Sundays are much better nowadays. They used to start with gentle encouragement for my daughter to practise the piano. Then mild threats. Then bribes. Five minutes of her pressing the wrong keys would be followed by, “Do I have to do it today?” The sunk costs of the grades she’d already done would lead me to exclaim, “Yes!” More grit needed, I’d think.

Monday morning at work, I’d try to put this grit to good use. We all have projects we keep deferring, roles we’ve grown tired of, or entire jobs that just pass the time. Yet we don’t quit. We grit. Because quitting is a dirty word. We think of the time already spent, the progress already made, and the promises to fulfil.

Then one Sunday I said to my daughter, “Fine, don’t do it.” I expected her to back down. But she didn’t. Thankfully. Instead, the time she normally spent on something she didn’t enjoy, and was frankly not very good at, went elsewhere. Now, Sundays are for dancing. She loves it. She’s good at it. She told me that it makes her feel more like her. And the girl who took her spot at the piano is happy, too. The answer wasn’t more grit, but more quit.

As leaders, we’re taught that quitting is failure. Yet I believe leaders are there to help others rise. Those others need a gap to fill. What if you are that gap? In Tim Harford’s excellent podcast Cautionary Tales, he discusses how Nobel prize winners—the ultimate gritters—have a much broader range of superficial interests than colleagues. They dip in and out, rather than staying committed to the end. They quit more.

Grit isn’t all bad, of course. Sometimes it’s essential. The answer is to apply it selectively. Keep trying hard at the things you love, the things you’re good at, or the things that make you feel more like you. Dance if you’re a dancer and not a pianist. At the same time, pass on that project that deep down you know you’ll never complete. Quit the roles that have become dusty and tired, freeing them up for others to love.

Medicine, too, should learn to quit. It can take 17 years to adopt research—yet even longer to stop using outdated treatments. Medicine finds it hard to quit. It needs fewer resilience workshops promoting grit, and more that teach us how to be better at quitting.

Covid-19 has shown us, tragically, that you only live once. In lockdown, some have embraced the JOMO (joy of missing out), replacing their FOMO (fear of missing out). But I’m here to stand up—or rather, sit down—for quitting. Let’s promote JOWO: the joy of walking out. You’re never too old to learn the piano.

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Cite this as: BMJ 2021;373:n1376
PERSONAL VIEW  Simon Williams

Public is given too much responsibility—and blame

Ministers’ emphasis on personal response and “common sense” once again displaces blame for its ineffective reaction to covid-19

In March last year, writing in BMJ Opinion, I argued the government’s focus on avoiding handshakes (while emphasising handwashing and other hygiene measures) as a means to prevent the spread of coronavirus placed too much responsibility on the public at the expense of quick, decisive, and effective policy. We now know the decision to delay lockdown ultimately cost many lives. However, 14 months later, the government is again attempting to shift attention away from its slow and indecisive policies and onto the public through a “personal responsibility” rhetoric, which this time includes a focus on the need for “caution” when hugging.

On 17 May this year the health secretary, Matt Hancock, attributed a majority of hospital admissions with covid in Bolton to vaccine hesitancy, while a senior minister was reported to have referred to those refusing the vaccine as “idiots” who could “ruin it for everyone else.” These comments were reported on the same day that substantial policy restrictions were eased to permit much more indoor socialising.

A week later it was reported that a “stay local” advisory was put in place in eight “hotspot” areas in England where B.1.617.2 (the so called Indian variant) is rising. Here, once more, the emphasis is on the public taking responsibility to be “cautious,” despite the government rolling out a national easing of restrictions only a week earlier.

Of course, maximising vaccine uptake is crucial. However, this focus on vaccine hesitancy and exercising caution detracts attention from the fact that B.1.617.2 should never have been allowed to spread as readily or quickly as it has done in the UK. Several prominent scientists were arguing for India to be placed on the travel “red list” long before 23 April. Moreover, with cases of B.1.617.2 reportedly doubling each week, it seems as though the test and trace system is failing to nip any emerging outbreaks in the bud, as has been the case throughout the pandemic.

Sustained compliance

In March last year, I argued that “the rationale for holding fire on more extensive and mandatory social distancing policies seems to be the government’s belief that people will not be able to sustain compliance over the long haul,” and that there was a lack of strong, transparent evidence for this assumption. We now know the assumption was mistaken, and adherence by the majority of the public has remained remarkably high.

Research I and others have worked on suggests a major factor determining adherence is trust in government. Paradoxically, rather than encouraging uptake, attributing the rise of B.1.617.2 to vaccine hesitancy might become a self-fulfilling prophecy. Research shows a major reason behind vaccine hesitancy is a lack of trust in government.

To complicate matters further, the prime minister’s narrative of exercising “caution and common sense,” while simultaneously easing restrictions, is another example of confusing mixed messages. This confusion partly stems from a disconnect between ministers’ deeds and words. In this case, permitting more activities while simultaneously emphasising their risks. A lack of clear communication does little to help understanding of, and trust in, government measures.

