comment

"It shouldn't take whistleblowers, legal actions, and campaigns to get at truths" **DAVID OLIVER**
"Studies reveal how bad we are at predicting how long patients will live" **HELEN SALISBURY**
PLUS How to improve obstetric care in operating theatres; the importance of civility

THE BOTTOM LINE Partha Kar

The anguish of the Indian diaspora

I have a strong sense of déjà vu, witnessing the scenes of carnage in India as covid rips through it. Perhaps I'm feeling the pain more intensely because, having seen the impact that covid had in January in the country where I live, I'm now seeing it replicated in the country where my heart lies.

Thousands in the Indian diaspora—especially those working in the NHS—are watching with similar, heart wrenching anguish and worry about families and friends. It's frustrating, as somehow India seemed to have dodged the bullet the first time around. Yet a toxic mixture of political myopia, religious sentiments, and perhaps a degree of overconfidence has culminated in a mostly self-inflicted rise in covid.

In some quarters, the response to covid has been about being somehow "better" than other countries—the exact same discussion that keeps raising its head in the UK. Rather than learning from mistakes, the reaction has been to think, "We got this right; you didn't." With such jingoistic debate in a world with a desperate need to work as one, we all stood to lose. And we did. The UK's decision to encourage festive shopping in December and allow Christmas gatherings was devastating for communities, and hospitals just about managed to cope with the demand only by cancelling most other activities. Yet India decided to ignore that. Bring in the Kumbh Mela, political rallies, ill informed leaders, a rapidly spreading mutant variant, and a cricket match attended by 75 000 spectators, and you have a potent mix. Then add a health infrastructure crying out for investment, and the touchpaper was lit.

Some committed and hardworking individuals work in India's health sector. But they do so mostly on the margins of possibility, using creativity to bridge the gaps between the needs of a huge population and the availability of appropriate interventions. In a pandemic wave, that system simply didn't stand a chance. Witnessing this has been the culmination of fears that many health professionals from India have always harboured. The present horrific scenes and statistics also have a feel of déjà vu, with some quarters looking at data through different lenses to justify them—or indeed compare them with other countries—along with the narrative that "we are not as bad as other places."

Devastated families perhaps wish there had been a willingness to learn from the missteps of countries such as the UK or the US. India is an incredibly resilient country, and it will get past this. Let us hope the experience will pave the way for increased healthcare investment, in a country where health professionals could make magic with their skill and ingenuity.

I ask you to keep this country in your thoughts and prayers as it battles through a low ebb: a country with a warm heart, vibrancy, and joy, let down by hubris in its time of need. However much I commit my life to work in the UK, my heart still beats for India—or, as the Bollywood saying goes, "*Phir Bhi Dil Hai Hindustani*."

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India is an incredibly resilient country, and it will get past this

BMJ OPINION Emma Evans and Monika Kupper

Humanising obstetric care in operating theatres

Around four in 10 pregnant women in the UK give birth in a forbidding, high tech environment and the experience can be traumatic. Patient groups and professionals are working together to improve the process

Emma Evans: consultant anaesthetist

Repeated conversations with women who described being fearful about being disconnected from their anticipated birth plan and facing delivery in an operating theatre environment with (perceived) rigid staff hierarchies, raised my awareness of how stressful this is for some patients. It prompted me to think about ways to improve the environment informed by the experience of women and staff with knowledge of maternity care in this setting.

It was clear that a formal initiative needed an interprofessional working group. I approached colleagues with experience of implementing quality improvement initiatives, as well as members of the theatre staff, and used various informal and formal staff forums to invite discussion. I also worked with our Maternity Voices Partnership to get patient input.

The initiative was launched in February 2018 and ran formally until September 2019. We broadly followed the EBCD toolkit. Discussions and one-to-one interviews with 27 medical, nursing, and midwifery colleagues and 15 patients were conducted and then thematically analysed to inform joint events where key co-design themes were identified. Once changes had been agreed, sign-off was obtained from the trust executive team.

Light bulb moments

Practical sessions putting staff in women's shoes, such as by lying on operating tables or being positioned in stirrups, enabled them to see their daily working environment through patients' eyes and their professional role in a different light. This motivated them to engage in change. Pairing peer staff with interviewees also reduced anxiety around expressing opinions and showing filmed patient interviews to clinical staff during quiet shifts broadened staff engagement.

During patient interviews it became evident how small, inexpensive changes could make a huge difference

Monika Kupper: patient advocate and co-chair of the Maternity Voices Partnership

A Maternity Voices Partnership (MVP) is an NHS working group of women, birthing people, families, commissioners, and maternity service staff collaborating to review and develop local maternity care. It is led by an independent lay chair to ensure service users are well represented.

I am a documentary film maker and my main role in the New Beginnings initiative was to advise on editing the filmed interviews. Eyewitness accounts and people's stories, which can be almost overwhelming to watch, are a good way to change hearts and minds. We agreed it was important to showcase how some women are emotionally scarred by their experience.

