DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Climate Change, Sustainability and the NHS – Page 10

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Not lethal, but debilitating?

Independent (adjective):

- free from outside control or influence;
- not depending on another for livelihood or subsistence;
- not connected with another;
- separate; (of broadcasting, a school etc) not supported by public funds.

Parasite (noun):

- an organism which lives in or on another organism and benefits at the other's expense
- a person who lives off or exploits others

Compact Oxford English Dictionary

The forerunner of DFNHS, the NHS Consultants Association (NHSCA), arose in 1976, to support the attempts of Labour Secretary of State, Barbara Castle, to remove beds for private patients from NHS hospitals [1]. The BMA was calling for industrial action to oppose this move: NHSCA was formed to emphasise that many senior doctors supported a clear separation between private and public healthcare. A Royal Commission was established "To consider in the interests both of the patients and of those who work in the National Health Service the best use and management of the financial and manpower resources of the National Health Service" and reported in 1979 [2]. Paybeds had already been abolished, but were reinstated 3 years later by the incoming Conservative government.

Four decades on, the arguments continue about the positive and negative influences of the private healthcare industry, but the landscape has changed out of all recognition. The Royal Commission declared, in 1979, that the influence of the private sector on the NHS was so small as to be essentially irrelevant in most areas of practice. Its influence is now greater than at any time since the NHS was founded. Interestingly, the Commission did recommend powers to restrict the number of private beds in each region of the UK – powers which were never enacted.

Although the private hospital companies prefer to be called "independent healthcare providers", they are anything but independent of the NHS and the tax-payer. They depend on the state for a large proportion of their income. They depend on the state to provide a supply of doctors, nurses and allied professionals, largely trained at public expense. And their fortunes are dependent on a weak NHS that is perceived as struggling.

Not supported by public funds?

The "independent" sector has become dependent on public funding. Before the pandemic, nearly half of the inpatients treated in private hospitals were funded by the NHS, as were a third of outpatients.

The fortunes of private healthcare companies have waxed and wained with the length of NHS waiting lists, thriving during the '80s and '90s as waiting times for elective treatments were measured often in years, before fading almost into obscurity by 2010, as the combination of targets, based on referral to treatment times, were backed up with the money to pay for the staff and facilities required to make this happen. Public satisfaction in the NHS was at a record level – people felt no need to seek private health insurance and many firms stopped offering it as an incentive to recruitment and retention.

Austerity policies came to the rescue. Switch off the cash and forget the targets, cut beds and let staff numbers dwindle. Lo and behold, waiting times rise and the sun shone again on the "independent" sector.

Even before the pandemic struck, 4.5 million people were waiting to begin treatment and the proportion waiting longer than 18 weeks was the highest since 2008. As the NHS turned to face the challenges of a pandemic that has now claimed over 150,000 lives in the UK, the suspension of so much non-urgent care for much of the past 2 years, was bound to drive those that were able to find ways to pay for their treatment to explore private healthcare and the good times could roll again.

All that was needed was to keep the private hospitals solvent during the time when they were unable to work normally, because of government restrictions and staff sickness and enable them to pay their overheads, such as rental and interest on previous borrowing [3]. The overall value of this support, ostensibly to provide capacity for the NHS, was believed to be around £400 million a month, but two-thirds of this "capacity" was never used, for one reason or another [4]. Never mind – just keep the money! Matt Hancock's attempt to strike a further £5 billion deal to help reduce the elective backlog was blocked by the Treasury, on the grounds that it did not offer value for money.

But as Omicron strikes staff and patients and disrupts business in both private and public hospitals, once again the Government is there to offer a helping hand, with a minimum income guarantee of at least £225 million for a group of "independent" hospital chains, without any guarantee of the capacity that this would secure and with enhanced rates of payment for any treatment that they are prepared to deliver [5]. Amanda Pritchard, Chief Executive of NHSE, was so concerned that this deal offered poor value for money that she sought a direct order from the Secretary of State [6].