I’ve argued before that there is no such thing as common sense in a pandemic. For many it also shown us the possibility, and benefit, of collaborative change and that the NHS has the ability to lead this change. The pandemic has shown us that large scale public health emergencies can lead to swift, decisive, and collaborative change and that the NHS has the ability to lead this change. The pandemic has also shown us the possibility, and benefit, of

BMJ OPINION  Adrian James

How the NHS can help tackle the mental health crisis posed by the climate emergency

As we increasingly frame the climate and ecological emergency as a health crisis, we must also think about how healthcare can be part of the solution. Currently, the NHS in England accounts for 4-5% of total emissions and is the single largest emitter of greenhouse gases in the UK public sector.

The Sustainable Development Unit and the Greener NHS campaign are helping the NHS move to reach net zero carbon emissions. To support this, the Royal College of Psychiatrists is calling for every NHS organisation, commissioner, and provider to produce a green plan by the end of 2021. The pandemic has shown us that large scale public health emergencies can lead to swift, decisive, and collaborative change and that the NHS has the ability to lead this change. The pandemic has also shown us the possibility, and benefit, of

The preventive ethos must be placed at the heart of healthcare

taking radical action when required, and we need to act now.

Taking a more holistic approach to health creation, health protection, and a service model where prevention is prioritised could be the cultural change needed. A sustainable and positive vision of mental health services will require a greater understanding, adoption, and integration of preventive principles and interventions. This preventive ethos must be placed at the heart of healthcare.

Keeping patients well is the most sustainable thing psychiatrists can do, and social prescribing has the potential to play a substantial part in reframing care to make it more preventive, holistic, and sustainable.
ACUTE PERSPECTIVE David Oliver

Action cannot wait for a covid inquiry

Within weeks of the first UK death from covid-19, calls began for an official inquiry into the government’s pandemic preparedness and response. These calls culminated in the Queen’s speech on 11 May, when Boris Johnson, the prime minister, promised to launch a full public inquiry within a year.

The evidence on the covid crisis given to MPs on 26 May by his former adviser, Dominic Cummings, further revealed a system not fit for purpose and renewed calls for a public inquiry without delay. We undoubtedly need such an inquiry—but shouldn’t we also focus on meaningful action right now to prepare for future pandemic waves?

A statutory public inquiry could demand access to evidence and compel witnesses to appear under oath. Its recommendations would carry some force and require parliamentary debate, with commitment to action by government and other public bodies. It might even lead to primary or secondary legislation or regulatory action.

It might uncover fraud, cronyism, or institutional negligence; serious incompetence or failures to heed expert advice; or faults at the heart of No 10’s decision making. It could provide an action plan for better pandemic preparedness and responses in the future. But there are potential drawbacks.

First, this prime minister and his party have shown they can promise things in a Queen’s speech (for example, social care reform or an NHS workforce plan) and fail to deliver adequately. The inquiry could easily be pushed back further.

Second, governments of all stripes have form in commissioning inquiries and then failing to act on recommendations. See the 2011 Dilnot commission on social care funding and the Lammy report on tackling racial discrimination in criminal justice.

Third, the rigour, detail, and due process inherent in a public inquiry mean that one starting in 2022 could easily drag on until after this parliament.

A public inquiry would fulfil an understandable desire to hold individuals and organisations to account. But I’m more interested in delivering concrete, deliverable plans of action right here, right now, based on what we already know.

A recent National Audit Office report, Initial Learning from the Government’s Response to the Covid-19 Pandemic, set out clear findings and recommendations. It pulled no punches over incompetence, disorganisation, poor messaging, or culpability. The NAO also produced earlier reports on PPE, test and trace, and awarding bodies. It might even lead to primary or secondary legislation or regulatory action.

Although prevention of illness should be prioritised, there is also an issue of how we treat patients who do become ill. Currently procurement accounts for 60% of the carbon footprint of the NHS in England. Psychiatric services need to reassess services and interventions to improve their sustainability.

Another necessary cultural change is to appreciate that the close relation between nature and mental health offers solutions to build a model of healthcare that has co-benefits for our planet. Integration of green spaces into mental healthcare should be central to the 25 year environmental plan. This will help provide treatments and could potentially improve public health, including reducing social inequality.

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I want to see a public inquiry, but I’d prefer plans to get on with meaningful change now and ensure better responses to any further pandemic threat.

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Learning to be a good doctor is a complicated business, one that doesn’t end until the day we retire. As well as understanding how bodies work and go wrong, and what can be done to put them right, we also need to learn many practical skills—how to listen so that patients feel heard, how to examine an abdomen or stitch a wound. While some of this knowledge is found in books or delivered in formal teaching sessions, a huge amount of medical training remains an apprenticeship where we learn from others who already know how to do it.

The problem I currently face is the gap between what I’m trying to teach and the experiences of the people I’m teaching. We’re training our juniors in the skills we value: how to listen with full attention, how to sensitively inquire about psychosocial details that may influence a patient’s presentation. It’s only after gaining the trust of the slightly aggressive man with high blood pressure and a fractured metacarpal that we might hear about the disintegrating marriage, the precarious employment, and the use of alcohol as respite. Once we know this, we may be able to offer more help than a sick certificate and blood pressure pills.