One mentioned the humiliation of walking half dressed into the operating room and then being asked to take off her pants in front of everyone and having to hand them to her husband. "What little dignity I had left, went out the window," she said. "My husband had post-traumatic stress disorder as a result of this experience and couldn't watch anything to do with hospitals on TV for months afterwards."

Watching these interviews made it evident how small, inexpensive changes to the environment could make a huge difference.

Challenges

Data protection regulation restrictions precluded using patient databases so we had to recruit patient participants through clinics and social media. As a result we were not able to get a truly representational input from our ethnically diverse patient population. The social networks that the MVP uses are mainly self-selecting by geography and language. In future projects the midwifery teams who have the most contact with parents should be actively involved in recruitment.

Key changes instigated

Improving antenatal information about operative birth

- Web pages with facts about operative birth rationale, process, and recovery
- Women now routinely directed to a caesarean section information video antenatally for a virtual tour of the theatre environment; translations created by multicultural staff to support diverse ethnic groups of mothers
- Emphasis in antenatal classes now reflects the fact that four in 10 women will experience a peri-partum theatre episode
- Positive images of theatre birth displayed along maternity corridors to reduce stigma associated with operative birth described by participants
- Virtual class on theatre birth and anaesthesia being trialled within an antenatal class programme.

Making care more person centred

- Installed a welcome board outside theatre for families
- Purchased name badges for staff in order to improve introductions
- World Health Organization surgical safety checklist team member introductions include parents
- Reduced barriers to skin-to-skin contact by adjusting electrocardiogram (ECG) placement, tying gowns differently, and moving blood pressure cuff to leg

AMELIE-BENOIST/BSIP/SPL

- Routinely offer music, gender reveal, drape drop for birth; previously these needed to be requested
- Purchased speakers and iPad for music requests
- Introduced water for women until they leave the ward and reduced fasting time ahead of caesarean section from 4 hours to 1.5 hours (average)
- Introduced disposable underwear for patient walk from fourth floor ward to first floor operating theatre—previously not worn.

Learning by doing

Creating website content and leaflets was easy, but influencing behaviours across a large staff group, particularly in relation to fasting policy, has been harder and lengthier. Despite being endorsed formally, staff and patients remained cautious about pre-anaesthesia fasting risks and so iterations including changing language cues from "sips til sending" to "just drink" and sharing safety data have helped. Repeated iterations also enabled us to "fail fast" with some initial ideas—including creating a theatre certificate incorporating staff names and a Polaroid photo of the family—where the practicalities were overwhelming.

Future directions

The project empowered staff to be active agents for change and its legacy has been a continued wave of collaborative improvement initiatives.

Senior leaders are currently helping us to work out how to embed the use of patient stories into training and to avoid returning to the tradition of viewing women's ideas for change as optional extras.

Emma Evans, consultant anaesthetist

Monika Kupper, member of the St George's Hospital Maternity Voices Partnership

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ACUTE PERSPECTIVE David Oliver

A vision for transparent government

Amid calls for a public inquiry into England's response to the pandemic, the King's Fund has proposed a potential framework for an inquiry under five key headings: "Intrinsic risk," "Public health response," "Healthcare system response," "Measures in wider society," and "Adult social care response." I realise a public inquiry can produce an evidenced narrative and recommendations, but the need for one highlights a serious failure of open government.

It shouldn't take inquiries, whistleblowers, legal actions, investigative journalists, and public campaigns to get at truths that should be in the public domain. I want to imagine a utopian, post-covid world, where transparency is the norm and where we openly acknowledge and learn from the positives, the failings, and the gaps in our response to this pandemic, to help plan for the next ones.

I'd have all relevant data reported by an independent statutory body, such as the Office for National Statistics, free of political interference. For a future pandemic this would include data on testing, tracing, isolation, and the cost and reliability of the technology; incidence and prevalence of deaths, comorbidities, hospital admissions, and bed use; and staff sickness, care home outbreaks, and hospital acquired infections. It would be one credible, independent point of reference for use in political and policy debate.

Instead several agencies have produced subtly different datasets with slightly different definitions. This sows distrust and distracts us from finding solutions. In my vision, ministers and their spokespeople would be routinely censured for inaccurate or misleading use of data.

NHS trusts would be free to speak to the media, as would their employees

I'd love to see the National Audit Office given more resources and staff to report on more issues more frequently: its output is reliably excellent and informative. It has reported on serious failures in procuring PPE and the numerous government contracts to private sector organisations, many with links to ministers or advisers. The Good Law Project has highlighted dishonesty, obfuscation, illegality, and cronyism in the awarding of key pandemic contracts and roles.

