My fellow BMJ columnist Rachel Clarke has rightly argued we should judge health secretaries according to their policies, not their appearance, after widespread criticism of a photo of England’s health secretary, Thérèse Coffey, “smoking a cigar while clutching a flute of champagne.” And there are plenty of terrible policies to pass judgment on.

But does the same apply to healthcare professionals? What about the heart surgeon who smokes? Or the whisky drinking hepatologist? Isn’t it true that medics can be hypocrites, handing out advice to patients that they themselves don’t follow?

I’ve felt guilty at work before now, caring for a critically injured cyclist after forgetting my own helmet that morning. Although the adage that “you’re only an alcoholic if you drink more than your doctor” is untrue, evidence suggests medical specialists tend to drink to hazardous levels more than the general population. Worldwide, over 20% of health professionals smoke, although this rate has probably decreased in recent times, with large variations by geographical region.

Physicians’ lifestyle choices may even affect the advice they give to patients. In one study, physically active GPs were more likely to initiate counselling about physical activity in patients. Shouldn’t we be held accountable for our bad habits? Are we not hypocritical in advising one thing while doing the opposite?

David Fleming, cultural historian and economist, said in his book Lean Logic, “There is no reason why he should not argue for standards better than he manages to achieve in his own life.” This way, we can view the health professional not as a role model but as a coach. As a player, the football manager José Mourinho had fewer than 100 games in Portugal’s second division. And one of the greatest ever football managers, Arrigo Sacchi, never played football at all. Just as playing elite sport is not a requirement for being a great coach, a healthcare professional doesn’t have to live the very best, doughnut-free life to support patients in making better choices.

There’s always a line to be drawn, of course, but not in the sand of lifestyle choices. Doctors, nurses, and physiotherapists, like all humans, contain multitudes, to quote Bob Dylan (channelling Walt Whitman). Perhaps striving for better for our patients than for ourselves should be celebrated, not ridiculed.

Fleming concludes his book by saying that “indeed, it would be worrying if his ideals were not better than the way he lives.”

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Cite this as: BMJ 2022;379:o2483
The previous PM promised to fix the sector; three years on it’s worse

We’re further than ever from solving the social care crisis

The previous PM promised to fix the sector; three years on it’s worse

What was then “brought forward” in August 2021 was a plan to raise around £30bn over the next three years through a “health and social care levy,” in the form of an increase in national insurance among working adults, with only £5.4bn over three years going to social care and the rest to the NHS.

Serial cuts

Modelling by the Health Foundation showed that many millions more would be required each year just to maintain current access to social care, let alone expand it. Since 2010, serial cuts had left fewer people in receipt of social care, so this was no “once and for all” solution. And at least half the money would go to protect the assets of better-off people by use of a payment cap. The government is now likely to legislate to scrap the national insurance rise, so even the £1.7bn a year uplift is in doubt.

Three recent reports have highlighted the growing scale of the crisis. First, the Nuffield Trust published Falling Short: How Far Have We Come in Improving Support for Unpaid Carers in England? The brief answer is, “We have got worse.” Despite specific entitlements in the 2014 Care Act for assessment of carers’ needs, and the ambitions outlined in the 2008 national strategy and the 2018-20 carers’ action plan, what has actually happened on the ground?

From 2015 to 2021 the number of carers in receipt of “direct support” and payments had fallen; access to breaks for carers was reduced too, with funding for this down by 42% and local authority spending on support for carers was down 11%. Carers were finding it harder to get support, and their satisfaction was falling.

Most care is provided unpaid by family and friends, often at serious cost to their own health and wellbeing or their ability to work, and often by older carers who are themselves in poor health. And population demographics mean that more people need personal care every year. If we fail to support carers we fail some of the most vulnerable people in society, who are in turn at risk of using health services more often.

Second, Skills for Care published The State of the Adult Social Care Workforce in England.

Tobacco control is an imperative

The healthcare community has for a long time pressed the government to produce a tobacco control plan that sets out how it will achieve its Smokefree 2030 objective, which was first articulated in 2017.

However, reports from “insiders” now suggest England’s health and social care secretary, Thérèse Coffey, does not intend to honour repeated pledges to do this. It was reassuring that the Department of Health and Social Care (DHSC) denied the story was true. Given that smoking is the leading preventable cause of death in the UK and that smoking causes more than 500,000 hospital admissions per year in England alone, only someone who was a committed enemy of human health and wellbeing would adopt such a bizarre position.

Coffey set out her “ABCD” priorities clearly on her first day in office—ambulances, backlogs and social care, as well as doctors and dentists. These are all complex problems, but all four will be significantly ameliorated by taking prompt action to reduce smoking rates. This is exemplified by Royal College of Physicians modelling which shows that investment in smoking cessation produces substantial in-year financial savings for the NHS.

Smoking cessation rapidly reduces the risk of acute vascular and respiratory events. Every person whose stroke, heart attack, pneumonia, or acute exacerbation is prevented is someone who is not having to call an ambulance and someone who will not have to join the hundreds of thousands of people now being forced to wait longer than 12 hours in A&E. Smoking increases the need for elective care in many conditions and quitting is associated with fewer surgical complications and shorter hospital stays. People who smoke require social care on average 10 years earlier than non-smokers, and the cost of social care attributable to smoking is at least £1.4bn a year. Achieving the 2030 smokefree goal throughout the country would improve the health and wealth of disadvantaged communities more than any other measure, lifting 2.6 million adults and a million children out of poverty.

As well as increasing the demand on the health and social care system, smoking increases sickness absence and worsens mental health. Supporting health and social care workers to become smoke free is an important step towards increasing capacity.

