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Among the failures, credit is due

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Mary Dixon-Woods has harsh words for the East Kent Hospitals University NHS Foundation Trust (doi:10.1136/bmj.o2755).¹ An investigation into its maternity services concluded that outcomes would have been better in roughly half of the cases reviewed if minimum standards of care had been achieved. Most of the maternal and neonatal deaths were judged preventable. Bullying, harassment, and unprofessional behaviour by consultants were common and tolerated. These issues had been identified in a 2014 investigation, yet nothing has changed. Dixon-Woods condemns the trust's decade long failure to tackle these problems as particularly egregious. The failures were cultural and institutional, she says, and solutions must be as well. "Diagnoses are useless unless effective treatment follows—and that requires leadership commitment and sound systems, both of which East Kent lacked."

Another reckoning is coming soon, in the form of the UK covid inquiry. Wang and colleagues say the inquiry should focus on the "infodemic" of both misinformation and disinformation that occurred during the pandemic (doi:10.1136/bmj-2022-070331).² The first arises from misunderstanding or ignorance; the second is deliberately deceptive. Where do these ideas come from, and how do they spread? Politicians, celebrities, and public figures, it seems, are not the commonest sources of misinformation and disinformation, but social media and other engagement with their pronouncements is substantial. This outsized influence means they play a big role in the spread of inaccurate health information. Once again, systemic solutions are identified as crucial. To prepare for the next pandemic, Wang says, we must learn the lesson of this one. Public health authorities should be ready to counter conspiracy theories and tackle disinformation head on: aggressive, "active management" of infodemics is what's needed.

Maggie Rae blames politicians and bureaucrats for a failure to support public health and prevention programmes, citing evidence that public health grants in England have gone down by 24% in real terms since 2015 (doi:10.1136/bmj.o2706).³ These cuts hit poor people hardest, and resultant poorer health further reduces their economic potential. To illustrate just what is at stake with funding cuts, it is perhaps useful to consider the real life example of a successful public health intervention. A 2020 programme in Liverpool provided rapid antigen testing for covid-19 to asymptomatic people, in the hope that widespread, easily available community testing might reduce hospital admissions. And so it did. The intervention was associated with a 43% reduction in covid related admissions to hospital during the period of most intense testing (doi:10.1136/bmj-2022-071374).⁴

Credit also goes to medical journals (including *The BMJ*) that now require research authors to share their data or publish a statement about the availability of the study's data. Authors of systematic reviews published in those journals were more likely to share code or data, although sharing and reporting quality remained suboptimal (doi:10.1136/bmj-2022-072428).⁵

The NHS Genomic Medicine Service, formed in 2018, is credited with transforming care for many patients (doi:10.1136/bmj.o2643).⁶ Targeted cancer treatments and personalised prescribing are realities for many patients now. Perhaps the most impressive improvement, however, has occurred with identification of rare diseases. Most of these have genetic causes. Genetic testing has "short-circuited" previously slow, imprecise methods of conventional diagnosis. Earlier diagnoses allow families and patients to identify possible treatments, locate needed specialists, and form support groups.

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