge public health challenge. Let’s hope the government doesn’t think “professional services” companies can do a better job, using low paid staff with minimal training.

David Barer, retired physician (geriatrician), Wylam

Cite this as: BMJ 2021;372:n259

CULTURAL COMPETENCE IN VACCINE ROLLOUT

Don’t forget migrants and asylum seekers

Cultural competence in the covid-19 vaccine rollout is important (Editorial, 9 January).

Attention should be paid to asylum seekers and undocumented migrants. A review of the impacts of the pandemic documented significant inequalities based on migration status. For these groups, the pandemic has brought longstanding problems to light; exacerbated pre-existing problems and health inequalities; and created new difficulties, many of which will persist after the pandemic has ended.

Government mistrust is prevalent and many worry that data collected when vaccines are given could be used by immigration authorities. Despite some healthcare being made free for migrants during the pandemic, including covid-19 vaccinations, some still fear being charged.

These populations must not be left out of vaccine considerations. Community leaders and charities should be involved in the rollout. Vaccinations for those without GP registration, an NHS number, a permanent address, or a mobile phone must be facilitated.

Lauren Z Waterman, specialty trainee year 5 psychiatry, London

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Use social media to maximise vaccine uptake

Some communities, such as ethnic minority groups and those of lower socioeconomic standing, may be left behind in the UK’s vaccination programme. Social media may play a role in ensuring that this does not happen.

Throughout the pandemic social media have been awash with false information regarding vaccine safety. To achieve herd immunity to SARS-CoV-2 it is paramount that the public make an informed choice to accept vaccination when offered. Currently, this choice is influenced by information and misinformation on social media. Recent estimates of UK vaccination acceptance rates are promisingly high, however they significantly under-represent people of lower socioeconomic standing and ethnic minorities.

Social media is the perfect platform to reach these demographics. A concerted effort from the medical and scientific communities to provide accessible and effective communication through targeted use of social media can help to maximise the uptake of covid-19 vaccines in the UK.

Daniel Patten, postdoctoral research fellow, Birmingham; Adelle Green, final year BSc education with biological science; Daniel Bown, programme leader, Scunthorpe; Craig Russell, lecturer in pharmaceutical sciences, Birmingham

Cite this as: BMJ 2021;372:n225
SOCIAL DETERMINANTS OF HEALTH

Your job influences your health

Moscrop and colleagues discuss social determinants of health (Analysis, 12 December). Occupation is also still an important health determinant. It is used for the National Statistics Socio-economic Classification (NS-SEC, rebased on the SOC 2020). If the National Statistics occupational codes were included in general practice computer systems, NS-SEC could be derived for every patient.

The data could then be used to remind healthcare professionals of the risks of certain occupations and to identify patients who might be at risk. At the moment, for example, “essential” workers are at higher risk of contracting covid-19. Occupation can be recorded currently, but several classifications are available and most of the data are missing.

Michael Soljak, honorary senior clinical research fellow, London

Cite this as: BMJ 2021;372:n134

Inequality is hidden in plain sight

Area based scores such as the index of material deprivation (IMD) are important tools, but they lack resolution at an individual level.

In 2019 Hackney Council interviewed 1024 residents aged 16 years and over. Participants were asked the question, “Do you ever have difficulty making ends meet at the end of the month?” The answers—always (5%), sometimes (33%), rarely/never (60%), or preferred not to say (2%)—were associated with greater discrimination at the end of the month. General practice could do at least as well for individually self-reported socioeconomic status.

John Robson, reader; Alexander Miller, public health analyst; Jayne Taylor, public health consultant; Kambiz Booma, senior lecturer; Sally Hull, reader; Carol Dezateux, professor of epidemiology and health data science, London

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Socioeconomic status is a social construct

IMD is a measure of accumulated social advantage and disadvantage of the people in a census area, but many researchers assume that it is an aggregation of individual socioeconomic statuses. Individual and area level measures of socioeconomic status are independent health risk factors.

Individual socioeconomic status is not straightforward to measure because it is a social construct—the education expectations of jobs have changed over time, 40% of the population is not in work at any one time (too young, carer, retired), and occupational prestige rankings also change over time.

Perhaps we should be asking some key questions. I can think of two that tap into areas shown to increase heart disease risk. Are you not in employment when you would like to be? Do you live alone? I’m sure we could come up with a core list. Where you live and your personal characteristics matter.

Shona Kelly, professor, Sheffield

Cite this as: BMJ 2021;372:n174

Authors’ reply

We are grateful for the interest in our paper. Soljak emphasises the importance of occupation, pointing to workers at higher risk of covid-19. The lack of socioeconomic data for individuals has limited our understanding of the pandemic. In the UK, occupation is included on death certificates, so we know that security guards and taxi and bus drivers have had an especially high covid-19 death rate. But we have no combined person level health and socioeconomic data to help us understand whether this was because people in those jobs had a higher chance of encountering covid-19, whether they had more pre-existing clinical conditions, or whether being relatively low wage earners was enough to threaten their health.