Fortunately, Coffey has a ready made set of polices for tobacco control—The Khan Review: Making Smoking Obsolete, commissioned by her predecessor. These include immediate and substantial investment in cessation services and mass media campaigns, increasing the legal age of tobacco sale annually, and embedding cessation support across all areas of NHS care. Other measures include reducing the affordability of tobacco, requiring a licence...
to sell tobacco products, and ensuring that trading standards enforcement is properly resourced. A “polluter pays” levy on the tobacco industry, which capped profits from UK sales at 10%, would bring in around £700m a year. This would be more than enough to fund the necessary measures twice over.

The delay in delivering a tobacco control plan is bemusing—the government is supposed to be committed to reducing health inequalities and increasing life expectancy. Perhaps also relevant is a curiously limited libertarian concept of freedom and capability to enjoy family life. Failure to deliver on the Smokefree 2030 ambition would be a choice to rob individuals of the ability to live a life of adequate length, free from disability, and able to pursue the goals they value. It robs them of parents and grandparents, denying the very children who should have been seen regularly. Apparently, this wasn’t the case either.

This is clearly unsafe practice, but repeated delays are still happening, and this may be the case in some other hospitals too. We already know about the frightening scale of delayed referrals, cancelled operations, and lengthening waiting lists in the NHS, but at least these are being measured. If routine outpatient care in some hospitals is also unravelling, it may be doing so invisibly and with no publicity.

Some simple measures could mitigate the likely harms and save lives. These could include phone reviews after a maximum interval or arranging for routine investigations to take place and be reviewed, even without an appointment, when safe to do so. If hospitals are having to reduce regular care for long term conditions, they should monitor this, prioritise any patients at risk, and have safety nets in place.

John Launer, GP educator and writer, London
Cite this as: BMJ 2022; 379:e2479

To sell tobacco products, and ensuring that trading standards enforcement is properly resourced. A “polluter pays” levy on the tobacco industry, which capped profits from UK sales at 10%, would bring in around £700m a year. This would be more than enough to fund the necessary measures twice over.

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Cite this as: BMJ 2022;379:e2491

2022, which found that vacancies had risen by 52% in one year and were at a record high, with 165,000 posts unfilled. Vacancy rates were now 11%, twice the average across all sectors. Yet projections showed the need for an extra 450,000 social care posts by 2035. Where will they come from?

Finally, the Health Foundation has published The Cost of Caring: Deprivation and Poverty among Residential Care Workers in the UK. This found that a quarter of the residential workers lived in poverty—one in 10 suffering food insecurity and one in eight whose children lived in material insecurity. Low pay is an issue, at a time when other sectors with less demanding roles are also short of workers. But social care and local government funding are not sufficient to allow employers to pay more and remain viable.

Three years and four health secretaries on from Johnson’s promise, we’re still no nearer to anything resembling an adequate future-proof plan for social care, or even a present-proof one.

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Cite this as: BMJ 2022;379:o2474

TALKING POINT John Launer

Cancelled appointment anxiety

I have a long term medical condition that requires regular hospital review. In theory this should happen every six months. Nowadays, most of the appointment letters or texts I receive from the hospital tell me that my next review has been postponed, usually for a further six months. A series of such delays, beginning before the pandemic but extending into it, led at one point to a gap of nearly three years without a face-to-face or phone appointment.

Because I’m a doctor and my condition is fairly stable, I can more or less cope with the resulting anxiety. I can access my GP fairly easily when I need to, and not only because I’m a colleague. I also know from the inside how much pressure the NHS is under and how threadbare its fabric has become: it was bad before the pandemic and is dangerously so now.

All the same, I’m concerned about the risks to other patients in the same position who may not have any of the advantages I have, nor be in a position to monitor themselves. My own wait ended when I contacted the consultant directly, but I have no idea how long it might have lasted for someone not bold enough to do so.

During my wait I saw no sign that the hospital was taking any precautions when putting routine care on hold in this way. I inquired whether arrangements were in place for a clinician to screen everyone’s notes for risks before a manager cancelled a clinic because of service pressures or covid-19. The answer was no. Everything is evidently done by managers and administrators only.

I also asked if there was a limit on how many times an appointment could be postponed or if there was a system for monitoring the consequences. I was thinking not just of heightened anxiety among patients but about adverse outcomes—medical complications, emergency admissions, or even preventable deaths among patients who should have been seen regularly. Apparently, this wasn’t the case either.

This is clearly unsafe practice, but repeated delays are still happening, and this may be the case in some other hospitals too. We already know about the frightening scale of delayed referrals, cancelled operations, and lengthening waiting lists in the NHS, but at least these are being measured. If routine outpatient care in some hospitals is also unravelling, it may be doing so invisibly and with no publicity.

Some simple measures could mitigate the likely harms and save lives. These could include phone reviews after a maximum interval or arranging for routine investigations to take place and be reviewed, even without an appointment, when safe to do so. If hospitals are having to reduce regular care for long term conditions, they should monitor this, prioritise any patients at risk, and have safety nets in place.

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Cite this as: BMJ 2022; 379:e2479

This is clearly unsafe practice, but repeated delays are still happening.
What happens if the lights go out?

Power cuts were thrilling in the 1970s: schools closed early, we cooked on a Primus stove, and stories were read to us by candlelight while we snuggled up around the coal fire. The adults around me kept any worries they had about the three day week under wraps, and we children had a ball.

Now that I have to be the grown-up, there’s no excitement in the prospect of electricity outages. Somewhere I have a copy of our business continuity plan that’s designed for just such an eventuality, which I should find and read again. GP surgeries are totally dependent on electricity, and it’s difficult to imagine how we’d even start to work without it. The automatic doors wouldn’t open, the phones wouldn’t ring, and we’d be working in the dark, both literally and metaphorically. And don’t forget the fridges, currently full of vaccines against flu and covid, as well as the usual childhood immunisations, which would be rendered useless by any power cut of more than a few hours. Remote working, which suits some of our admin staff, would be impossible.

