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.

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COVID-19 and the anti-lessons of history

Published **Online** March 2, 2020 https://doi.org/10.1016/S0140-6736(20)30468-2

This online publication has been corrected. The corrected version first appeared at thelancet.com on March 16, 2020

As the outbreak of coronavirus disease 2019 (COVID-19) in China's Hubei province continues and new cases of the disease increase globally,[1] there is pressure on historians to show the value of history for policy. How can the past assist in the real-time management of the crisis? What insights can be gleaned from the ongoing epidemic for future disease preparedness and prevention? Lurking in the background of these interrogatives is a more or less explicit accusation: why haven't past lessons been learned? The gist of some commentaries seems to be: "there is almost nothing surprising about this pandemic".[2] The history-as-lessons approach pivots on the assumption that epidemics are structurally comparable events, wherever and whenever they take place. The COVID-19 outbreak "creates a sense of déjà vu" with the 2003 outbreak of severe acute respiratory syndrome (SARS).[3] Citing early estimates of the disease's infectiousness, based on an analysis of the first 425 confirmed cases in Wuhan,[4] comparisons have been drawn with the 1918–19 influenza pandemic.[5]

Anthony Wallace/Contributor/Getty Images

Although in some respects the outbreak of COVID-19 presents a compelling argument for why history matters, there are problems with analogical views of the past because they constrain our ability to grasp the complex place-and-time-specific variables that drive contemporary disease emergence. A lessons approach to epidemics produces what Kenneth Burke, borrowing from the economist and sociologist Thorstein Veblen, called "trained incapacity"—"that state of affairs whereby one's very abilities can function as blindnesses".[6] Habitual modes of thinking can diminish our capacity to make lateral connections. When the present is viewed through the lens of former disease outbreaks, we typically focus on similitudes and overlook important differences. In other words, analogies create blind spots. As Burke commented, "a way of seeing is also a way of not seeing—a focus on object A involves a neglect of object B".[6]

A lessons approach to the past, which usually comes from outside the discipline of history, reinforces an idea of the past as a series of interlinked crises that offer instructive insights into cause and effect.[7] Historians need to push back against easy analogies and examine the specific contexts of outbreaks, asking, for example, in what ways SARS and COVID-19 are in fact comparable. The designation of the new virus as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) by

the International Committee on Taxonomy of Viruses[8] recognises it as genetically related to but different from severe acute respiratory syndrome coronaviruses (SARS-CoVs).

What is striking, but too little commented on, are the differences between the historical moments of the emergence of SARS and COVID-19. The SARS outbreak occurred in late 2002 and 2003, not long after China had resumed sovereignty over Hong Kong in 1997. Under the terms of the Sino-British Joint Declaration signed between the Chinese and UK Governments in December, 1984, the former British colony was guaranteed the status of special administrative region. In March, 2003, Hu Jintao formally succeeded Jiang Zemin as President of China. Although the Chinese Government was initially condemned for withholding information and concealing the extent of the SARS epidemic,[9] the early 2000s saw China's increasing international engagement. China acceded to the World Trade Organization in 2001, the year that Beijing was elected to host the 2008 Summer Olympics.

Over the past 7 years, China's President Xi Jinping has sought to extend Chinese influence abroad while tightening his grip on power at home.[10] Some would argue that this enhanced authority has enabled him to put in place draconian, Mao-style infectious disease containment measures including the lockdown of cities.[11] Bruce Aylward, a senior adviser to WHO's Director-General who co-led the WHO-China Joint Mission on COVID-19 in late February, 2020, praised China's efforts as "probably the most ambitious, and I would say, agile and aggressive disease containment effort in history".[12]

Meanwhile, the protests in Hong Kong from June, 2019, have been a reaction to a perceived erosion of the territory's quasi-autonomy as a special administrative region. While ostensibly an anti-government protest against the introduction of an extradition bill, the Hong Kong protests could be viewed as an attempt to push back against Xi's expansion of central power.[13] Concurrently, a US–China trade war instigated by President Donald Trump's imposition of tariffs on China in 2018 is hitting the Chinese economy.[14] The COVID-19 outbreak is compounding this economic situation, holding out the potential for a global recession with major disruption to global supply chains.[15]