The "independent" sector is even more dependent on the public purse for the supply of clinical staff. They do not employ the doctors that work on their premises, who are largely working in a self-employed capacity, but they will have been trained, and kept up to date, largely at public expense. The contribution of private hospitals to the training of the next generation of consultants is negligible. Although some nursing apprenticeships are being offered by some private hospitals, this is a recent development and the vast majority of their nursing staff were trained by the NHS [7].

Cavalry or tapeworm?

So it seems misleading to refer to organisations like HCA and Spire as independent healthcare providers, but do they benefit at the expense of the NHS and the wider public interest – can they really be regarded as parasites? [8]

Yes they can, if they divert funding into profits or excessive overheads that would otherwise be used to invest in the capacity and capabilities of the NHS or social care, or addressing the social determinants of health. Health funding is finite.

Yes they can, if they reduce the political will to maintain an excellent and accessible health service for all of us.

Yes they can, if they produce perverse incentives which may encourage some clinicians to undermine efforts to reduce waiting times, in the hope that the same patients will turn up in their private consulting rooms, seeking quicker treatment.

Yes they can, if they reduce the opportunities of the next generation of doctors to develop their surgical skills on people with relatively straightforward problems. The Royal College of Ophthalmologists recently reported, "Training requirements are proving difficult to meet as regional training programmes report reduced surgical opportunities, especially of "routine" cataracts. These cases are now often undertaken in the IS, leaving more complex cases, which are less suitable for training, to be delivered by NHS providers. This is making it more difficult for trainees to successfully complete training and, most importantly, more difficult to develop the skilled and experienced surgeons our patients need. The provision of cataract training by ISPs has disappointingly been very limited to-date though, with few trainees involved." [9]

It isn't just about the money

But if we are going to be seeing more NHS patients receiving their treatment in private hospitals, we should be insisting that the safety standards in those hospitals are the same as in NHS hospitals, are subject to the same monitoring and are easily available for public inspection. The Centre for Health and the Public Interest called for an overhaul of safety standards in the wake of the Ian Paterson scandal. One of their concerns that has yet to be addressed is the role of the Resident Medical Officer (RMO) [10].

Typically employed by a recruitment agency, rather than by the hospital, the RMO is expected to opt out of the European Working Time Directive (EWTD) as a condition of employment. The normal shift pattern is to work one week on duty / one week off, without a break. The EWTD was intended to reduce the risk of patients being treated by a sleep-deprived doctor whose concentration or judgment may be impaired, but apparently this is ok in the "independent" sector.

RMOs are usually junior doctors with limited experience. In an NHS hospital a Consultant would be responsible for assessing their abilities and limitations, they would work as part of a team, and they would be able to call on more experienced colleagues for support when needed. In contrast, in most private hospitals, the RMO is responsible to the hospital's Matron, rather than a doctor, even though they are delivering medical care and are looking after the patients of many different Consultants. If a patient is getting into difficulties, there are unlikely to be facilities to care for seriously ill patients, there is unlikely to be any on-site back-up and the RMO would be expected to try and find the patient's Consultant for advice, which might not be straightforward. If this would be unacceptable in an NHS hospital, why should NHS patients be exposed to such risks if their care is diverted to private hospitals? And is it acceptable to put inexperienced doctors in this position purely in the interest of maximising profit?

Lords to the rescue?

The Health and Care Bill is now being scrutinised by the House of Lords. If the Bill remains unamended, it will permit commercial organisations to sit on decision-making bodies that determine what healthcare is available to the public, where it is delivered, and by whom, with the clear possibility that those decisions could shape services to match the preferred business model of those same profit-driven commercial organisations, rather than the needs of the population. The arrangements for preventing conflicts of interest and transparency in the way contracts are awarded and monitored are not specified in this legislation, and won't be. They will instead be included in a Governance Handbook, which is not mentioned in the Bill and is yet to be published. So far, the emphasis seems to be on managing conflicts of interest, rather than trying to prevent them in the first place.

Large numbers of amendments have been tabled in the Lords, including amendments seeking to remove the influence of commercial bodies on Integrated Care Boards and their sub-committees; to ensure that strategic decisions are taken only by statutory bodies and in an open and transparent process; to ensure that Integrated Care Systems (ICSs) should be responsible for providing emergency care to anybody who happens to be within their geographical area; to ensure that specialist palliative and end of life care is a core responsibility of the Integrated Care Board; and that a duty to develop a workforce plan and report biennially on its progress becomes a duty of the Secretary of State.