Should I be confident that, if the electricity is turned off, GP surgeries will have a protected supply? I gather that we’re included. Should I invest in a generator now, before they sell out? With a bit of forethought, we could even rig up some exercise bikes with dynamos in the waiting room and ask our patients to generate power for us while they wait.

I entered general practice just as it was becoming a paperless service, and it’s now impossible to imagine how we’d cope without access to computers, even for short periods. All relevant information is now recorded digitally with no paper back-ups. Without the patient’s notes to prompt me there will be nothing to follow up, no test results to discuss, no routine checks to complete. We might expect this to make consultations shorter, but handwritten notes and paper prescriptions would slow us down. We’ve become used to information and guidelines being instantly available at the touch of a mouse, and although my neglected textbooks and my own notes could replicate some of this, it would take much longer, and they’re sadly out of date.

This is shaping up to be a miserable winter. A few months ago we worried whether vulnerable people could afford to keep warm this winter, but this has turned into a fear that there may be no energy available, at any price. Let’s hope for mild weather and for good sense and collaboration among politicians, so that the lights (and computers) can be kept on, in our surgeries and across Europe.

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LATEST PODCAST

Sharp Scratch: Being out of your depth

At all stages of their career, doctors will encounter situations where their clinical knowledge or experience is limited. This episode of the Sharp Scratch podcast discusses how doctors can navigate feeling out of their depth.

Kayode Oki, a foundation year 1 doctor in London, describes how, for medics, learning is never over:

“Nobody knows everything, that’s literally impossible. Even as a consultant, there will be times that you’re not too sure about things. I’ve been in theatre with a consultant colorectal surgeon and she was being taught how to use a new surgical implement by one of the other consultants. It is genuinely about lifelong learning and I don’t think there’s any shame in asking questions because you’re not being tested for an exam. The important part is that you didn’t get it wrong on a human being when you could have just asked someone else to clarify what you’re doing.”

Jennifer Rasanathan, a primary care physician and clinical editor at The BMJ, emphasises the benefits of a support network:

“One thing that I’ve done over the years has been to build up a circle of colleagues who I trust and support, and who I can ask questions of when things are unclear. It’s been really helpful to know that you have people who you can be really honest with about areas where your medical knowledge is lacking and who can provide some kind of experience of different ways that things might be done.

“I would also reiterate trying to be as honest as you can about your own limitations and the importance of reading and double checking, because it makes a big difference for me to know that I have done the best I can.”

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Edited by Kelly Brendel, deputy digital content editor, The BMJ
Learning networks in the pandemic: mobilising evidence for improvement

Maninder S Sidhu and colleagues examine how communities of practice developed and shared knowledge about covid-19 and how the process could be more effective.

The challenges of embedding evidence into practice are well known in clinical practice, service organisation, and delivery. Less discussed is an effective mechanism to generate and implement evidence rapidly into clinical practice. During the covid-19 pandemic clinicians needed to develop and spread novel practice both for managing patients with covid-19 and to adapt existing models of care to make them safe for patients with other conditions.

Clinicians and researchers came together organically to develop learning networks, in the absence of national or regional coordination. At the onset of the pandemic sharing of evidence was reliant on personal relationships and individual leadership but was eventually supported by regional and national NHS systems to facilitate evaluation. We consider whether more could have been done earlier to support communal learning and how the networks formed can be embedded to improve implementation of research both routinely and in future pandemics.

Rapid knowledge generation

Covid-19 was a new disease with no evidence on treatment. Clinicians initially extrapolated from existing evidence of other viral respiratory diseases, but it rapidly became clear that previous guidance was inadequate for the complexities of covid-19. This led clinicians to begin sharing emerging knowledge about “what works best” nationally and then internationally in real time.1,2 UK research funders responded to the pandemic by mobilising rolling rapid research calls from February 2020. In parallel, several national and regional groups emerged to develop innovations in practice during the early stages of the pandemic.3-4 Such collaborations are described as communities of practice.5 They provide a mechanism for people working across health services to share tacit knowledge, leading to innovative practice and new learning.6-7 Communities of practice move beyond the

**KEY MESSAGES**

- The paucity of evidence during the early phase of the pandemic provided an opportunity for real time learning driven by communities of practice
- Learning from these communities led to clinical and service innovation
- A mix of opportunistic and strategic support from regional and national bodies in England created clinical learning networks, which adopted and spread change rapidly
- Health systems should develop learning networks to coordinate resources to innovate, evaluate, and implement emerging best practice for both pandemic and non-pandemic times

They support formal and informal interaction between members with resultant learning and knowledge sharing

acquisition of knowledge and centre on three domains: joint enterprise (what it is about); mutual engagement (the interactions that lead to the shared meaning); and a shared repertoire (of resources such as techniques, tools, experiences, or process and practice).8-10 They allow people to come together to solve complex problems with common goals using mechanisms for synthesising knowledge from their practice and support formal and informal interaction between members with resultant learning and knowledge sharing.11-12

Some of these communities of practices evolved into more formal clinical learning networks. These networks are characterised by structured exchange of information and learning with members, sharing of practical insights of adoption and adoption of evidence based protocols, and using innovation to overcome deficiencies in care.5-11 As the pandemic unfolded these networks were supported to incorporate data and emerging evidence while also generating new evidence through partnerships with NHS England’s academic health science networks, NHS regional offices, National Institute for Health Research (NIHR) applied research collaboratives, and rapid research and evaluation centres. Below we describe three examples of these new care models and draw lessons from their approach.