But when do we get a chance to model these skills? And more crucially, beyond the protected 20 minute consultations of the training period, when will our juniors get to use them? During an event on shared decision making, some despairing junior doctors described how the skills they’d enthusiastically learnt as students, and practised through role play, were now atrophying. Nowhere in their hospital had they seen the theory put into practice, and they were reluctantly concluding that little of it was applicable to the real world.

There’s been much talk of doctors’ moral injury incurred in the pandemic. It starts as that horrible, haunting feeling that you haven’t been able to do the right thing for your patients and that some have suffered as a result. In general practice this is now worse than at the height of the pandemic. There’s an increasing mismatch between what patients demand and our capacity to provide it.

On top of this, I’m surely not the only one suffering from pedagogical distress—an awareness that what I’m teaching as good practice departs significantly from what I can offer my patients. There are moments of calm, when I can listen and help without awareness of time, remembering why I like this job, but I worry we may be selling our juniors a lie and setting them up to feel like failures.

If they want to offer the standard of care we train them for—and examine them in—they may have to resign themselves to 12 hour days. Or they can compromise, doing the best they can in the time available. But that’s not what they or their patients would choose.

I worry we may be selling our juniors a lie and setting them up to feel like failures.
over the past year, numerous individuals and institutions have called on governments and other authorities to engage, involve, or include the public in covid-19 response and recovery efforts. In the UK, for instance, the Nuffield Council on Bioethics urged the government to ensure that key decisions about covid-19 are “taken with the widest possible engagement across all sections of society.” In the US, a coalition of more than 100 voluntary associations pressed government agencies to “recommit to, and not retrench from, their duty to include the public” in policy making processes related to the pandemic.

These calls follow a long campaign to increase public engagement in urgent or controversial matters of health and science policy and make an intuitively compelling appeal to democratic values. They rest on the premise that consequential decisions about the response and recovery from covid-19 should not be left to experts but should instead be subject to inclusive debate and deliberation. Public engagement is particularly important during the covid-19 pandemic when the effectiveness of measures such as the wearing of masks, social distancing, and vaccination requires cooperation and trust across all sectors of society.

However, as with previous calls for public engagement, the meaning of “engagement” and its practical implications for covid-19 response and recovery are complex and at times ambiguous. We examine the different types of demands found in calls for public engagement in pandemic decision making and explain how to meet them (table). We focus on the responsibilities of governments because their decisions have far reaching social consequences, but institutions such as hospital systems, schools, corporations, and universities also make decisions that profoundly affect the communities they serve and should engage affected communities in their decision making.

**Key Messages**
- Growing numbers of voices have called on governments and other authorities to engage the public in pandemic response and recovery efforts.
- Transparency about decisions and their ethical framework is essential for engagement.
- Informal discussion through media and public meetings can help ensure success of interventions.
- Formal deliberation methods are slower and may be more suited to longer term planning.

**Transparency**

Common to almost all calls for public engagement in covid-19 response and recovery is a demand for transparency on the part of government officials and other authorities responding to the pandemic. As the Nuffield Council wrote in an open letter to the UK prime minister, government should “show the public what it is doing and thinking across the range of issues of concern.” But a review of decision making related to covid-19 in 24 countries found “little transparency regarding whom decision making bodies are consulting as their source of advice and information.”

Transparency involves the flow of information from government to the public. It does not require that members of the public take an active hand in responding to the crisis but is critical to enabling more direct involvement in at least two ways. First, knowledge of how government agencies are managing the pandemic gives individuals, civil society organisations, and businesses the information they need to play their parts in pandemic response and recovery. Second, transparency allows individuals and institutions outside of government to scrutinise government plans, highlight errors, criticise misguided policies, and recommend alternative courses of action. Several government guidelines on mask wearing, testing, and other areas of pandemic response have been constructively revised in response to public criticism.

Transparency can also build public trust in government. An investigation of public perceptions of the UK government’s covid-19 response found that “the extent to which a government may be able to foster public trust in their responses to pandemics appears to be closely linked to the coherence and transparency of their communication strategies.” Notably, however, the study also found “significant differences in levels of trust across geographical, income and educational backgrounds,” which suggest the need to “develop measures such as targeted community engagement that tailor messaging and public deliberation to the realities faced by particular social groups.”

Municipal and regional governments have a critical role in delivering this type of locally targeted outreach. In the US, several city leaders have partnered with local community and faith based organisations to counter concerns about vaccines among communities with “historical experiences with discrimination.” This is a successful example of a complementary relationship between national and local leaders. While national health agencies have the resources...
to synthesize scientific information into guidelines, local officials need to tailor and explain guidelines to their communities. 16

**Ethical reasoning**

Beyond pushing for transparency about the substance of policy decisions and planning around covid-19, the Nuffield Council called on governments to “set out the ethical considerations” underlying these decisions. 7 This demand is based on the principle that government policies must be justifiable to those affected by them, particularly those negatively affected by a decision.