If you know, or can develop a correspondence with any Members of the House of Lords, please encourage them to support any amendments that might reduce the most damaging impact of the Bill, as it currently stands.

Missing the point?

Research from the London School of Economics was published in December, which showed that the number of management staff, and the amount that they were paid, made very little difference to the performance of acute hospitals. They measured five aspects of performance, including elective waiting times, A&E waiting times and Summary Hospital-level Mortality Indices (SHMI) and expressed surprise that, "Hospitals hiring more managers do not see an improvement in the quality of management leading to better performance, and increasing the numbers of managers does not appear to improve hospital performance through any other direct or indirect mechanism." [11]

They attributed this to the notion that "NHS managers have limited discretion in performing their managerial functions, being tightly circumscribed by official guidance, targets, and other factors outside their control. Given these constraints, our findings are unsurprising." A previous study had also shown that increased spending on management did not improve hospital performance and spending on management consultants has even been shown to reduce efficiency! [12-14]

Are the authors naïve? Certainly poor management, with destructive behaviour, can have a terrible impact on clinical services, while good hospital managers and administrative back-up can be a huge benefit. But hospital managers cannot magic up trained staff from thin air. The best manager cannot conjure up the capital funding to replace clapped-out equipment, or obsolete or decaying buildings. Isn't it highly likely that these and other factors exert so large an influence that any beneficial impact of managerial quality is lost in the noise?

However, Sajid Javid has drawn the conclusion that the remedy for failure of management is more management. Managers should be granted much greater freedom, by creating Academy-style Hospitals, in partnership with private or charitable sector organisations, and directly answerable to the Secretary of State, along the lines of the academisation of schools. He is apparently preparing a White Paper to outline these plans. Again, the blinkered assumption that care can be improved simply by managerial reorganisation, without addressing the lack of resources. Moving schools from local authority control into multi-academy trusts, directly responsible to the Secretary of State does not, of itself, improve the quality of education a child receives: why should a similar model be any more successful in healthcare? [15]

We were told that Sajid Javid wanted to withdraw the Health and Care Bill, but was blocked by Number 10, but can't they see the irony in conducting a major redisorganisation of the NHS in the name of integrating care across a region, while intending to set up hospitals that would be able to set their own agenda and accountability? What could possibly go wrong?

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Hospital investigatory procedures: Proposals for change

Many doctors feel they have been unfairly targeted when formal disciplinary action is taken against them. They report that such action is often retaliation for speaking out about patient safety issues. The unfairness is compounded by the fact that the sound guidance detailed in the recommended disciplinary procedure "Maintaining High Professional Standards in the Modern NHS" (MHPS) [1] is cynically disregarded.

MHPS is a framework for the handling of concerns about doctors and dentists in the NHS issued by the Department of Health. Parts I (Action when a concern arises) and II (Restriction of practice and exclusion) were issued in 2003, and the final document with three further parts was issued after the introduction of appraisal and revalidation in 2005.

Recognising that the unfair proceedings prevalent at the time had wide implications for individuals as well as the NHS, the stated aims of MHPS guidance were:

i) Tackling the blame culture: recognising that most failures in standards of care are caused by the systems' weaknesses not individuals per se.

ii) Abandoning the "suspension culture" by introducing new arrangements for handling exclusion from work.

These aspirations have sadly not been realised and furthermore, there is an overlay of bias and discrimination. This has been acknowledged, and guidance issued by NHSE/NHSI [1-4]: "Freedom to Speak Up", "A Just Culture Guide", "A Fair Experience for All". This has had little effect in improving the situation. A report of an external review published recently in the *BMJ* [5], details how Dr Patricia Mills was victimised after she raised concerns about patient safety. An external review is a very rare event. Unjustly victimised doctors resign, leave the NHS or pursue a long drawn out and expensive appeal to an Employment Tribunal (ET) with no guarantee of redress.