Networks in action

**Intensive care unit clinical learning network**

As a pragmatic response to covid-19, clinicians in intensive care initially applied National Institute for Health and Care Excellence (NICE) guidance for managing acute respiratory distress syndrome. However, this was associated with high mortality. The Intensive Care Society (ICS) approached UCLPartners, an academic health science partnership, to form a collaboration to share emerging clinical experience (eg, insights from experts, ICU staff, and patients) between intensivists across the UK. Weekly webinars were established for ICS members to share emerging experience such as the value of proning and the early recognition of thromboembolic disease.13 The sessions were recorded, and the academic team carried out thematic analysis. Within 24 hours these analyses were distributed by email to ICS members. Applied health researchers supported the group with evidence searches of trial data where relevant.

Within the first week members had begun to disseminate the summary through multiple media channels to over 5000 intensivists worldwide. As it became clear that covid-19 was a multisystem disease, experts in renal medicine, haematology, respiratory, and cardiology were drawn into the learning network.
Shared learning to develop national remote home monitoring

An evaluation, completed in two months by the two NIHR rapid evaluation teams, provided evidence of how remote home monitoring with pulse oximetry (also referred to as virtual wards) was implemented during the first wave.15 This, together with a rapid systematic review,16 helped prepare for the second wave and the national roll out of these services.17-19

Findings from the evaluation were rapidly disseminated during autumn 2020 through networks that had been established to share best practice, resources, and learning, including the covid-19 oximetry community of practice groups, the National Learning Network, and its regional forums. The forums were facilitated by patient safety collaboratives established by academic health science networks and supported by the NHS Futures Platform (a network of NHS staff who want to connect with each other to accelerate their work). Some communities of practice were established from scratch while others built on established networks such as the National Deterioration Forum, an NHS funded improvement community of practice that sits within the Patient Safety Collaborative, but all brought together clinicians from primary, community, and secondary care. As a result, this programme was rolled out across the whole of England within weeks in late 2020.20

Adapting to virtual first approach for transient ischaemic attack and stroke care

Researchers and clinicians rapidly pivoted to focus on managing the pandemic, but less attention was given to evidence on how to provide services for patients with other conditions. Oxford academic health science network and programmes such as Getting It Right First Time adopted a learning network approach, rapidly producing guidance and resource hubs to support clinicians and health system planners organise non-covid-19 services during the pandemic, synthesising existing evidence on remote evaluation and management as well as drawing on the early experiences of sites (eg, guidance on the organisation of stroke and transient ischaemic attack services).21

In some instances, this work supported the rapid rollout of service models that had been tested before the pandemic, such as senior clinicians remotely assessing patients with acute stroke for reperfusion therapies.22 In other instances recommendations were based on clinical experience and reasoning without drawing on a research evidence base—for example, remote assessment of suspected transient ischaemic attack and stroke more generally.22,23

Delivering change

The three cases described evolved differently but all show how new clinical learning networks can rapidly deliver change when facilitated by an administrative infrastructure. The networks brought together researchers, evaluative and academic organisations, and funders to incorporate emerging evidence. Several mechanisms enabled the networks to produce real time evidence without robust methodological evaluation. First, the networks generated new learning through collaborative and interdisciplinary working. For example, gathering both evidence based and tacit knowledge from key experts, frontline clinicians, and patients led to new learning that was applicable to different clinical contexts.

Secondly, both evaluation and research were grounded in service need, with clinical innovation driving the research agenda across networks. Notably, the networks show that transferable learning can be obtained from rapid service evaluation and not just formal research. Lastly, electronic media offered an unrealised opportunity in forming networks and in disseminating learning. This was observed both in the formal use of video conferencing software such as Microsoft Teams and Zoom to facilitate organised meetings and informally by the personal use of WhatsApp and Twitter among those with a shared interest. This can be a particularly effective mechanism for spreading learning quickly across clinical specialties. Electronic media were most effective in networks that achieved a high level of trust among their members and those which had a clear collective commitment under a common purpose.24,25

What worked well?

A key strength of clinical learning networks was clinicians stepping up and focusing on a clinical priority that brought large numbers of multidisciplinary experts together in a common cause. As part of a shared community of purpose, clinicians had to be honest about the challenges they faced (and expected) when establishing relationships that grew organically as part of the networks. For example, the networks were proactive in getting the “right” people (that is, active practitioners and key leaders who were able to share current experiences that were relevant and valuable to others involved). This may partly explain why the networks that emerged during the pandemic had novel collaborative and hierarchical structures.26

The engagement between applied health researchers and the networks was vital to the speed of dissemination of the knowledge generated.27 A key component to achieving this engagement was the role of knowledge brokers—that is, people with hybrid professional roles who were members of several networks, facilitating interaction and coordination.28

As the pandemic progressed, regional NHS services provided leadership to support system-wide service change. Such coordination was absent before the pandemic, and the risk is that such collaborations will diminish as the health sector returns to business as usual. However, some examples of good practice did exist before the pandemic. The National Patient Safety Collaborative,29 for example, operates with support from the academic health science networks. Manchester Academic Health Science Centre also operates across regionally based research and innovation organisations to provide a rapid research response group.30 Other collaborations emerged during the pandemic, including the London evaluation cell,31 which brought together the NHS regional team with three regional NIHR applied research collaboratives and three academic health science networks to agree on priorities for research evaluation of pandemic related service changes. Importantly, none of these initiatives had central oversight.

QUESTIONS FOR THE COVID-19 INQUIRY

- What were the plans to support and evaluate the innovation (both clinical and service) required of the NHS during the first phase of the pandemic?
- What infrastructure is necessary to integrate research and services, to ensure rapid evaluation of service innovation takes place?
- Should there be a national repository of all NHS service evaluations supported by national funders?
- How can we encourage NHS trusts to integrate evaluation into their practice?
- How can a system be developed across the NHS for the rapid dissemination of new learning during events such as a pandemic?
What were the challenges?