I'd prefer all of these appointments and contracts to be open and easy to scrutinise without the need to resort to civil law. And I'd legislate to ensure large public contracts outsourced to the private sector were not exempt from freedom of information requests. Nor would we require the private court action brought by Moosa Qureshi, an NHS doctor, simply to get the 2015 Cygnus pandemic preparedness report released in full. It would have been in the public domain by statute.

We'd see all advice from advisory committees. NHS trusts would be free to speak to the media, as would their employees, without message control and blocking from central agencies. Investigative reporters wouldn't need to use FOIs to collect key data—as, for instance, the *Mail on Sunday* did for hospital acquired covid cases and resultant deaths.

I'm not so naive to think any of this will happen, but anyone promising to restore trust in politicians and government would need to be far more transparent than we've been about the covid response.

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PRIMARY COLOUR Helen Salisbury

Routes to recovery

One of the hardest parts of being ill is not knowing when, or even if, you'll be well again. As doctors we're often asked about this, but only sometimes can we provide a definitive answer.

There are published estimates for some conditions, although a quick look online shows these vary widely, even for relatively well defined problems such as broken bones. Patients often have over-optimistic ideas (occasionally acquired in the emergency department) about how quickly they'll be back to normal, and then need reassurance that ongoing discomfort isn't a sign that something's gone wrong.

For more complicated conditions, and in cases where recovery can't be guaranteed, we can turn to research findings (if they exist) and our own experience, but this often feels no better than peering into a crystal ball. To encourage conversations about end-of-life care planning, the "surprise question" has been advocated, where clinicians ask themselves, "Would I be surprised if this patient died in the next 12 months?" However, studies around the use of this question have revealed just how bad we are at prediction, especially in patients without cancer.

My own experience bears this out. There are patients I still look after whose death would not have been surprising any year in the past decade, but they live on—sometimes in frailty and poor health or just in extreme old age.

Other patients surprise me not just by their survival but by their ability to turn their lives around or rebuild them after adverse events. I take no particular credit for patients who have overcome drug or alcohol misuse, lost significant weight to reverse a type 2 diabetes diagnosis, or finally escaped an abusive relationship. The effort was all theirs, and I merely cheered from the sidelines.

However, it's deeply heartening when things go well, especially when patients encounter other parts of our care system that have really worked for them. Complex cases involving social services, the alcohol and drug team, and mental health services can leave us with low expectations of a happy, healthy outcome, but the extent to which we can communicate and work together probably influences the chance of success. This is even harder to imagine when we're all so busy that finding time to talk seems nearly impossible.

Knowing patients who have changed their lives for the better, and sometimes even gone on to work in the very services that helped them, is a useful reminder not to give up hope. I may not feel as though I have much to offer some patients—I can't be their willpower and I can't provide the refuge they may need—but I can offer my support and my belief that things can change. A better life is possible, and they deserve it.

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Patients who have changed their lives for the better are a useful reminder not to give up hope

BMJ OPINION Karen Ellison

The power of civility during a pandemic

A few years ago, I heard a talk by Chris Turner, a consultant in emergency medicine, about the power of civility in medicine and the Civility Saves Lives initiative. He explained how incivility in the workplace creates a toxic web of negative outcomes, in both interpersonal relationships and the wider organisational culture. The talk still resonates with me, and it is particularly pertinent now, with healthcare professionals facing extreme and unrelenting pressure during the covid-19 pandemic.

In his talk, Turner cited research showing how civility really does save lives. For recipients of mild to moderate rudeness there is, on average, a 61% reduction in cognitive ability and, in his words, "in the moment, we make people less." Not only that but the impact of rudeness extends to onlookers who experience a 20% reduction in performance and a 50% reduction in willingness to help.

During the pandemic, the NHS has witnessed increasingly complex clinical scenarios and there has never been a greater need for supportive teamwork. At the Medical Protection Society, however, we have heard of several cases where the care of patients with covid-19 has been affected by suboptimal team working, which was in turn related to communication problems between team members. More than ever, with this complex new disease, incivility, rudeness, and our inability to treat each other with respect can make the difference between a poor outcome and a good one.

Increasing tension among medical staff against a backdrop of exponential demand on services seems to result in ever more common incivility, feeding a continuous loop of stress and burnout. We can—and must—all do better and this includes NHS organisations that must embed a culture of civility. Harnessing the power of civility in medicine allows healthcare professionals and their teams to perform at their best, optimising outcomes and ultimately saving lives.