While it’s tempting to believe that effectively managing the pandemic is simply a matter of following the science, 17 critical questions such as when and under what conditions to reopen businesses or how to allocate vaccine doses are value laden, involving trade-offs between competing goods and interests. 18 Authorities need to justify the selection of a particular course of action not just in technical terms but in ethical ones, and commit to principled decision making.

This promotes accountability by enabling members of the public to pressure authorities to live up to their stated principles. For example, criticisms of the UK government’s handling of covid-19 in adult social care settings noted that, although the government espoused a commitment to be “transparent about why decisions are made and who is responsible for making and communicating them,” it failed to provide “detail on how a decision was taken to leave

| Public engagement on response to covid-19 |
|-----------------------------|-----------------------------|
| **Elements of engagement** | **Responsibilities** | **Examples** |
| Transparency | • Hold regular press briefings on policy and planning decisions | • Norway’s government developed a covid-19 information website that includes information on national response measures as well as a special section directed towards families and children and a section where users can follow live press conferences* |
| | • Promptly publish relevant data and draft proposals online | • Canada’s Department of Justice created a webpage that allows citizens to easily access “all of the legislative and other measures related to covid-19”19 |
| | • Partner with local stakeholders and community organisations to deliver targeted messaging | |
| Ethical reasoning | • Articulate the ethical values and frameworks informing policy decisions | • US Centers for Disease Control and Prevention’s advisory committee on immunization practices uses an open process to develop and review its ethical framework for vaccine allocation. All committee meetings are open to the public, and meeting minutes and archived webcasts are available online; members of the public are invited to submit written and oral comments to the committee; and the committee includes 30 non-voting representatives from liaison organisations intended to “facilitate engagement with professional medical and public health organisations and other stakeholders and partners” |
| | • Acknowledge trade-offs between competing goods and interests and explain how they will be navigated | |
| Informal deliberation | • Foster informal deliberation by meeting demands for transparency | • Several governments, including those of Estonia, Korea, Norway, Canada, Germany, and Italy, have developed apps, websites, and portals for citizens to call or submit questions and comments, including proposals for ideas, feedback, or services* |
| | • Respond to questions and concerns emerging from the public sphere | • In Providence, Rhode Island, city officials worked with local neighbourhood and faith leaders to arrange meetings where members of minority communities could raise questions and concerns about vaccination to state health professionals* |
| | • Remain mindful of underlying power dynamics with the potential to influence public discourse and seek out under-represented voices | • Scotland’s Citizen Assembly, already in existence before the pandemic, turned its attention to discussing the effect of covid-19 and how it may influence views on what is important for the future of the country11 |
| | • Clearly communicate how the outputs of mini-publics would be used to inform decision making | • France set up a 35 person citizens’ panel to help steer government strategy on covid-19 vaccinations12 |

* Authorities need to justify the selection of a particular course of action not just in technical terms but in ethical ones, and commit to principled decision making

Informal deliberation

While some calls for public engagement in the covid-19 response emphasise governments’ responsibility to share information with the public, others emphasise ways that the public should be actively involved. These often appeal to ideals of deliberative democracy, arguing that citizens can and should engage in politics not just by voting in elections but through ongoing debate and discussion. This can happen through “informal” types of deliberation across civil society and “formal” deliberation involving structured dialogue in institutional settings. 14 Informal deliberation about covid-19 encompasses activities ranging from small scale conversations in online forums to opinion articles in national media and organised demonstrations. Informal deliberation can enhance institutional decision making by contributing information and perspectives that are not represented by experts and policy makers. As New York City moved to lift restrictions on businesses, for example, essential workers, advocates, and unions organised to demand workplace protections and to pressure state and local officials to enact regulations requiring employers to comply fully. 15 By participating in this sort of deliberation, citizens communicate the challenges they face from covid-19 and apply political pressure to authorities responsible for addressing those challenges. Governments have a central role in fostering informal deliberation by meeting demands for transparency by responding to questions and concerns emerging from...
the public sphere. But it is also critical that they remain aware of how underlying inequalities and power dynamics shape public discourse. Informal deliberation often amplifies the voices of those with greater resources and access to media platforms while crowding out the voice of marginalised groups that have been hardest hit by the pandemic and whose voices are crucial to designing equitable policy responses. Similarly, while events like virtual townhall meetings can provide a forum for community members to share their concerns and experiences, they perpetuate disparities in access to technology and the internet, widening existing gaps.

Given these structural inequalities, responsible informal deliberation requires seeking out perspectives of disadvantaged groups that are often under-represented in the media, public meetings, and digital platforms. Doing so requires soliciting input across “multiple, accessible channels,” including community events and faith based gatherings. Authorities should work with non-profit and academic organisations that have compiled testimonies from disadvantaged communities. In the UK, for example, National Voices, a coalition of organisations “supporting people with physical and mental health problems and disability and those who are facing inequality or discrimination,” collects and publishes first person accounts of people’s challenges and experiences during covid-19. In the US, the Black America and Covid-19 Project collects and publishes evidence of the effect of covid-19 on the Black community with the goal of creating “material for teaching and learning about the contemporary effects of covid-19 among Black communities as it is tied to the historical legacy of race in America.”