The first challenge was an apparent lack of national planning for or coordination of real time clinical learning and service innovation at the onset of the pandemic. In parallel, there was no national plan to use existing administrative structures to support emerging clinical networks. All were initially hampered by the lack of a supportive infrastructure at national and regional level. This could have provided access to clinical data, research organisations for rapid evaluation, and planned rather than opportunistic support from academic health science networks. As a result, few of the clinical learning networks systematically incorporated patient and carer co-design, and only the home monitoring network considered health inequities as a key driver. Many of the networks developed for covid-19 have now discontinued rather than continue with revised goals because of lack of ongoing national or regional NHS support and direction.26 There was also a shortage of staff with the expertise to support rapid evaluation of frontline innovation during the pandemic. The lack of national alignment of the NIHR infrastructure was a result of a pre-existing failure to systematically address the competing pressures from the academic and policy worlds, while many staff were deployed to respond to the national research agendas.31

Barriers to shared learning and how to overcome them

Across our three cases we identified several barriers. Shared learning was largely limited to members of the networks. Disseminating learning in real time to frontline practitioners took time and constant refinement to ensure messages were clear. Furthermore, traditional dissemination strategies such as conferences and roundtable discussions were paused. However, other much faster routes of dissemination were developed such as electronic media (WhatsApp, Twitter) as well as NIHR rapid evaluation teams working closely with clinical learning networks to share feedback on findings using slide decks and online workshops. National alignment of networks with NICE when it occurred helped facilitate shared learning and dissemination but was limited as well as unsystematic.

The organically developed clinical learning networks during the pandemic provided an opportunity for an alternative model of knowledge generation linked to rapid implementation rather than traditional research methods. The NHS has run clinical networks previously and last made major policy changes to these in 2013,32 the same year that academic health science networks were established. However, the two were never formally linked. These previous iterations established effective knowledge sharing, but their effect on bottom-up service transformation was ultimately diminished by top-down government demands and an absence of a formal implementation partner. As NHS clinical networks were not linked to the academic research and evaluation community, and ultimately relevant and contemporary data, they never met the criteria for a true clinical learning network.

Other countries had established successful learning networks before the pandemic, including the United States (100 000 lives),34 Denmark (operation LIFE),35 and Japan (Partners campaign).36 These all sought to create a sustainable national learning network that would outlive a time bounded health improvement initiative.37 They had clear aims and leadership alongside brokering relationships with a range of stakeholders, rapid dissemination of learning to frontline practitioners using web based applications, and encouraging critique and reflection.38

Achieving an effective clinician-academic alliance requires change throughout the research system

In the UK, common interests broke down silos between specialties and across secondary and primary care. Relationships developed with the research community that highlighted the need for rapid evidence generation through evaluation and research so binding clinicians and academics to an aligned purpose. Most importantly, collaborative knowledge production and mobilisation, as part of clinical learning networks, during a pandemic required health system improvisation and collective leadership to drive forward an agenda in the absence of evidence.

However, promulgating “best practice” before robust evidence is available could result in implementing a clinical practice that later proves to be ineffective or harmful. Determining what is good enough evidence to support best practice is an ongoing challenge: whether clinicians believe available evidence is sufficiently reliable and relevant to support service change and if more robust evidence will be generated. Collaboration between clinical learning networks and academics is needed to evaluate new practice rapidly and provide evidence in a format that supports its implementation into practice. Alignment of rapid evaluation and applied health research generated by clinical learning networks is essential to create robust evidence on relevant questions for the NHS (eg, effect on workforce and workflow) and to optimise translation at scale and pace.

This approach has been used successfully overseas with strategic partnerships between academic researchers and clinical services such as the United States Veterans Administration’s Office of Research and Development37 and Kaiser Permanente’s Health Research Institute.38 Others have embedded academic researchers within the health system to promote research priorities driven by the needs of the health system. Achieving an effective clinician-academic alliance requires change throughout the academic research system. A recent analysis of UK research showed that half of all funding is spent on underpinning (understanding normal biological, psychological, and socioeconomic processes, which forms the basis for subsequent research) and aetiology (the risks, causes, and development of disease).39 In comparison just 5.6% of funds were allocated to health service research,40 and this is compounded by the limited capacity within NHS non-research budgets for evaluation.

So what is the opportunity for the future? The box (opposite) suggests some questions for the English government’s inquiry into the covid-19 pandemic to consider. Learning from the pandemic experience, government funding bodies, including the NHS and NIHR, should recognise the potential to align clinical communities with evaluation, research, and implementation resources to establish clinical learning networks. Linking multiprofessional clinical communities, together with patients and carers, into existing regional and national infrastructure can create an effective system for change. Those who commission current academic and applied research networks and other regional support structures now need to show decisive leadership on alignment so that we can maintain the value of working as a collaborative system.

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Cite this as: BMJ 2022;379:e070215
The name of the game is “conflicts of interest”

Although the involvement of big companies in dictating the terms of tobacco control and responses to climate change are too obvious to escape attention, the situation is no different in other areas of public health (BMJ Investigation, 17 September). From drug manufacturers to vaccine lobbyists, deciding on aspects of national health programmes to deciding on specific public health interventions, conflicts of interest seem to be all pervasive.

The seeds of allowing conflict of interest in public health were probably sown after the Alma-Ata declaration, which was claimed as a watershed in public health. At a declaration on primary healthcare, which public health were probably sown after the Alma-Ata declaration, India

Sunil Raina, professor and head of community medicine, Tanda, India

Cite this as: BMJ 2022;379:o2408

Physician burnout and unsafe healthcare

Staff welfare is vital

Weigl discusses the effects of physician burnout on the quality of patient care (Research, 17 September). But focusing on patient safety misses the point. Burnout is bad because it affects staff welfare. We don’t need to justify intervention against burnout by citing its effects on productivity or patient safety. When a substantial portion of staff is miserable at work, that should be enough for us to make major changes to our work environments and training programmes so that we might improve our colleagues’ quality of life. So far, strategies seem focused on nebulous concepts of wellness, wellbeing, and resilience. An increase in trainee burnout year on year implies that these strategies are not working.