Karen Ellison is medicolegal consultant at the Medical Protection Society

ANALYSIS

Making medical leadership more diverse

Shannon Ruzycki and colleagues examine why women and minority groups are under-represented among medical leadership and call for quotas to improve diversity

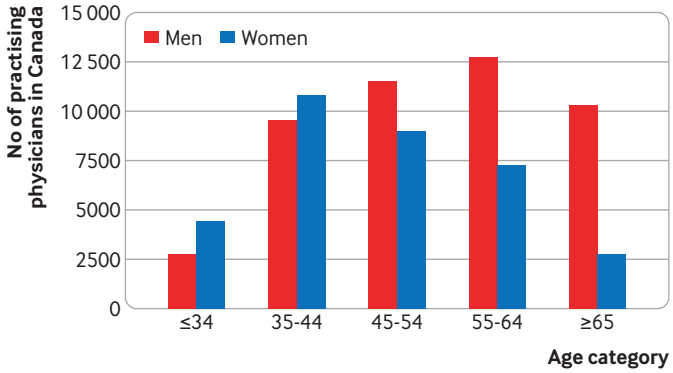
The medical profession has faced criticism for its lack of diversity. This lack of diversity is harmful to healthcare workers[1 2] and patients.[3] Despite increases in the number of women admitted to medical schools in many countries, the proportion of under-represented minorities, including ethnic minorities,[4] people with disabilities, and members of the LGBT+ community, remains low[5 6] or unmeasured.

Furthermore, despite equal numbers of men and women in medical school, women remain under-represented in leadership and decision making positions, suggesting that numerical equality alone will not improve the diversity in medical leadership.[7]

Intentional action by institutions is required. Mandating inclusion of women and people from under-represented minorities, a mechanism that has been successful in the political and corporate worlds, could be an effective means to diversify medical leadership.

KEY MESSAGES

- Despite increasing numbers of women becoming doctors in many countries, institutional leadership remains dominated by white men
- Under-representation in leadership and decision making is both a cause of and result of a demographic mismatch between those in leadership and the populations they represent
- Reducing barriers faced disproportionately by under-represented groups of physicians will require deliberate action to increase their participation in leadership and decision making
- Quotas, or deliberate inclusion, of under-represented physicians in decision making can increase diversity of leadership and promote equity and inclusion in medicine



Demographic mismatch between age and sex among practising doctors in Canada, 2018

Lack of diversity is self-perpetuating

Gender and ethnicity based disparities in medicine have been documented for over 30 years.[8] Disparities in promotion,[9] compensation,[10 11] discrimination,[11 12] and harassment[13] that disadvantage women and racialised physicians have been found in every setting and specialty where such inequities have been studied.

Disparities are partly the results of barriers that disproportionately disadvantage women and under-represented minorities. The persistence of these barriers to entering leadership positions for female and under-represented minority doctors is likely to be both a cause and consequence of under-representation in leadership. The criteria for holding decision making roles are often based on years of experience, which disadvantage junior doctors, a group that includes more women and racialised physicians. This leads to over-representation of historically advantaged groups in leadership (figure).

However, our research shows that senior male doctors thought there was gender equity in their departments, while junior women reported frequent barriers to career progression, sexual and maternal harassment, and gender discrimination.[14] These barriers often concentrate at the beginning of careers—a critical time for career trajectories and leadership attainment; early career is when remuneration is negotiated, career tracks are chosen, and, for many, childbearing occurs.[14] Many physician leaders do not have direct experience of these barriers, and the presence of these barriers excludes the people who are best suited to address them from attaining leadership and decision making positions.

This demographic mismatch between the doctors in leadership roles and the physician workforce undermines a key principle of democratic governance—that decision makers share relevant characteristics with those affected by their decisions.

Numerical equality is not enough

Increasing diversity among the physician population might be expected to reduce the disparities experienced by under-represented minority and female physicians. However, despite nearly 25 years of numerical equality among men and women admitted to medical schools in Canada,[15] gender disparities and inequities persist. Medical leadership positions are held predominantly by men,[16] harassment continues to be more common among minority and female physicians,[17] and female physicians are still paid less than male colleagues for the same work.[10]

Similar trends have been observed in the UK,[7] the US,[18] Japan,[19] and Australia.[20] Medical leadership must proactively tackle under-representation rather than assume that parity in the medical profession alone will reduce disparities over time.

Intentional inclusion

To affect change, doctors from under-represented minorities must have leadership and decision making roles.[7] One way to increase representation among medical leadership is quotas. Government quota policies exist in more than 130 countries,[21] and corporate quotas have expanded considerably in Europe[22] and the US.[23] Quota policies are consistently effective for increasing diversity in government and business.[24-28] Beyond increasing the number of women elected, quotas improve women's engagement in the political process, expand the breadth of policies that positively affect women and families,[24-29] reduce negative stereotypes about women's leadership capabilities,[30] decrease the gender gap in earnings,[31] and increase the legitimacy of leadership.[32]

Existing quota policies fall into three types with differing target groups, thresholds, and sanctions (table).[22] Mandatory gender quotas require a minimum threshold of the target group. Examples include electoral gender quotas in Europe, which mandate a minimum threshold of female candidates for each political party, and corporate gender quotas, which set targets for the boards of directors of publicly traded companies. Sanctions for non-compliance vary considerably, ranging from financial penalties to de-listing companies from the stock exchange.