### Formal deliberation

Finally, some calls for public engagement urge governments not simply to foster or engage with informal deliberation, but to convene formalised deliberative bodies, also called mini-publics. These are small groups of people (from around 10 to several hundred) who are selected, often at random, to engage in facilitated deliberation about policy topics related to covid-19.

Formal deliberative mechanisms create environments in which citizens with different backgrounds and identities are placed on equal footing and given the opportunity to learn from experts and share their perspectives on complex policy matters. Ideally, participants in mini-publics refine and revise their views through conversation with their peers, such that their recommendations or outputs can be said to reflect the “considered views” of participants.

Encouraged by recent successes of mini-publics, some believe that formal deliberation can inform covid-19 responses. In the UK, for example, local officials commissioned a 36 member citizen’s panel to consider evidence and weigh trade-offs in different recovery plans before forwarding a set of recommendations to the local recovery authority. Similarly, Oregon convened a seven day citizens’ assembly which developed a set of core principles and actionable recommendations to guide the state’s pandemic response and recovery plans with respect to housing and education.

Despite their potential to capture a range of perspectives and to generate nuanced and considered feedback, mini-publics require substantial time, planning, and financial resources to succeed. This limits their use in responding to urgent problems during a public health crisis, and they should not be viewed as a substitute for other aspects of public engagement.

Before convening a mini-public, governments should identify particular questions or policy decisions for which the considered opinions of a diverse group of lay participants would be illuminating and how those opinions would be used to inform policy. In light of their strengths and limitations, mini-publics may be best suited to reviewing failures, success, and lessons from the current pandemic in order to prepare better for the next emergency.

The ongoing process of responding to and recovering from the covid-19 pandemic should not be managed by policy makers and experts alone. It will continue to require extraordinary levels of communication and coordination across all levels of society. Governments and other authorities can realise these goals only by recognising and taking steps to meet demands embedded in calls for public engagement. Consolidated research suggests this is crucial.

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Cite this as: BMJ 2021;373:n1207
LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Structural racism hide and seek

Gopal and Rao made me reflect on five UK reports published in the past year, generating controversy about institutional and structural racism (Editorial, 1 May).

The government commissioned Public Health England (PHE) to report on inequalities in covid-19, including ethnicity. The report was criticised for having no recommendations and no reference to extensive public consultations by PHE. A second report, including the consultations with more than 4000 people, emphasised racism. The paragraph preceding the recommendations stated: “Throughout the stakeholder engagement exercise, it was both clearly and consistently expressed that, without explicit consideration of ethnicity, racism, and structural disadvantage in our responses to covid-19 and tackling health inequalities, there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention.”

The government then delivered two reports through the Race Disparities Unit of the Cabinet Office, showing progress in tackling covid-19 but largely denying racism. Media coverage was dominated by arguments over such denials. The fifth report, included a comprehensive review of health status and inequalities is difficult to demonstrate empirically, the strongest evidence being in mental health.

The UK does not have large scale, ongoing quantitative data collection on racism that can be linked to health status databases to test hypotheses—a long recognised but largely unresolved problem. We should aim for progress towards validated questions on racism in our national social and health surveys, potentially for inclusion in the 2031 national censuses.

Raj S Bhopal, emeritus professor of public health, Edinburgh

Cite this as: BMJ 2021;373:n1340

STRUCTURAL RACISM

 Cumulative harm over a lifetime

UK healthcare may owe a great debt, in future, to the perceptive analysis of Gopal and Rao (Editorial, 1 May).

Prejudice has been poisonous to the care of some communities for a long time, and the government has institutionalised this around healthcare for “migrants.”

I am especially concerned that young people can internalise the prejudice of adults they encounter; people in positions of authority are likely to be “British white.” Structural racism might be most destructive when privilege and professional power add to an ethnic disadvantage. That inequality is most stark where professionals can use compulsion to detain young men of West Indian or West African heritage. Hopefully people from these backgrounds were empowered to participate in the consultation on reforming the Mental Health Act.

An Office for Health Disparities could remove structural barriers to health but needs to understand the cumulative harm that can occur across the lifespan.

Woody Caan, retired professor of public health, Duxford

Cite this as: BMJ 2021;373:n1341

Change must start in medical school

Covid-19 has had a disproportionate effect on ethnic minorities (Racism in Healthcare, 24 April). The reasons for this are complicated and multifaceted, but we need to learn from covid-19 and tackle the reasons that ethnic minorities have considerably worse healthcare outcomes.

Change must start in medical school. I have had no communication teaching for people who don’t have English as their first language. Every picture bar two in my online dermatology training showed a pathology in a white person, despite dermatological conditions presenting very differently in ethnic minorities. In my psychiatry placement, no thought was given to why black people are much more likely to be detained under the Mental Health Act.