If the headline message is reduced to burnout undermining safe healthcare, then further strategies will focus on safe healthcare and not on safety for those providing that care. The mental wellbeing of physicians is vital.

George Huntington, acute care common stem trainee, London

Cite this as: BMJ 2022;379:o2435

Returning to the core practices

Burnout results in reduced professionalism and patient satisfaction; this is in turn erodes public trust in physicians. Perception of low trust from patients is associated with more substantial burnout, and the vicious cycle continues.

Establishing the link between physician burnout and poor patient care might provide an impetus for change. The higher prevalence of burnout among hospital based doctors should prompt further examination of the contributing social, cultural, and systemic factors. Causes for burnout seem to be complex, and interventions at both individual and organisation level are important.

An intervention might involve rekindling enthusiasm and ambition by returning to the core practices of being a doctor. These encourage a balance between the demands of busy clinical work, teaching and learning, and measuring outcomes through research. It would be interesting to explore the burnout rate in doctors enabled to participate in balanced practice compared with a total focus on patient care.

Feng Liang, rehabilitation physician; Stephen F Wilson, senior rehabilitation staff specialist, St Leonards, Australia

Cite this as: BMJ 2022;379:o2437

New health secretary

The politicisation of climate change

Wise’s analysis of the position of the new health secretary Thérèse Coffey is informative but one part confuses me (News Analysis, 17 September). Why on (a warming) Earth has she “generally voted against measures to prevent climate change?”

Neither the science nor our current lived experience leaves any doubt that the Earth is warming, and the culprits are clear. Different opinions regarding solutions to this increasingly imperative problem are understandable (and possibly healthy) but to deny the existence of the problem itself is not.

This politicisation of such a major problem has become a gross distraction, the time and energy used in squabbling needs to be harnessed to look for solutions. Continued pumping of greenhouse gases from human activity into the Earth’s atmosphere has been likened to sawing off the branch we are all sitting on. Why do some of us, including, apparently, our new health secretary, simply call for a sharper saw?

Scott Fraser, consultant ophthalmologist, Sunderland

Cite this as: BMJ 2022;379:o2410
Cultural competencies are advantageous

The article reporting that more UK students are choosing to study at eastern European medical schools is problematic for several reasons (News Analysis, 24 September). For one, the article overgeneralises, mentioning four distinct countries—Bulgaria, the Czech Republic, Poland, and Romania—with different curriculums. This is like assuming that education in the Republic of Ireland and the UK is the same.

The opportunity to study abroad is a longstanding European tradition, evidenced by programmes like the Erasmus exchange. It allows students to expand their medical knowledge while gaining international exposure. In a society that is becoming increasingly diverse, these cultural competencies are advantageous to our patients and colleagues.

Reducing trainees’ knowledge to the origin of their primary medical qualification ignores the experience obtained through foundation training. Where there is a shortage of doctors, it is not fair to diminish the quality of an education obtained abroad, however foreign it may seem.

Anna Christina Morawski, psychiatry specialty trainee year 4, London
Cite this as: BMJ 2022;379:o2447

Prejudice against international medical graduates

There seems to be prejudice against international medical graduates. We know there is a limited number of medical school places in the UK; failing to get one does not reflect one’s potential to become a competent doctor. There are many reasons candidates apply to overseas medical schools, such as family, relationships, and finances, especially given the rising cost of tuition in the UK.

Medical training teaches us to consolidate our knowledge and develop a process of disease pattern recognition, but I doubt it is ethical to stereotype international medical graduates. Some of these graduates are recruited from countries that have a much greater need for doctors than the NHS. It is not fair to see them as inferior to locally trained graduates.

When individual doctors are found to lack certain benchmark skills, training programmes can help. Sadly, it seems the preference is to blame their inadequacy on their origins or primary medical qualifications.

Eugene Y H Yeung, retired NHS doctor, Lancaster
Cite this as: BMJ 2022;379:o2445

Editor’s note. We have considered the comments in response to the original version of this article. A new version of this story was published online on 11 October in order to remove some assertions that were made without supporting data.

IMPROVING CHANCES OF A HEALTHIER FUTURE

Widen the capture of gestational diabetes

Xie and colleagues show the negative long term effects on maternal and child health associated with gestational diabetes, based on International Association of Diabetes and Pregnancy Study Groups (IADPSG) oral glucose tolerance test thresholds (fasting: 5.1 mmol/L, 1 hour: 10.0 mmol/L, 2 hours: 8.5 mmol/L) (Research, 24 September). These thresholds were endorsed by WHO and have been adopted internationally. They can only go so far without facilities.

NICE diagnostic thresholds (fasting: 5.6 mmol/L, 2 hours: 7.8 mmol/L) are used. Thus, fewer women with risk factors such as obesity are offered an opportunity to make lifestyle changes. NICE diagnostic thresholds also disproportionately underdiagnose gestational diabetes in Asian women, compounding existing health inequalities.

NICE should acknowledge a place for IADPSG glycaemic thresholds in UK districts with higher rates of obesity or larger populations from ethnic minority groups. The drive should be towards widening the net, not constricting it.

Amaju E Ikomi, obstetrician and gynaecologist, Brentwood
Cite this as: BMJ 2022;379:o2444

WHAT SHOULD I KEEP IN MY LOCKER?

We all should have somewhere safe for our belongings

I’m pleased two of the doctors interviewed by Torjesen have got lockers, but Rohana Mir’s need to fill an imaginary locker captured how many trainees feel (Careers Clinic, 17 September). Having access to safe and secure storage is not only in doctors’ interests, but organisations’ interests too.