In Europe, both electoral and corporate quotas focus on women rather than ethnic minorities. California has recently extended a corporate quota for women to include under-represented minorities, with large financial penalties for non-compliance.[23]

Voluntary quotas, sometimes called "soft" quotas, use incentives instead of sanctions. Examples include the Athena Scientific Women's Academic Network programme in the UK, which encourages inclusion of women in leadership roles through research funding.[7]

The third approach, candidate quotas, requires a prespecified proportion of applicants to come from under-represented groups without mandating the proportion ultimately selected.[40] An example is the Rooney Rule, which requires businesses to interview a minimum number of women and minority applicants.[39]

Reliance on merit disregards the extensive evidence that implicit and explicit biases disadvantage under-represented minority and female applicants in science and medicine

Countering criticism

Careful design and thoughtful leadership can help avoid some of the criticisms of quota policies (table).

Opponents of quotas often invoke arguments about merit.[21-29] Critics equate merit with selection based on intrinsic talents, meaning that those who are selected are inherently more suited to leadership than those not selected; however, merit harbours implicit biases and perpetuates non-transparent selection processes.[29 34] There is ample evidence that factors beyond intrinsic talent are involved in evaluation of merit; these factors include "likability," sponsorship, and mentorship—all of which often exclude women and under-represented minority physicians.[42 43] In addition, reliance on merit disregards the extensive evidence that implicit and explicit biases disadvantage under-represented minority and female applicants in science, technology, engineering, mathematics, and medicine.[44 45]

Traditional definitions of merit ignore characteristics commonly found among women and minority groups that positively affect leadership skills, such as lived experiences of oppression, discrimination, harassment, and care giving.[46 47] Importantly, there is evidence that quotas improve organisations; after implementing gender quotas in local elections, the quality of elected councillors improved rather than declined.[48] The overemphasis on individual merit ignores the demonstrable benefits of diversity at the level of the team[49]: while an individual may be "the best" for the job, a team that lacks diversity does not have the diversity of thought, perspectives, and creativity to function optimally. Diverse leadership teams also foster perceptions of legitimacy.[32] The "myth of meritocracy" has perpetuated a cycle of leadership selection that favours a homogeneous population of physicians.[29]

An important consideration for implementing quotas is whether they are constitutional; most countries bar discrimination on the basis of sex, gender, and race in employment decisions, and to some, quotas represent illegal "reverse discrimination" that disadvantages majority candidates. Despite legal challenges, many countries have successfully implemented and defended quota policies.[28-50] The House of Lords in the UK and the European Court of Justice have ruled against some quota policies as discriminatory but allowed others, and the European Court of Human Rights has ruled that quota policies are permissible.[50]

Legal scholars have argued that well designed quota programmes that are voluntary and incentive driven rather than mandatory are likely to withstand legal challenges.[37] Any discussion of the legal risks of a quota policy must be balanced against the legal risks of continuing to allow documented discrimination in hiring processes, ongoing workplace harassment and exclusion, and pay inequality.[14 54] Consultation with the human resources department or an employment lawyer may be helpful.

The opinions of women and under-represented minorities on quota policies are conflicting. Some may worry that gaining a leadership position through these policies may lead to perceptions that they are not qualified.[55] However, in one study all 400 African American students attending predominantly white universities thought that affirmative action policies were valuable.[56] Similarly, despite initial opposition from men and women, quotas adopted in 2008 to increase women in corporate leadership are now viewed positively in Norway.[33] Quotas for women in political leadership have decreased bias against women leaders, and these benefits may extend to other under-represented groups.[30] Organisations that develop quota policies should confidently endorse people who are advanced because of these policies. Furthermore, members of under-represented groups should co-design these programmes.

Design considerations for deliberate inclusion (quota) policies for medical decision making and leadership roles

Quota Design	Description	Examples	Strengths	Barriers	Mitigation strategies
Mandatory quotas	Specify a minimum proportion of people from under-represented groups, with penalties for institutions who do not meet targets	Sex quotas for public servants in France[9] California's Corporate Board Diversity Bill[23]	Will immediately and definitively increase the number of under-represented people in leadership[22] Removes implicit and explicit bias as obstacles to leadership for under-represented groups Example policies have been implemented in multiple countries	May face legal challenges Controversial and may be unacceptable to stakeholders who endorse the meritocracy[22] Individuals promoted through quotas may be viewed as less qualified despite evidence to the contrary[33] Difficult to select targets	Quotas have been successfully implemented and defended from legal challenges in the United States and internationally.[34] Consider legal implications of ongoing exclusion and discrimination. Consultation with legal and human resource experts. Implicit bias or empathy training for leadership and other physicians[35] Proactive and vocal leadership endorsement of individuals selected through quota policies Co-development of quota policies with individuals from under-represented groups Refine goals of quota policy and select targets based on these goals and available evidence. Engage stakeholder groups when determining targets
Voluntary quotas	Provide individual or organisational rewards for voluntarily meeting diversity targets	Athena SWAN[7] Mansfield certification[36]	Avoids potential legal challenges faced by mandatory programmes[37] May be more acceptable to stakeholders Evidence suggests that this is effective	Requires institutional and leadership buy-in Could have variable uptake, depending on the incentives	Include an understanding of diversity or barriers faced by under-represented groups as a requirement for committee membership and leadership roles[38] Monitor uptake and iteratively address challenges, as needed
Candidate quotas	Require a target proportion of applicants from under-represented groups	Rooney Rule[39] All-women shortlists in the UK[28]	Avoids legal challenges because of hiring based on protected characteristics such as race, sex, or gender[39] Evidence suggests that this is effective	May prolong the selection process May lead to tokenism in the application process rather than true change	Use alumni lists or networks from under-represented trainee or physician associations to identify potential applicants Include an understanding of diversity or barriers faced by under-represented groups as a requirement for committee membership or leadership roles[38]