Robson and colleagues provide important evidence of the acceptability in Britain of the poverty screening question, and Kelly reminds us that estimates of area and individual deprivation are both important.

Andrew Moscrop, primary care physician; Sue Ziebland, professor of medical sociology, Oxford; Gary Bloch, family physician; Janet Rodriguez, Iraola patient representative, Toronto

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THE HOSPITAL BED IS BROKEN

Beds don’t wear out, staff do

It’s not the beds that are broken but the staff (Matt Morgan, 9 January). In Stockholm, with normally double the number of hospital doctors and nurses as the UK, staff are exhausted with the recent surge, exacerbated by covid-19 and stress related illnesses.

Your colleagues here admire what you have achieved, but there are limits. How you can now add a rapid vaccination programme is remarkable and is perhaps the second wind just before the finish line, but some of us are sceptical about being able to reach those goals. Maybe we should be asking some key questions. I can think of two that tap into areas shown to increase heart disease risk. Are you not in employment when you would like to be? Do you live alone? I’m sure we could come up with a core list. Where you live and your personal characteristics matter.

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OBITUARIES

James Charteris Lea Rawes
Medical missionary and GP (b 1929; q Cambridge/ St Thomas’ Hospital, 1956), died from old age on 25 October 2020
After national service in Germany, James Charteris Lea Rawes gained further medical experience in Bath. In 1960 he attended Cuddesdon theological college and took a post as a medical officer at Mmadinare Mission Hospital, Botswana; then in Matabeleland; next in Zimbabwe; and finally at St Francis’ Hospital in Katete, Zambia, where his future wife, Clare Hodges, was the matron. James and Clare returned to England in 1966 and settled in Great Dunmow, Essex. James took a GP partnership at Rood End surgery, Dunmow, where he remained until he retired in 1990. He was also medical officer at Felsted School in 1985-90. James was a committed Christian all his life. Clare predeceased him by 18 months. He died at home and leaves four children and nine grandchildren.

Gervase Vernon
Cite this as: BMJ 2020;371:m4526

Malcolm Keene
Consultant ear, nose, and throat surgeon (b 1947; q London Hospital Medical College 1970; FRCS), died from amyloidosis secondary to lymphoma on 26 October 2020
Malcolm Keene trained as an ENT surgeon at University College and the Middlesex hospitals and carried out research in Toronto before being appointed consultant at St Bartholomew’s Hospital in 1984. He was much in demand both in the NHS and in private practice; he had a special interest in head and neck surgery, sinus disease, paediatric otolaryngology, and voice. The latter resulted in him being awarded an honorary fellowship at the Guildhall School of Music, of which he was immensely proud. Away from surgery he had numerous interests including painting, wine, cooking, vintage cars, golf, and everything aeronautical. He bore his long illness with dignity and stoicism. He leaves his wife, Sandra; two sons; and his first grandchild on the way.

Norman Williams
Cite this as: BMJ 2020;371:m4524

James Finbarr Cullen
Consultant ophthalmologist (b 1928; q Dublin 1952; FRCS Eng, MD NUI, FRCS Ed, FRCOphth), died from cardiac ischaemia on 23 September 2020
In 1962 James Finbarr Cullen (“Barry”), already a master of neuro-ophthalmology, foresaw that the days of the generalist were over. During the following decade, he brought Edinburgh out of the 1930s with both ideas and equipment. Into ophthalmology he attracted the best local graduates, for whom he arranged subspecialty fellowships. On retirement in 1994, he was invited to Singapore for two years and stayed for 17. During that time, he created what became the main referral centre for neuro-ophthalmology in South East Asia, where he also extended the reach of the Royal College of Surgeons of Edinburgh with joint examinations. He and his endearing chuckle will be remembered with gratitude, respect, and love. He leaves Ann, whom he married in 1954; five children; and 11 grandchildren.

Hector Bryson Chawla
Cite this as: BMJ 2020;371:m4515

Sarita Rai Gurung
Specialty doctor in paediatrics South West Acute Hospital, Northern Ireland (b 1965; q Assam Medical College, Dibrugarh, Assam, India, 1992; MRCPCH), died from acute left front temporal haemorrhage and rheumatic heart disease on 6 October 2020
Sarita Rai Gurung moved to the UK in 2004 to start as a clinical observer in paediatrics at the Hull Royal Infirmary. In 2008 she moved to London and worked at various hospitals there as well as the South West Acute Hospital in Northern Ireland. Personal circumstances prompted a move into short term roles. Sarita was the centre of her family, who had all moved to London from Nepal. She loved gardening and flowers, was a devout Christian, loved to be silly at times, was generous and kind to all, cooked great meals, and brought colour and joy to family and friends. She leaves her husband, Dan B Gurung, and a son.