Much is made of staff welfare initiatives, but how often are trusts getting the simple things right? Reliable access to a secure locker enables storage of good food, hydration, and personal hygiene products. Many trusts seem to promote active commuting, but this can only go so far without facilities.

With staff morale and welfare at a crisis point, isn’t this a simple win for trusts? It was only in my first job outside of the NHS that I was given a locker on my first day. A secure place to store personal belongings should be a basic provision in NHS hospitals.

Gethin P Hopkin, specialty trainee year 1 public health medicine, Manchester
Cite this as: BMJ 2022;379:o2404

DEATH—THE GREAT LEVELLER?

A good death takes effort

Salisbury talks about death as the great leveller (Helen Salisbury, 17 September). The recent death of Queen Elizabeth II reminded me of the long forgotten paper by Edwin Shneidman on criteria for a good death.

The Lancet Commission recently published a piece of work on the value of death. It focuses on attempts to reframe death as a spiritual rather than physiological event. It calls for better support for people dying, caring, and grieving. It wants to establish a narrative about death as very much a part of our heritage and our culture—bringing it back into life. It recognises one of Shneidman’s criteria—it wants death to be generative, passing wisdom to younger generations. It is clear that a good death takes effort.

Queen Elizabeth II cared deeply about her subjects and perhaps we can imagine that in her death there is also a message for them.

Piotr Szawarski, consultant in intensive care medicine, Slough
Cite this as: BMJ 2022;379:o2406
**OBITUARIES**

**David John Austin**
Consultant ophthalmologist
(b 1943; q Royal College of Surgeons in Ireland, Dublin, 1968; FRCS, FRCOphth), died from complications after a cerebral vascular accident on 21 May 2022

David John Austin did his intern year in Drogheda, Ireland, and subsequently worked at Birmingham Eye hospital for 10 years. During this time he became successful in his application to become one of four consultants at the Leicester Royal Infirmary. In 1992 he and a colleague set up the second excimer laser centre in the country at BUPA Hospital, Leicester. He travelled widely to teach the use of the laser in the UK, Europe, and Russia. David had a stroke in March 2018. He worked hard at his recovery, but sadly deteriorated in health from November 2021. He died peacefully at home and leaves his wife, Liz; two stepchildren, three step grandchildren; and two children by his previous marriage to Margaret.

Liz Austin
Cite this as: BMJ 2022;379:a2454

**Sylvia Joyce Jordan**
Associate specialist in rheumatology and rehabilitation East Surrey Hospital (b 1930; q King’s College Hospital, London, 1954), d 20 March 2022

Sylvia Joyce Jordan won a scholarship to Christ’s Hospital during the second world war and was the first of her family to attend university. At King’s she met her future husband, Kenneth Trigg. After having four children, she returned to medicine. She took a great interest in patients with intractable conditions in institutional care. Her multidisciplinary team developed bespoke seating for patients with complex neurodisabilities. This enabled enjoyable activities instead of lying in bed or experiencing painful dystonias when not comfortably supported. We were all inspired by her example in pursuing interesting careers. Predeceased by Kenneth ("Liz") moved to London after house jobs. Appointed registrar at Great Ormond Street, she worked with children who had thalassaemia and haemophilia. In 1967 she was appointed to the Veterans Hospital in San Francisco to do research. On returning to Great Ormond Street Hospital she undertook the earliest clinical trials of iron chelation therapy in the UK for patients with thalassaemia. In 1983 she was appointed to the new post of consultant haematologist at Queen Charlotte’s Hospital. Liz regretted not having children of her own but took comfort from the fact she was responsible for the healthy birth of many children who might otherwise not have survived. She leaves her sister, Nadia, and two nephews.

Gabriel Gabriel
Cite this as: BMJ 2022;379:a2452

**Kenneth Theodore Evans**
Professor of radiology
University Hospital of Wales (b 1925; q Birmingham, 1948; FRCP Lond, DMRD Eng, FFR, FRCR, FFR RCS), died from a stroke on 9 October 2021

Kenneth Theodore Evans ("Ken") became a consultant in Bristol in 1959 and went to work in Ibadan, Nigeria, for a year in 1963. He was appointed as the first professor of radiology in Wales in 1966, based in Cardiff. He was instrumental in enhancing the status and reputation of the department and worked closely with architects in the design of what is now the University Hospital of Wales. He was vice president and warden of the Royal College of Radiologists and vice provost of the Welsh National School of Medicine. He retired in 1988. Ken was an enthusiastic teacher and examiner. Predeceased by Susanne, his wife of 68 years, he leaves four daughters, nine grandchildren, and five great grandchildren.

S Haslam, V Stephens, P Curtis, G Haworth, J Haslam
Cite this as: BMJ 2022;379:a2402

**Gwyn Amman Evans**
Consultant paediatric orthopaedic surgeon
Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry (b 1946; q Barts, London, 1967; FRCS, FRCS Orth), died from pancreatic cancer on 20 July 2022

Gwyn Amman Evans was appointed to the Oswestry rotation in 1974. A fellowship at Newington Children’s Hospital, Connecticut, USA, completed his training. On his return to Oswestry, he was ushered into a consultant children’s orthopaedic post. He started in 1980 and also did sessions treating adults at the Wrexham Maelor Hospital. During his career, he established a progressive children’s unit, introducing the skills and knowledge from his training. He became recognised for his abilities and lectured across the world. Gwyn retired in 2004 but worked part time for another five years. He was diagnosed with pancreatic cancer four years ago, but maintained good health until a few months before his death. Gwyn leaves his wife, Mary; three children; and grandchildren.