SWAN=Scientific Women's Advancement Network.

Defining under-representation

Deciding who is "under-represented" for a quota policy is challenging because the selection of a reference population is not clear cut. The general population is often used as a reference for defining under-representation in medicine,[57] but some have suggested that the proportions of women and under-represented groups in leadership should instead reflect the proportion of these groups as physicians.[58] For example, despite accounting for 63% of all paediatricians in the US, women comprise only 26% of paediatric department chairs[59]; it is not clear whether aiming for 50% female paediatric chairs is more appropriate than 60%. Other industries have used 30% as a target for diversity[36] based on conflicting evidence that this is the critical mass needed to overcome barriers for under-represented groups.[60]

We suggest that the goals of the policy should guide the definition of under-representation and target quotas. Quota policies intended to diversify organisational decision making roles to remove institutional barriers for under-represented groups might target 30% women and under-represented groups. Quota policies for medical school or residency enrolment intended to reduce healthcare disparities for marginalised patients[61] might use the proportion of under-represented groups in the local population as a target.

The harms of homogeneous leadership warrant a strong policy response

Other strategies to increase representation

Alternative strategies to increase representation should be trialled and evaluated, including paired mentorship to increase interest in leadership attainment, outreach methods to identify and train promising candidates,[38 62] research funding incentives for institutions that adopt best practices for increasing diversity,[7] or empathy and implicit bias training for leaders to help those in power understand issues unique to under-represented groups.[35]

These methods are, however, unlikely to have an immediate and definitive effect on the diversity of leadership and decision making roles. Unlike quotas, they work indirectly to increase opportunities or reduce barriers for under-represented groups.[11] Directly increasing the number of women and under-represented groups in decision making roles by using quotas will increase the ability of under-represented physicians to promote additional interventions that may best suit the needs of their communities.[63]

Bold interventions like quotas also signal the importance of diversity in decision making. Rather than waiting for the face of leadership to change gradually over time, the harms of homogeneous leadership warrant a strong policy response. Ongoing failure to increase the representation of under-represented groups in leadership positions is unethical and may further perpetuate inequities in medicine.

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OBITUARIES

Colin Bennett Keith

General practitioner and practice partner Southview Surgery, Woking (b 1940; q London Hospital, 1963; MRCS, LRCP, DObst RCOG), died from multiple myeloma on 14 April 2020

Colin Bennett Grogono divided his first four years between the family home in Stratford, London, and escaping the blitz to Abingdon and the family home in St Mawes, Cornwall. His father later adopted "Keith" as the family surname. Colin represented the British Universities Sailing Association on its tour to the USA in 1962 and spent a semester at the University of Virginia Hospital in Charlottesville. In 1975 Colin moved to Southview Surgery in Woking, Surrey, as joint partner. A severe head injury ended his medical career in his late 40s. He rehabilitated himself and remarried. He retired to Penzance and focused on yachting, charity work, and choir singing. He leaves his family, including two sons, two stepsons, and eight grandchildren.

Paul Keith

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Ann Gath

Consultant child and adolescent psychiatrist (b 1934; q London 1958; DCH, FRCPsych), died from covid-19 and dementia on 15 December 2020

Ann Gath started her career working in paediatrics, which triggered a lifelong interest in the health of children and young people. With a young family of her own, she moved into child psychiatry, and in Oxford, in the 1970s, she researched the impact of having a child with Down's syndrome on families. In 1980 she was appointed to a consultant post at the West Suffolk Hospital. In the early 1990s she was appointed chair in child and adolescent psychiatry at UCL-Middlesex. She was the first female honorary registrar officer of the Royal College of Psychiatrists from 1988 to 1993. Her passion for breeding Connemara ponies drew her back full time to Suffolk, and she returned to the West Suffolk Hospital. She leaves three children and seven grandsons.