A culture of fear appears to be pervasive in many NHS Trusts, affecting retention of staff and disengaging clinicians from their role in ensuring patient safety.

I have been critical of the BMA for allowing this situation to continue but I acknowledge that unions face a dilemma. They can be persuaded to defend doctors against ministers and bureaucrats but here hostilities are primarily between two groups of doctors. Disciplinary procedures are likely to be driven by or even initiated by medical managers. ET judgement reports show that many also appear unable to manage disruption of and dissent within clinical teams in a fair and robust manner.

The Trust CEO is a key player but his views are channelled through the Medical Director and Clinical Directors. MHPS allocates an objective, influential role to non-executive directors but they appear unable to influence proceedings and may well feel intimidated or out of their depth.

Several professional organisations and affected doctors met under the auspices of Our NHS Our Concern to discuss the current situation and consider proposals to improve the current situation. DFNHS Executive member Arun Baksi, aided by fellow EC members Helen Fernandes and myself, has lead on formulating a proposal which is awaiting ratification. The final document will be circulated and posted on the DFNHS site before its launch.

In essence, we put forward a proposal for the

establishment of a Scrutiny Panel in each Trust comprising senior doctors, a smaller number of senior nurses and designated Trust non-executive directors. Each application will be considered by at least two senior doctors, one senior nurse and one non-executive director drawn from the panel. Doctors and nurses will be elected by their peers and should not hold and not have recently held a managerial post. All members will follow the guidance outlined in MHPS. We are confident that an independent elected panel will be objective and fair.

It is expected that this proposal will lead to a fall in the number of formal procedures as well as reduction in the duration of exclusions and the time taken for completion of disciplinary procedures: all leading to cost reduction. The panel will also ensure costs and outcomes are audited as recommended in MHPS. The proposed measure should be mandatory rather than circulated as good practice. It should be incorporated into MHPS and Trust disciplinary policy to ensure it constitutes an integral part of the formal employment contract.

We hope to garner support for our proposal from as wide a range of medical organisations as possible as well as from medical unions, medical defence associations and from politicians.

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The effects of climate change on health – what can we do about it?

When it comes to sustainability the NHS should be leading by example not lagging behind many companies in the private sector, says Executive Committee member Alison Hallett

Climate change has a vast array of adverse effects on health including: air pollution; spread of tropical diseases to new areas; mass migration; and war over resources due to flooding, droughts and difficulties with food production.

Whilst these impacts may currently be more visible in scenes of flooded lands in Bangladesh and typhoons in Japan and the Philippines, the impacts are still very real closer to home. The German heat wave of 2018 was the hottest year in its history with over 1,000 associated deaths.

In the UK long-term exposure to man-made air pollution has an effect equivalent to 28,000 to 36,000 deaths a year. To put that into perspective air pollution is contributing to more deaths than diabetes (contributing to around 26,000 premature deaths a year). We've all seen the debilitating effects of diabetes on so many of our patients, but air pollution is the unnamed killer. It creeps in under the radar contributing to coronary heart disease, stroke, asthma and lung cancer.

When we give patients lifestyle advice, minimising contact with air pollution is rarely mentioned. Perhaps it seems futile because minimising contact with air pollution in congested urban areas is challenging, particularly for those without the privilege to choose where they live. But this significant public health issue is so rarely talked about that we are depriving patients of the opportunity to make changes for their health and that of others. Thanks to awareness campaigns and education, conditions such as diabetes are far better understood. We empower patients to make lifestyle changes that can prevent, reverse or better control this condition before significant harm is done. Restrictions on smoking in public areas are now generally accepted and we needed public awareness of the dangers of passive smoking to help drive change at a higher level. With better awareness of the dangers of air pollution, real change can happen.

1 in 20 vehicles on the road is linked to the NHS (including supplies vehicles and commuters). We are the biggest employer in the country making up 10% of the economy. So, if we as an organisation make changes, this will have a real impact on the overall levels of air pollution in the UK. Just as we make quality improvement projects to work more effectively in our department so we can look for projects to improve the NHS's sustainability and help achieve our goal to get to net zero.