Taken together, these entangled circumstances have created a unique setting in which the COVID-19 outbreak is evolving. In an interview with the Hong Kong newspaper *Ming Pao*, the physician Joseph Sung, who had a leading role in the fight to contain SARS in 2003, underscored the striking differences between Hong Kong society then and now. "At that time, society was more united", Sung said of the SARS era, "whereas now people feel they have to rely on themselves for protection. They have less trust in the government".[16]

Analogies of COVID-19 are rarely extended to encompass these intermeshing social and political environments. The lessons approach skates over this history, even as history's expediency as a tool for instruction is flaunted. Historians need to contest false analogies that obscure, rather than elucidate, the social processes partly driving new infections. They need to challenge efforts to corral and straitjacket the past into summary lessons. By contrast, espousing an anti-lessons approach to history might prevent trained incapacity. Such an approach could help to ensure a strategic open-mindedness to emergent threats at a time when borders of many kinds are going up across the globe.

I declare no competing interests.

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Global commitments to disability inclusion in health professions

See Online for appendix

Recognition of the need for equitable health care for people with disabilities and the need to appropriately educate the health-care workforce has emerged over the past few decades.[1–3] Although people with disabilities experience the same general health-care needs as other people, they are more likely to experience health-care inequities due to the inadequate skills and knowledge of health-care providers and inaccessible health-care facilities.[4] In 2009, an art of medicine essay in *The Lancet* by Tom Shakespeare and colleagues[5] posited that "perhaps the most dramatic learning can come when it is a peer who is disabled, rather than a patient". Medical schools are beginning to consider students with disabilities as a constituent part of their diversity, equity, and inclusion agenda, and several organisations and academic leaders from around the world are now offering formal guidance to medical schools, with the goal of fully realising the value that people with disabilities bring to medical education.[6–9]

We share *The Lancet*'s commitment to promoting diversity in medicine[10,11] and concerns about the structural biases that negatively impact patient care. Health-care disparities for patients with disabilities are universal, and while efforts towards inclusion of more health-care providers with disabilities have been made, there is a global under-representation of clinicians with disabilities (appendix). The barriers to health care for people with disabilities are ingrained. The *United Nations 2018 Flagship Report on Disability and Development* maintains that "attitudinal barriers have compromised access to health services for persons with disabilities, as health professionals often have little experience interacting with or providing services to persons with severe and/or complex disabilities, or have negative, stigmatizing attitudes towards these patients".[12] This segregation of patient and provider, healthy and disabled, has adverse impacts on the wellbeing of people with disabilities and constitutes a barrier to health-care services and education.

The inclusion of more health-care providers with disabilities offers one way to improve understanding about the needs of patients with disabilities.[13]

Further progress will require attention to several different dimensions of disability inclusion. Health professions programmes could reassess the criteria by which they evaluate applicants for admission to focus on the core skills and perspectives that are vital for competent care.[14,15] Medical schools and their affiliated clinical institutions must be able to determine and provide, with appropriate support, the optimal reasonable accommodations or adjustments for equal access to the curriculum, while ensuring competence for health professions practice. Changes to institutional culture are needed to ensure that all students and health-care providers are able to practise in inclusive environments.[16,17] Some organisations have addressed the need to improve inclusion and have translated

	Year	Guidance
Association of American Medical Colleges	2018	Accessibility, inclusion, and action in medical education: lived experiences of learners and physicians with disabilities[7]
General Medical Council of the UK	2018	Welcomed and valued: supporting disabled learners in medical education and training[6]
Australian Medical Council; Medical Deans Australia and New Zealand Inc	2017	Inherent requirements for studying medicine in Australia and New Zealand[18]

Table: **International organisations' guidance on inclusion of learners with disabilities**