Charlotte Gath

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Sarah Scott-Barrett

Consultant radiologist (b 1960; q Guy's Hospital Medical School, London, 1984; MRCP, FRCR), died suddenly on 15 January 2021

Sarah Scott-Barrett was born in Birmingham, the daughter of a surgeon. After a brief time in anaesthetics and general medicine she trained in radiology at Charing Cross, the Royal Brompton, and the Royal Marsden hospitals. She was appointed as a consultant at the Norfolk and Norwich University Foundation Hospital NHS Trust in July 1996, the first female consultant in the department. Sarah was an excellent radiologist with particular expertise in cancer imaging, and she took great pride in her clinical work. She worked hard and did not suffer fools gladly but was a fiercely loyal colleague and friend and was at her happiest when she was at a cricket match, in a gallery, or at the opera. She leaves a son, William; a sister, Liz; and brother, Johnny.

Will Scott-Barrett

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Geoffrey David Dunster

Consultant obstetrician and gynaecologist (b1942; q University of Cardiff 1966; FRCOG, FRCS (Ed)), died from cardiac failure on 17 November 2020, six years after major surgery for an aortic dissection

Of Welsh parents, Geoffrey David Dunster ("Geoff") was evacuated to grandparents in Newport. He was awarded a scholarship to Latymer Upper School, Hammersmith, London. Having initially considered dentistry, he switched to medicine and trained at the Welsh National School of Medicine in Cardiff, with an elective at Ann Arbor, Michigan, USA, fostering his specialist interest. After posts in Wales and Liverpool, he became senior registrar on the Bristol-Bath rotation, before being appointed as a consultant in Bath in 1976. Geoff had an interest in laparoscopy and ultrasound. With endocrinology he began joint diabetes services and medical and obstetric services. He was an active teacher. He leaves his wife, Julie, a haematologist; two sons; and four grandchildren.

John Reckless, Doug Bamford

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Peter Bernard Iles

Consultant physician (b 1948; q Westminster Medical School, London, 1971; DM, FRCP), died from a chronic neurological illness on 26 November 2020

Peter Bernard Iles was a physician at Dudley Road (now City) Hospital, Birmingham, and Birmingham Chest Clinic from 1981 to 2009. He trained in Nottingham and Liverpool. As a consultant he developed a comprehensive respiratory service in a socioeconomically deprived area and was an expert in a wide range of respiratory diseases, especially tuberculosis. He was a pioneer of multidisciplinary team working at the hospital. He developed and organised the highly regarded "Dudley Road" part 1 MRCP course, which gained a national reputation. He was honorary secretary to the Midland Thoracic Society. An exceptionally able physician and educator, he was highly regarded by patients as well as colleagues. His outside interests included the French language and oenology. He leaves his wife, Marie-Elina.

David Honeybourne, Brian Cooper

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Ursula Rachel Smyth

Accident and emergency doctor Solihull Hospital, West Midlands (b 1923; q Birmingham 1952), died from a malignant neoplasm of the brain on 17 October 2020

Ursula Rachel Smyth (née Mindelsohn) trained as a nurse at the Queen Elizabeth Hospital in Birmingham during the second world war. After five years of nursing she wished she'd studied medicine. While working at the QE after qualifying she met her future husband, Alan Smyth. After her junior posts in Birmingham they moved to Hampton-in-Arden, Warwickshire, where Alan became the GP and Ursula helped run the surgery. After the birth of her children she worked part time at Solihull Hospital for 20 years. Ursula sang in the church choir and Hampton Singers, along with Alan. They regularly attended concerts at Symphony Hall, Birmingham, and enjoyed travelling, walking, and nature. Predeceased by Alan in 2014, Ursula leaves three children, five grandchildren, and four great grandchildren.

Rachel Quick, Roger Shinton

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Brice Pitt

Emeritus professor of old age psychiatry

Brice Pitt (b 1931; q Guy's Hospital Medical School 1955. MD, BSc, FRCPsych, DPM), died from covid-19 on 16 January 2021