While many other healthcare systems have rising carbon emissions, the NHS is planning to change for the better. But to find what can be achieved and what will be best for our patients they need us as front-line staff to highlight ideas to them and help implement them. We can, for instance, raise awareness of 'Cycle To Work' schemes and campaign for the use of hybrid or electric vehicles. We can highlight the need for effective insulation and renewable, efficient heating control systems. Insulation is an extremely cost effective and simple change in the battle against climate change. And with antiquated and expensive old heating systems in many hospitals pumping out heat and burning gas all year, we could be doing so much better. I've worked in hospitals unable to turn off their heating in the summer, contributing to dehydration and AKI

in elderly patients, or requiring air conditioning to battle the heat from the radiators. There may well be grants available for energy efficiency schemes in hospitals and from April this year grants are becoming available for heat pump installation in the home, making renewable heating options more affordable for us as individuals too.

A further issue we will all be familiar with is the use of disposable plastics. The World Health Organisation has expressed 'great concern' regarding microplastics and evolving research is exploring its effects on human health including respiratory distress, cytotoxic and inflammatory effects, and autoimmune diseases. Legislative and societal changes were coming in leaps and bounds in recent years as awareness spread about the devastating effects of microplastics on aquatic life. Understandably with the adjustment of priorities for COVID, tackling this issue has taken a backseat. As we require vast quantities of disposable plastic items for infection prevention, this is going to be a very challenging issue for us to overcome. Not only the waste product but also the manufacture and transport of these disposable items is impacting on health through air pollution and climate change.

So, what can we do about plastic? Bioplastic alternatives seen increasingly in non-clinical environments may well be able to help solve this problem, as well as working with suppliers to reduce plastic packaging. As individuals we can moderate our own use of disposable plastics and ask for recycling facilities in our offices and staff rooms. We can also suggest our organisation swaps out plastics for alternatives, particularly in non-clinical areas such as canteens. We clearly don't want to compromise our patient care, but just as we re-thought our approach to ordering blood tests with the recent blood bottle shortage, we also can rethink our use of disposable plastics to see where we can safely reduce our usage.

Demonstrating the extent of the evolving impact of modern-day environmental damage is that we have lost 50% or more of our insects since 1970. Have you noticed the reduction of insects splattered across your windscreen? Or the lack of bees buzzing round you at the park? Whilst this may be a relief in the short term even these tiny critters are essential not only as food for other birds and animals, but also for breaking down waste and recycling it and pollinating the food we need. Providing bee friendly garden areas and trees around our hospitals not only provides a better environment for staff and patients, but also contributes to keeping our local ecosystems thriving. Maintaining green spaces for patients to look out on also has quite immediate health benefits. These include reduced: stress, symptoms of depression, blood pressure and heart rate. Evidence also shows a reduction in overall length of hospitalisation and even reduced need for strong pain medications post-operatively. A further major benefit to growing trees in hospital grounds is their role in intercepting and reducing air pollution and providing carbon capture. There are so many positives to maintaining our natural environment that cannot be measured by profit margins.

We want to keep our NHS out of Private hands. So, let's show the country what we in the public sector stand for. Let's show them that we will provide better for our patients and think not just about profit or short-term gain, but also keeping people and planet healthy long term. The NHS has now committed to net zero. So let's help make that happen.

In order to meet the current target for greenhouse gas emission reduction, around 87% of UK electricity would need to come from low carbon sources by the end of this decade, up from over 50% now. The need for these drastic changes is because whilst these changes may seem manageable now there are various tipping points that could lead the rate of environmental change to gain such independent momentum as to leave us unable to reign it in. Two tipping points that we could be on the brink of now include: the melting of arctic permafrost and the destruction of the amazon rainforest (along with loss countless species and unique habitats). These aspects of our natural systems have contributed to the relative stability of the earth climate for over 10,000 years but as environmental changes go

beyond various tipping points the continued loss of nature's stabilising habitats and escalating climate change are predicted to become self-perpetuating and beyond our control. As this happens, we may no longer be able to adjust for the pace of change: the spread of disease, food shortages and fighting over resources will be the likely consequences.