Nigel Kiley
Cite this as: BMJ 2022;379:a2399

**Elizabeth Alin Letsky**
Consultant perinatal haematologist
(b 1958; q London, 1980 and also did sessions treating adults at the Wrexham Maelor Hospital. During his career, he established a progressive children’s unit, introducing the skills and knowledge from his training. He became recognised for his abilities and lectured across the world. Gwyn retired in 2004 but worked part time for another five years. He was diagnosed with pancreatic cancer four years ago, but maintained good health until a few months before his death. Gwyn leaves his wife, Mary; three children; and grandchildren.

Nigel Kiley
Cite this as: BMJ 2022;379:a2399

**Alexander Munn**
Occupational health physician (b 1923; q Glasgow, 1947; DIPH, FFOM), died from old age on 22 October 2021

Alexander Munn ("Alex") first became interested in occupational health as a national service doctor in the Royal Air Force when he saw cases of "the bends"—decompression sickness caused by high altitude flying in unpressurised aircraft. In 1950, he joined ICI as an assistant works medical officer in the dyestuffs division at Huddersfield. In 1976 he was approached by the Monsanto Chemical Company to become director of medicine and environmental health at its European headquarters in Brussels. He participated in the work of many committees concerned with chemical hazards to health. His wife of 68 years predeceased him in 2018, and he leaves his two daughters, five grandchildren, and two great grandsons.

Cite this as: BMJ 2022;379:a2451

Jennifer Trigg, Hilary Trigg, Cecilia Trigg, Miles Trigg
Cite this as: BMJ 2022;379:a2403
Nafis Sadik (b 1929; d Dow Medical College, Karachi, Pakistan, 1951), died from heart failure on 14 August 2022

Nafis Sadik’s tireless advocacy of women’s rights was fired when she was a young doctor, seeing countless poor women having 10 or more children and no control over their lives. Her courage, in the face of death threats, matched her passion and stamina. In 1996 the Times named her as one of the 100 most powerful women in the world.

She spearheaded a broad plan to curb global population growth, which 179 countries adopted at a UN conference in Cairo in 1994. It put women’s rights rather than birth control quotas at the centre of the global population debate. Sadik insisted that women should control all parts of their lives, including their sexual and reproductive health, especially the right to choose whether to get pregnant.

Tackling taboos
Now widely recognised as an uncontentious social ideal, her central goal was highly controversial in 1994. It enraged both the Vatican and Muslim fundamentalists, who saw Sadik, a devout Muslim, as a US puppet to force Western values.

The outrage did not stop there. As secretary general of the fifth UN International Conference on Population and Development in Cairo, Sadik shaped the agenda. The meeting tackled taboos such as incest and female genital mutilation. Told that these cultural matters were “none of your business,” she replied, “Women being harmed is our business.”

In a private audience before the Cairo meeting, she urged Pope John Paul II to reverse the Holy See’s ban on contraception, prompting allegations that the UN was trying to destroy the family. In their 1996 papal biography, His Holiness, journalists Carl Bernstein and Marco Politi, report that the pope asked Sadik why she was taking this new approach to individual rights. She replied, “What other kinds of rights are there?”

Alarmed by “a pervasive feminist influence,” an extraordinary gathering of 114 of the 139 Roman Catholic cardinals claimed that the Cairo proposals would legitimise “abortion on demand and sexual promiscuity and distort notions of the family.”

When UN security experts feared for her life in Cairo, Sadik reportedly said, “If they kill me, I’ll be a martyr for the cause and it would undo everything they want. Either way, I don’t think I can lose this one.”

Sadik maintained that the first mark of respect for women is support for their reproductive rights. This included liberating women from “a system of values in which reproduction is their only function.” Other Cairo goals included universal primary education in all countries, wider access for women to secondary and higher education, and reduction of infant, child, and maternal mortality.

The first woman to direct a UN agency—the UN Population Fund (UNPF)—Sadik headed a staff of about 800 with a budget of about $300m, and spent decades confronting government and church leaders to secure rights and dignity for women.

Early life and career
Born in Jaunpur in British ruled India, Sadik was the daughter of Iftat Ara and Muhammad Shoaib. An economist, her father became Pakistan’s finance minister and a vice president of the World Bank.

Young Nafis’s strong independent spirit led to her persuading the family chauffeur to teach her to drive at the age of 13. She had varied interests. An outstanding science student, she played Indian classical music, tennis, and tournament bridge. She also nursed ambitions “to change the world.” In her biography, Champion of Choice, author Cathleen Miller pointed out that this was unusual for a female of her era and background, “because it was assumed that all girls would become wives and mothers.”

Sadik considered various careers, including tennis, singing, and engineering, but later recalled wanting to help the poor. Her mother berated her when she became a medical student, saying, “I don’t know why you’re doing all this medicine. You’re not going to work. Why don’t you get married, and I’ll give you lots of jewellery and clothes?”

After graduating from Dow Medical College in Karachi, Pakistan, she underwent obstetrics and gynaecology training in the US in Baltimore and at Johns Hopkins University.

After working in women’s and paediatric wards in Pakistani armed forces hospitals between 1954 and 1963, she led the health section of the government planning commission.

In 1966 Sadik joined the Pakistan Central Family Planning Council, becoming director general before joining the UNPF in 1971. Six years later she became executive director. She retired from the UNPF in 2000 and became special adviser to the UN secretary general and special envoy on HIV/AIDS in Asia and the Pacific.

Interviewed by the New York Times before her retirement, she said that when she arrived at the UN, family planning in developing countries mostly involved pressuring poor women to have fewer babies, as determined by government quotas. Noting that such quotas had been eliminated, she said, “The world has come very far since then.”

A dedicated wife and mother, she was married to Azhar Sadik, a retired businessman, who died in 2011. Sadik leaves their three children, two adopted children, 10 grandchildren, and four great grandchildren.

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Cite this as: BMJ 2022;378:o2111