Ashish Gurung
Cite this as: BMJ 2020;371:m4520

Michael Allbeson
GP (b 1947, q Manchester 1970, MRCP, MRCGP), died from Parkinson’s disease on 8 August 2020
Michael Allbeson (“Mike”) was humane, irreverent, inspiring, and occasionally exasperating. He was also a bibliophile, wordsmith, cyclist, photographer, prankster, pudding enthusiast, and a much loved son, husband, brother, father, father-in-law, grandpa, friend, and GP. After qualifying and doing house jobs, Mike married Sue. Together they went to Papua New Guinea to do Voluntary Service Overseas, miles from anywhere. They worked in Australia, where their daughter was born, and then returned to the UK to do some hospital training jobs and pass his royal college membership exams. He settled in Penkridge to work as a GP. He retired early because of increasingly debilitating Parkinson’s disease, which he bore with courage and a determination. He leaves Sue, who cared for him so well; two children; and their children.

Richard Feinmann
Cite this as: BMJ 2020;371:m4513
Peter Sleight
Visionary cardiologist and inspiring leader

Peter Sleight (b 1929; q St Bartholomew’s Hospital, London, 1953; MD, DM, FRCP, FACC), died from natural causes on 7 October 2020

Peter Sleight, a professor at Oxford University, helped to transform heart attack treatment and prevent cardiovascular disease with angiotensin converting enzyme inhibitors and statins. He was among the first cardiologists to recognise the critical importance of large simple trials involving thousands of patients and rigorous statistical analysis of treatment outcomes.

This put him at odds with fellow cardiologists, who regarded statisticians, according to one commentator, as “aliens and Martians.” But Sleight’s reputation persuaded clinicians all over the world to enrol patients into the groundbreaking International Studies of Infarct patients into the groundbreaking all over the world to enrol reputation persuaded clinicians all over the world to enrol patients into the Isis trials.

Cardiology sceptics were finally won over in 1988 when Isis-2 showed that prompt treatment of suspected heart attacks with streptokinase and with aspirin each reduced 30 day mortality by about a quarter, while jointly halving 30 day mortality. That the two clot busters, acting in different ways, complemented one another was a surprise.

Having recruited some 140 000 patients, the four Isis trials had a profound impact on the emerging science of evidence based medicine. Isis methodology influenced the design of studies into other conditions, including the Recovery trial, which showed that dexamethasone reduces COVID-19 mortality.

Sleight, a celebrated leader and mentor, inspired great loyalty. Moreover, unlike many eminent men, he was able to laugh at himself—for example, when medical students lampooned him for his real name being Peter Flight. He would reply “What’s the difference between God and Peter Sleight? Answer: God is everywhere, but Peter Sleight is never in Oxford.”

Inspiration
Born in Hull and brought up in Leeds, Sleight did national service with the Royal Air Force before starting as a junior doctor. His early career was extraordinary because of the stream of luminaries and inspirational figures he worked with.

In London, there was Paul Wood at the Brompton Hospital and Aubrey Leatham at St George’s Hospital. Dubbed the “gale force of British cardiology,” Wood was credited with transforming London into an international centre of excellence. Leatham turned the art of auscultation into a science—until then listening to the heart had been a hit-and-miss business.

In San Francisco—where Sleight went to spruce up his CV—there was Maurice Sokolow and Julius Comroe. Sokolow’s ambulatory blood pressure recorder led to the concept of “white coat hypertension.” Comroe developed the internationally recognised cardiovascular research unit.

Oxford
San Francisco was lifechanging for Sleight, leaving him hooked on physiology. After discovering C fibres in the heart, he moved to Oxford to investigate hypertension and baroreceptors. Appointed as a consultant physician at the Radcliffe Infirmary in 1964, he split his time between clinical medicine and research. In 1973 he became the first Field Marshal Alexander professor of cardiovascular medicine.

His path to prominence at Oxford coincided with that of the statistician Richard Peto, who convinced Sleight that the methodology of existing trials was too complicated and too small to give unequivocal results. The spectacular impact of antibiotics had created the impression that trials with just a few hundred people would be enough to establish a drug’s efficacy.

Sleight was in the right place at the right time. He was part of the “gale force of British cardiology,” a professorial standard set by his mentor, inspired great loyalty. Moreover, unlike many eminent men, he was able to laugh at himself—for example, when medical students lampooned him for his real name being Peter Flight. He would reply “What’s the difference between God and Peter Sleight? Answer: God is everywhere, but Peter Sleight is never in Oxford.”

Sleight met his future wife, Gillian, at Barts in 1950. She was a fellow medical student and later a public health specialist. They married three years later. They lived in the Oxfordshire village of Wheatley for more than 50 years before moving together to a care home in 2018. Sleight leaves Gillian and their children.

John Illman, London
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Cite this as: BMJ 2020;371:m4442

Survival (Isis) trials.

The critical importance of large simple trials involving thousands of patients and rigorous statistical analysis of treatment outcomes.

Who convinced Sleight that the methodology of existing trials was too complicated and too small to give unequivocal results?