Unfortunately, instead of the 7% drop annually in carbon emissions planned at Paris there have been 7% rises annually – excluding the year of lockdown. These changes are so profound, and so rapid, that it is difficult to predict the long-term consequences, but this also opens up many opportunities to influence the outcome. But it is vital that we act now, before the dust settles and these countless changes have become engrained in society. If people and the government can be encouraged to focus on the habits and regulations that will help benefit health and wellbeing then the benefit will be seen for decades. And in the spirit of the common, as well as the individual good, those habits and legislation changes must include caring about our environment.

There will likely be increased health problems associated with home working producing more sedentary lifestyles, loneliness and financial insecurity. But we could also see decreased air pollution with less commuting and less international travel. There may be improvements in health and wellbeing from increased family time, more time for walks in local green spaces, and reduced loneliness with people engaging more in their local community. Healthcare professionals are trusted and looked to for guidance, so as people are settling back into their own lives, we can encourage them to continue helpful habits picked up during lockdown by sharing our knowledge and perspective with them.

And with the upcoming challenges as we transition into a post-Brexit Britain with an economy severely destabilised by COVID we cannot afford to let the other aspects of the nation's health be put to one side. As busy healthcare professionals, it is easy and understandable to focus all of our energy on patching up the sick and dying patients in front of us. But we can have so much more impact if we can look at preventative measures for maintaining public health and wellbeing. An increased focus on public health and the environment would provide a much-needed message of hope for a brighter future at this time where the world feels so out of control. With health being a key focus for the general public and media in light of the pandemic we have more of a platform than ever to talk about these broader health related issues.

We must take this opportunity to be visionaries for a healthier, cleaner world.

We can make changes in our own organisation to lead the way and show that in caring for health we also need to care for our environment. We can take a much more holistic approach to healthcare, thinking not only of the final consequences (which in the case of air pollution are often irreversible), but of keeping people well for longer. That means thinking about reducing our carbon footprint, maintaining nature and nurturing communities. As people are looking to us more and more let's give them a vision beyond just jabs and pills. Let us look towards a way forward that will make for happier and healthier people and planet.

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What is environmental medicine? A personal view

The first essay I wrote at primary school in 1946 was in defence of the concept, given our teacher's title, of "nationalisation of doctors" and I remain an enthusiast for the need for government to address the effects of Sir William Beveridge's five giant evils: illness, ignorance, disease, squalor and want.

My early years in medicine in Liverpool made obvious the importance of the environment in determining the health and illness of individuals: air pollution, cigarette smoke, poor diet, poverty. To me, genetics was a curious if interesting side issue in the causation of disease; what really mattered and was most readily influenced by society and the State was the environment. This concept developed into an appreciation that the practice of medicine should be based on an understanding that an individual's illness is a failure of adaptation to his or her environment, or what has sometimes been characterised as "Darwinian medicine".

During my early career, death from rheumatic heart disease and chronic lung disease were commonplace. Our patients had grown up in relative poverty when streptococcal infections and smoking were rife. The environmental determinants were obvious. Later, as a young chest physician, I witnessed the decline in tuberculosis in UK, which had started with public health measures and was being driven by drug therapy. These initial successes were viewed generally as a success in anthropocentric terms – clever humans developing magic bullets to kill dangerous bugs. But antibiotic resistance changed this and from the 1970s I started to teach my students that what was happening was a temporary shift in advantage for most but far from all humans in the evolutionary struggle for survival between species on the planet. This struggle was one that has required increasing ingenuity on our part since micro-organisms have an inherent advantage in terms of adaptation and from our point of view can only be overcome by our development of immunity to their effects. This lesson has recently become obvious to all with Covid-19.

Over the same period, I witnessed the increase in asthma in the population, predominantly in westernised countries, and realised that such changes in incidence of disease must be related to change in the environment, but what had changed? And I saw patients with strange allergic lung responses to inhaling a common fungal spore, *Aspergillus fumigatus*. Why was this happening only in people with asthma or cystic fibrosis? And why only to that fungus and not to any of the many other ones we inhale every day?

