Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

It is unhelpful to characterise lockdown scepticism as a neoliberal political stance. Lockdown is demonstrably not egalitarian in either its costs or its benefits. We must assess lockdowns and other measures holistically,[6] remembering that the costs will mostly fall, as ever, on the global poor.

We declare no competing interests.

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Ethnic disparities in COVID-19 mortality: are comorbidities to blame?

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On June 2, 2020, Public Health England (PHE)[1] reported on the disparities in the risk and outcomes of COVID-19. After adjusting for sex, age, deprivation, and region, people from a Black, Asian, and Minority Ethnic (BAME) background had a higher risk of death from COVID-19 than White British people. This analysis did not adjust for comorbidities, and the PHE report highlighted this to be an important limitation as comorbidities were postulated to be "more commonly seen in some BAME groups".[1]

PHE[1] refers to a study from the COVID-19 Clinical Information Network (CO-CIN), led by Harrison and colleagues,[2] of the difference in survival from COVID-19 associated with membership of an ethnic group. In this study,[2] once comorbidities were accounted for, there was no difference in COVID-19 mortality between ethnic groups. This initially appears to support PHE's conclusion that differences in the distribution of comorbidities may account for the increased COVID-19 mortality of BAME patients.

However, in CO-CIN's analysis[2] of more than 14 000 patients with COVID-19 admitted to UK hospitals, BAME patients were more likely to have diabetes, but less likely to have other comorbidities such as chronic cardiac, pulmonary, kidney, and neurological disease, malignancy, and dementia. In the multivariate analysis of risk factors for COVID-19 mortality, the adjusted hazard ratio for diabetes (1·11) was less than that for chronic cardiac (1·20), pulmonary (1·24), and kidney disease (1·28), and dementia (1·40), and equal to the adjusted hazard ratio for malignancy (1·11).

Furthermore, age was by far the largest contributor to risk of death, with an adjusted hazard ratio of 9·09 for patients aged 70–79 years and 11·72 for those aged 80 years and older, compared with people younger than 50 years. 60·7% of White patients admitted to hospital with COVID-19 were aged 70 years and older, compared with 30·7% of Black, 29·2% of Asian, and 35·2% of Minority Ethnic patients.

As patients from a White ethnic background were more likely to be older and have comorbidities associated with a higher risk of dying from COVID-19, it is very concerning that the case fatality at 30 days after hospital admission for COVID-19 appears to be the same in Black and White patients.[2] The lack of association between ethnicity and COVID-19 mortality after adjustment for comorbidities is not reassuring. This suggests that research into ethnic disparities in COVID-19 mortality must consider social as well as biological factors.

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The ongoing torture and medical neglect of Julian Assange

On Feb 17, 2020, Doctors for Assange demanded an end to the torture and medical neglect of Julian Assange.[1] Yet no responsible authority has acted. Nils Melzer, the UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, and two medical experts visited Mr Assange in prison in May, 2019, concluding that his treatment constituted psychological torture, a form of torture aimed at destroying the personality of an individual.[2] The situation has deteriorated since then, with continued abuses of Mr Assange's fundamental rights and the medical risks posed by COVID-19.

Since February, 2020, there has been a string of hearings in the context of Mr Assange's US extradition trial. A timeline is provided in the appendix. His treatment throughout has been described as "shocking and excessive" by the International Bar Association's Human Rights Institute (IBAHRI).[3] He has been held in a bulletproof enclosure unable to fully hear proceedings and denied meetings with his lawyers. He was strip-searched, handcuffed 11 times, moved to five different holding cells, and had privileged client–lawyer communications seized.[3]

Mr Assange attended, by videolink due to ill health, only one hearing, missing the four following hearings because of COVID-19-related restrictions and medical risks.

Prison lockdowns in the UK have prevented meetings with his lawyers to prepare for future hearings. These irregularities and excesses cause helplessness, arbitrariness, threat, and isolation, all key components of psychological torture.

Mr Assange is at grave risk from contracting COVID-19. As he is non-violent, being held on remand, and arbitrarily detained according to the UN Working Group on Arbitrary Detention,[4] he meets internationally recommended criteria for prisoner release during COVID-19.[5,6] A bail application with a plan for monitored home detention was refused, however, and Mr Assange is held in solitary confinement for 23 h each day.

Isolation and under-stimulation are key psychological torture tactics, capable of inducing severe despair, disorientation, destabilisation, and disintegration of crucial mental functions. Given recent attacks against journalists, the psychological torture of a publisher and journalist sets a precedent of international concern.

Human rights organisations and others have called for Mr Assange's release and condemned the extradition proceedings. Amnesty International has advocated for Mr Assange's release on bail.[5] The Council of Europe considers[7] Mr Assange's treatment to be among "the most severe threats to media freedom".[8]

We reiterate our demand to end the torture and medical neglect of Julian Assange.[1] IBAHRI states that, in view of Mr Assange being a victim of psychological torture, his extradition to the USA would be illegal under international human rights law.[3] The World Psychiatric Association emphasises that withholding appropriate medical treatment can itself amount to torture,[9] and under the Convention Against Torture, those acting in official capacities can be held complicit and accountable not only for perpetration of torture, but for their silent acquiescence and consent.

As physicians, we have a professional and ethical duty to speak out against, report, and stop torture.[10,11] Silence on Mr Assange's torture might well facilitate his death.[12] The silence must be broken. Now. Please join us!

We are members of Doctors for Assange. This Correspondence has 216 signatories, representing 33 countries. A longer version of this Correspondence and the list of signatories is available in the appendix.

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See **Online** for appendix

For the **Convention Against Torture** see https://www.ohchr.org/en/professionalinterest/pages/cat.aspx

Time for WHO to declare climate breakdown a PHEIC?


Bay Ismoyo/Contributor/Getty Images

At the opening plenary of the World Health Assembly in May, 2019, Richard Horton urged member states and the Secretariat of WHO to recognise climate change as a planetary emergency. A few days later, during a side event on air pollution, climate change, oceans, and health sponsored by the Government of Sweden, the Minister of Health for the Seychelles Jean Paul Adam argued that climate change has to be recognised as a public health emergency at the international level. Johan Giesecke[1] once stressed that as public health emergencies of international concern (PHEICs) evolve into more complex forms, it becomes necessary to identify gaps in