I could go on. Not equipping the doctors of tomorrow with the skills to treat a substantial minority is a scandal. While medical education only focuses on treating the white majority, we will continue to have these conversations.

George Penty, fourth year medical student, Manchester

Cite this as: BMJ 2021;373:n1362

WORLD HELP TO INDIA

Learning from humanitarian disasters

Observing the unfolding tragedy in India is like watching the news of a humanitarian disaster such as an earthquake or tsunami—the sheer scale necessitates an international response (The Big Picture, 1 May).

The failure to learn from humanitarian disasters ultimately costs lives; negatively affects women, children, older people, and other marginalised groups of society; and widens the divide between those who have and those who do not. In a country such as India, which has endemic societal inequality, the response will inevitably further exacerbate the divide, unless mitigating steps are taken.

Applied learning from the humanitarian sector would help to ensure that we don’t fall into the trap of contributing to a shortsighted foray into chaos and secure the need for resilience and recovery. This is one way in which India could regain global leadership, thereby avoiding being relegated to another “lessons learnt” exercise and a familiar failed response.

Najeeb Rahman, consultant in emergency medicine, Leeds

Cite this as: BMJ 2021;373:n1316
CONCERN ABOUT LATERAL FLOW TEST USE

Limitations of covid-19 pilot events
We note the image of the spectator crowd attending the English League Cup final on 25 April (right, This Week, 1 May). This was a pilot event to investigate the safe return of supporters to stadiums. Measures to mitigate covid-19 transmission included pre-attendance lateral flow tests and the wearing of face coverings.

The image showed about 125 spectators with evident limitations of social distancing; about half were wearing face coverings correctly. About 29% were not (no mask or mask not covering both mouth and nose), and the rest could not be seen. This crowd is likely to be shouting, projecting respiratory droplets across further distances.

The absence of linked covid-19 cases or clusters after the pilot events might be because no infectious people were present, rather than successful mitigation measures. Evaluation of these pilot events must consider the limitations of the data collected and real world adherence to intervention measures.

Keely McCarthy, senior improvement manager, Improvement Cymru; Llion Davies, public health consultant, Knowledge Directorate, Public Health Wales
Cite this as: BMJ 2021;373:n1366

Inappropriate use of LFTs
Concerns have been raised about the use of lateral flow tests in the government’s mass testing programme as a means of facilitating the easing of lockdown.

As a GP, I have encountered patients using these tests, largely for work based asymptomatic testing. But I am now seeing patients who have symptoms that could be due to covid-19 and are undertaking lateral flow tests in lieu of booking PCR tests. These patients are potentially falsely reassuring themselves that they do not have covid-19. As a result, they do not self-isolate and are potentially spreading the virus.

As professionals, we are aware that the sensitivity of these tests for detecting covid-19 is very low. But we cannot expect the public to know this. The government should make a concerted effort to educate the public on the intended use of these tests. This should probably be backed up by public health and healthcare input.

Milan Dagli, GP, GP at Hand
Cite this as: BMJ 2021;373:n1370

TRAINING IN CRISIS

A pilot surgical simulation training initiative
Munro and colleagues list strategies for mitigating the negative effects of the covid-19 pandemic on surgical training (Editorial, 27 March).

We are piloting a plan to incorporate remotely supervised surgical simulation training into weekly deanery-wide teaching. Each trainee will be provided with simulation models and suturing equipment and can be supervised using a videoconferencing platform linked to a training microscope camera. A syllabus is being developed to cover essential surgical skills specified in the training curriculum.

Funding is an important consideration. Sources might include underused study leave budgets and charitable funds. When applying for funding, it might be useful to emphasise that simulation is cost effective and enhances patient safety. We advocate maximising cost effectiveness and minimising waste by reusing equipment for multiple simulated procedures.

These innovations can also be expanded beyond covid-19. We encourage trainees to participate in developing simulation practices in their region and driving this initiative forward.

Aoiife Naughton, ophthalmology specialty trainee year 6, Aylesbury; Aisling Higham, ophthalmology specialty trainee year 6; Ariel Yuhan Ong, ophthalmology specialty trainee year 3, Oxford; Martin Wasik, consultant ophthalmologist and simulation lead for Oxford Deanery, Aylesbury
Cite this as: BMJ 2021;373:n1301

MASS SCREENING

We still lack a coherent covid-19 strategy
Raffle and Gill shine an uncomfortable light on a major strand of UK government policy—mass screening for asymptomatic SARS-CoV-2 infection (Editorial, 1 May).

Presumably there are convincing counter arguments or we would not be spending so much energy and money pursuing mass screening, but it is hard to identify them.

More than a year into the pandemic, this is shrouded in controversy. We still lack a coherent and clearly articulated strategy that is securely based on public health principles and promoted from the heart of government. Instead, public debate is conducted by an assortment of distinguished advisers with different connections to the Scientific Advisory Group for Emergencies and its subgroups, “speaking in a personal capacity,” whereas the chief medical officer and colleagues’ principal roles seem as adjuncts to Downing Street press conferences.

There is little reason to believe that the new Health Security Agency will fill this gap.