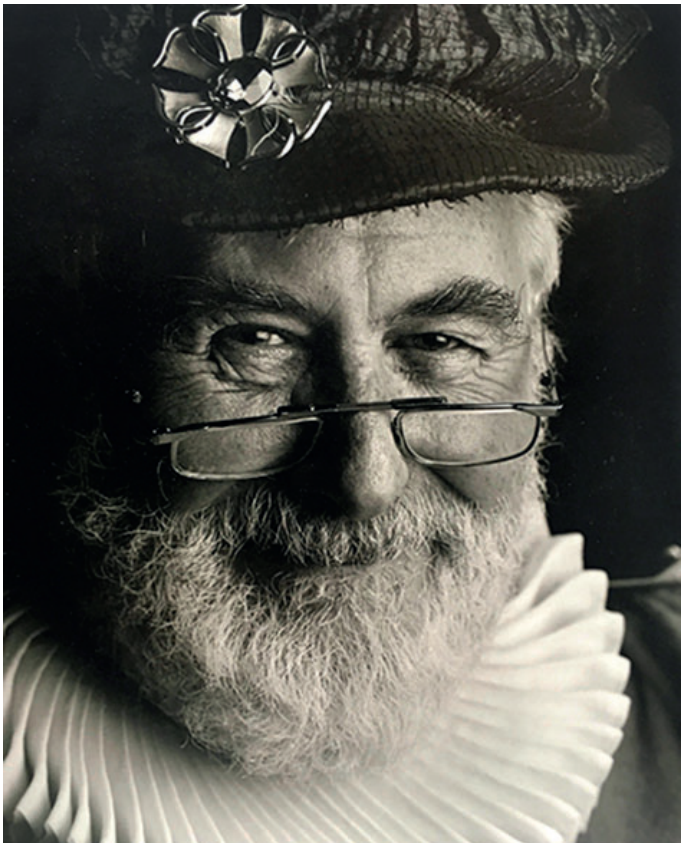
Optimism, Brice Pitt once remarked, "is a piece of evolutionary equipment that carried us through millennia of setbacks." Colleagues found it one of his defining characteristics. "Brice loved everybody and everything," said David Jolley, former chair of the section of old age psychiatry at the Royal College of Psychiatrists. "He loved the world, and was emotionally and spiritually rich."

"He could breeze into any meeting and infuse it with life and cheerfulness," he added.

Writing

A man of wide interests, Pitt, who has died aged 89, wrote widely and with ease for a variety of audiences. "His letters to GPs were works of literary art," said Tim Stevens, consultant in old age psychiatry at St Margaret's Hospital, Epping, Essex, who inherited some of Pitt's patients.

Psychogeriatrics, a textbook first published in 1974, was reprinted five times. As a registrar at St Clement's Hospital in London, he had researched postnatal depression—"far and away the best thing I have done"—and in 1978 wrote *Enjoying Motherhood* for a general audience. He served on the committee of the Association for Post Natal Illness for 20 years, and was its president as well as president of the international Marcé Society. Other books for the general reader included *Midlife Crisis* and *Making the Most of Middle Age*.



GUY DRAYTON

Pitt, whose curiosity about psychiatry was prompted by "Spellbound", maintained a lifelong interest in theatre

In 1992, as part of the Royal College of Psychiatrists' five year Defeat Depression campaign, he wrote *Down with Gloom* with cartoonist Mel Calman. "A gem of a book," according to the *British Journal of General Practice*—author and illustrator both described experiencing depression in the introduction.

As director of public education at the Royal College of Psychiatrists, Pitt also initiated the publication of leaflets for the general public. He was honorary editor of *Old Age Psychiatrist* and chaired the section of old age psychiatry. In 2013 he was awarded the college's old age faculty lifetime achievement award. He made his acceptance speech in verse, describing himself as a Falstaffian figure who was delighted with his career. His novel, *Mordred's Version*, a retelling of the Arthurian legend, written under the pseudonym of Beric Norman, was published the same year.

Early life and career

Born in Wallington, Surrey, in December 1931, Brice was the eldest of five children (two of whom became doctors and three nurses) of surgeon Norman Pitt and his wife, Emily Crawford, a nurse.

After Radnor House prep school, Redhill, he became a boarder at Epsom College, where he appeared in several plays and was set on becoming an actor, before his father directed him to medicine. After qualifying he did national service in Southampton, Singapore, and Hong Kong, undertaking psychiatric training and leaving with the rank of acting major.

After registrar posts he was appointed consultant psychogeriatrician, one of the first such posts, at Claybury psychiatric hospital in Essex, in 1966. He started with 400 beds in 10 wards, and a catchment area of 650 000 across four boroughs. "I had no idea this was an impossible task—because there were no templates. I didn't have anybody to say, 'this is the way you do old age psychiatry,'" he would later recall.

After posts at Princess Alexandra Hospital, Harlow, the Royal London Hospital, and Barts he was appointed professor of old age psychiatry at St Mary's in 1986. After retiring from St Mary's in 1995 he ran a memory clinic at Hammersmith Hospital for six years.

Pitt said that his curiosity about psychiatry was originally prompted by *Spellbound*, the 1945 Alfred Hitchcock film featuring Gregory Peck and Ingrid Bergman as two doctors who fall in love at a psychiatric establishment in Vermont; he maintained a lifelong interest in performance and the theatre. He acted with the Tower Theatre Company of non-professionals for 20 years, in parts including Frank in *Educating Rita*, Badger in *Wind in the Willows*, and Alonso in *The Tempest*.

A friend of the playwright Christopher Fry, Pitt directed his play *The Dark is Light Enough* to mark Fry's 90th birthday in 1997.

He leaves his third wife, Judy; their daughter, Rosalind Gerrie, a counsellor; and two sons and a daughter from his first marriage.

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