Graham Winyard, former deputy chief medical officer, Winchester
Cite this as: BMJ 2021;373:n1355

CLINICAL EXCELLENCE AWARDS

Iniquitous, opaque, and akin to cronyism
Essex and colleagues shine a long overdue spotlight on the Clinical Excellence Awards (CEA) scheme (Analysis, 1 May). The scheme is iniquitous, opaque, and akin to cronyism. Vested interests and the risk of antagonising influential leaders mean that the BMA and royal colleges remain unwilling to tackle the issue.

As a former member of my local CEA committee, I found that people who were “well connected” or able to blow their own trumpet were much more likely to get an award. This would sometimes lead to friction and divisiveness. The detrimental effects of this on patient care should not be underestimated.

The first step is to recognise and admit the flaws of the scheme and acknowledge that it is not fit for purpose. Whether it is replaced, and what with, is a separate issue. The status quo is unacceptable if we truly believe in equity, justice, and transparency.

Fraz A Mir, consultant physician, Cambridge
Cite this as: BMJ 2021;373:n1328
OBITUARIES

Iain Hayden Arthurson
General practitioner (b 1939; q Edinburgh 1962; DA), died postoperatively after mitral valve surgery, during which time he contracted covid-19, on 30 October 2020
Iain Hayden Arthurson (“Hayden”) was a partner at the Ladywell Medical Centre East in Corstorphine, Edinburgh. He enjoyed the great range and variety of his work. He retired after approaching 30 years in practice and then worked with the Benefits Agency, along with carrying out medicals for army recruitment. Hayden was a great storyteller, a master mimic, and could be screamingly funny. Another skill was playing the accordion, which he did regularly at hostleries on the Royal Mile. Hayden had two sons with his wife, Margaret, the younger of whom, Michael, sadly died from a cerebral tumour as a 7 year old. His first marriage ended in divorce. Hayden leaves his second wife, Colette; his son; and two granddaughters.

Ken Stewart
Cite this as: BMJ 2021;372:n767

Robert John Ham
Consultant vascular surgeon (b 1948; q London Hospital Medical College 1972; DRCOG, FRCS), died from renal cancer after a short illness on 16 January 2021
Robert John Ham (“Bob”) possessed a rare combination of the gifts of judgment, insight, empathy, and humour. He had an encyclopaedic knowledge of surgery, together with a good appreciation of most medical conditions. He was never an enthusiastic administrator but when called on to carry out such duties he did so well. When the Helicopter Emergency Medical Service was established at the Royal London Hospital, he took up his trauma duties with enthusiasm and efficiency. He had a slightly waspish and quite quirky sense of humour, which was always appreciated by his colleagues. Having retired in 2007, he had recently moved to Wiltshire and just settled into his new home when he died, quite suddenly. He leaves his wife, Rosalind.

Frank Cross
Cite this as: BMJ 2021;372:n763

Keith Llewellyn Rogers
Consultant pathologist (b 1930; q Middlesex Hospital 1954; FRCPath), died from progressive frailty of old age on 23 October 2020
Keith Llewellyn Rogers became director of the South London Blood Transfusion Centre in its new premises in Tooting in 1970. For the following 20 years he drove the centre through the modernisations and innovations needed to safely meet evolving clinical demand for blood products. He married Frances in 1962. Three children and many French holidays followed before the pair separated 25 years later. After taking early retirement in 1991, Keith built a single life around family, friends, travel, classical music, cooking, and computers. In 2003 he married Ewa Brookes (former director of the East of Scotland Transfusion Service) and they relocated to Dundee. He leaves Ewa, Frances, three children, eight grandchildren, six digital cameras, three computers, an iPAD, and his adored copy of ANGOSS SmartWare.

Jeremy Rogers, Ewa Rogers
Cite this as: BMJ 2021;372:n761

John Michael Welchman
Consultant radiologist (b 1920; q University of the Witwatersrand, Johannesburg, South Africa, 1950; DTM&H, DMRD), died from covid-19 on 5 February 2021
John Michael Welchman joined the British Colonial Service in 1953 and was allocated Uganda, a British protectorate. He worked for what is now called the Department of International Development for 11 years. He was part of the first cohort of overseas trained radiologists, supervised by visiting professors from the UK, and returned to the UK for exams and courses. From 1960 to 1964 he worked as a specialist radiologist in the newly established x-ray department at Mulago Hospital in Kampala. He returned to South Africa to work in Durban, where he took charge of the computed tomography head scanner. He leaves Betty, his wife of 74 years; three children; eight grandchildren; and three great grandchildren.

Jenty Young
Cite this as: BMJ 2021;372:n770

Stuart Menzies
General practitioner North Shields (b 1939; q 1962; MRCGP), died in hospital after experiencing the effects of covid-19 on 4 January 2021
Stuart Menzies studied medicine at the University of Durham and came to North Shields in 1965. He had spells as a police surgeon and as an officer on the local medical committee, and maintained a thoughtful eye for practice development. He championed the role of the practice nurse, saw the benefits in practice based diabetes clinics, and was involved in medical audit. He instigated regular multidisciplinary team meetings and retired in 1999. Stuart was a committed Christian and an elder and lay preacher in the North Shields Christian Fellowship. Stuart was also a scholar with an enduring interest in the history of medicine and a great interest in medical philately. Stuart’s wife, Sylvia, predeceased him in 2019. He leaves three children and six grandchildren.

Andrew Bates
Cite this as: BMJ 2021;372:n762

John Tanat Williams
Consultant surgeon and administrator Russells Hall Hospital (b 1940; q Welsh National School of Medicine, 1966; FRCS Ed, FRCS Eng), died from pneumonia secondary to chronic lymphatic leukaemia on 26 December 2020
John Tanat Williams was appointed to the newly built hospital at Russells Hall in Dudley in 1980 and immediately became medical director of the clinical commissioning team. He oversaw the creation of new surgical facilities and the establishment of a new department of gastrointestinal endoscopy. These tasks he completed with tact and ability. After relinquishing his management post he continued in colorectal and breast surgery, especially in cancer. His retirement was a loss to many who missed his gentle Welsh cadences, compassion for patients, and understated humour. He leaves his wife, Anne, a general practitioner whom he met at medical school; and three children.

Adrian Hamlyn
Cite this as: BMJ 2021;372:n760
Caldicott knew the public have to trust clinical staff and, by extension, what happens to their medical records

Fiona Caldicott
President of the Royal College of Psychiatrists and the first national data guardian

Dame Fiona Caldicott DBE (b 1941; q 1966; DBE, BM, BCh, MA, MD (Hon), DSc (Hon), FRCPsych, FRCP, FRCPI, FRCGP, FMedSci), died from pancreatic cancer on 15 February 2021

In November 2018 the Royal College of Psychiatrists honoured Fiona Caldicott with a lifetime achievement award. She was the college's first female dean in 1990 and its first female president in 1993.

She led many public bodies, and her name is enshrined in data protection: today patients’ confidential information is protected by the Caldicott principles, which are upheld by Caldicott guardians. Her skills in psychiatry, where she was one of just three female part time trainees in the Midlands.

Early days
Fiona Soesman was born in Troon, Ayrshire, on 12 January 1941. Her parents, Joseph and Elizabeth, had moved there when Joseph (who later became a barrister) was working in munitions. In 1944 the family moved to Ilford in east London, and her sister, Judith, was born in 1946. Fiona won a local authority scholarship to the City of London School for Girls and rose to be head girl. She had to retake an A level, needed to study medicine at St Hilda's College in Oxford. Much later, when speaking at schools, she liked to use this to motivate pupils, saying, “You can fail an A level and still get to be head of an Oxford College.”

In 1965 Fiona married Robert Caldicott, who ran a family wine business, and the couple set up home in Warwickshire. They had two children. After qualifying, Caldicott worked as a GP, which she found invaluable, saying it was “something every doctor should do,” before specialising in psychiatry, where she was one of three female part time trainees in the Midlands.

Leadership
In 1976 Caldicott was offered a place on the Department of Health and the BMA’s central manpower committee. She joined, saying, “I was interested in how things worked,” and shone a light on the need for more psychiatrists throughout the UK.

She became a consultant psychiatrist and psychotherapist in Birmingham and in 1990 was elected dean of the Royal College of Psychiatrists. It was a difficult year—her son, Richard, had just died in an accident—but she accepted nonetheless, shuttling between London and her home in Warwickshire.

In 1996, concerns about the potential of IT systems to spread data indiscriminately led the chief medical officer for England and Wales to commission a review into how confidential patient records might be protected.

Caldicott, who in 1995 had become chair of the Academy of Medical Royal Colleges, was invited to chair a committee of 50 experts and make recommendations. She knew the public have to trust clinical staff and, by extension, what happens to their medical records.

Bringing integrity and clarity to the role, she reconciled differing views and produced a report, which the Department of Health accepted. The six “Caldicott principles,” as they became known, state that confidential patient information should only be shared when necessary, for a justifiable purpose, and access should be on a need-to-know basis. It recommended each NHS organisation have a senior person act as “guardian” to uphold the principles. They quickly became accepted, so much so that in 2012-13 Caldicott led a second review, resulting in a seventh principle to prevent staff (they had been employed by mental health trusts).

The Caldicott principles were enthusiastically adopted, so much so that in 2012-13 Caldicott led a second review, resulting in a seventh principle to prevent staff interpreting the confidentiality guidance too rigidly. It said the duty to share information in the patient’s interest is as important as to protect confidentiality.

Caldicott felt passionately about the need for transparency, and recommended an eighth principle, accepted last December, which stated patients should be informed about how and why their confidential information is used.

In 2014, Caldicott was appointed national data guardian and was confirmed as the first statutory holder in 2019. She was to stay in this role until March 2021, but in the latter half of 2020 she became unwell with pancreatic cancer. She leaves her husband, Robert, and their daughter.

Penny Warren, London

Cite this as: BMJ 2021;372:n665