"What is environmental medicine?" is a question that I have often been asked; a follow-up to my answer to the question "What do you do?" I am, or rather was, a professor of it and have taught it for decades, so I should know. But what is it? Although there are two or three others in UK who hold similar posts, there are not as far as I know any medical practitioners of the subject, you cannot train in it, and it rarely features in medical school teaching. Even those who are professors of it carry the additional title of occupational medicine, which is perhaps easier to understand.

The question came back to me recently when I was asked to record the history of my university department. In 1987 a Chair in Environmental and Occupational Medicine was endowed in Aberdeen with money from a company concerned with providing support to the North Sea oil industries. The three responsibilities of medical departments in universities are to do research, to teach and to keep in clinical touch with their specialties,

usually through honorary NHS appointments. At the time, the General Medical Council was requiring wholesale revision of the curriculum, and this afforded a unique opportunity to introduce my subjects into clinical teaching. With fellow department heads in paediatrics, geriatrics, psychiatry, public health, and general practice, we introduced teaching of the importance of the environment and of work to human health in all years from year one. It was based initially on general practice, but it was taught as part of all the different subjects, not as a separate one. The aim was that our graduates would appreciate the relevance of the occupational and social history to making decisions about diagnosis, treatment, and prognosis in whatever specialty they finally chose.

At a post-graduate level, teaching embraced clinical diagnosis and assessment of the effects of disease on ability to work, basic epidemiology, toxicology and ergonomics, and occupational hygiene and environmental measurement. These are the core subjects that practitioners of occupational medicine need to understand. Occupational medicine is a well-established specialty with its own Faculty and examinations. Its concern is with the welfare of workers, in preventing work-related accidents and illness, and in facilitating return to work of those recovering or suffering from ill health; it has both preventive and rehabilitative roles.

Research in a new department proved more of a challenge. Taking a broad view of the remit revealed many research opportunities but few obvious sources of grants. Moreover, universities had become obsessed with league tables and research ratings; research of international quality was required. How and whether we met this is debatable, but the scope can be illustrated by mention of some of the areas that we addressed. Starting with various epidemiological studies of lung health in relation to oilseed rape cultivation, thunderstorms, and diet, and the biology of fungi [1,2], we moved to air pollution and investigated the association of this with heart attacks, proposing the first plausible explanation via inflammation and its effects on blood coagulation [3]. We then found that air pollution seemed to affect endothelial cell function, and this has led to an interest in nanotoxicology and speculation as to how air pollution may increase risks of cognitive impairment [4-7].

> "Occupational medicine is a well-established specialty.... Its concern is with the welfare of workers, in preventing work-related accidents... and facilitating a return to work; it has both preventative and rehabilitative roles "

Over the same period, the documented rise in asthma in schoolchildren led to the idea that it may have been related to maternal diet during pregnancy and for almost 20 years we followed up a cohort of children whose mothers' diets we had studied during their pregnancies. This ultimately showed that a maternal diet low in vitamins E and D significantly increased risks of asthma in the child up to the age of 15 by which time the effect had waned [8-10]. Experimental studies demonstrated possible mechanisms affecting in utero airway growth.

What you breathe and what you eat are obviously important environmental determinants of health. What happens at work is another. One obvious area of research was the long-term effects of diving, and cohorts of professional divers were studied. This was extended to include welders, since North Sea deep divers did a considerable amount of underwater welding [11,12]. The availability of a compression chamber allowed the researchers also to measure the effects of lowered

pressure and oxygen levels, mimicking the effects of long-distance flight on blood coagulability when fears began to be expressed about risks of venous thrombosis associated with air travel [13].

Seeing patients with heavy exposure to solvents led to an interest in chronic neurological diseases, such as Parkinson's disease and multiple sclerosis, and the possibility of causation by toxic agents in workplaces. A series of studies of industrial painters in Scotland and China showed organic solvents to increase risks of multiple neuropsychological symptoms [14,15], and a cross-European study of Parkinson's disease showed that risks were increased in relation to estimated exposures to pesticides [16,17].

All these studies were characterised by careful estimates or measurement of the environmental exposures. This was not well advanced scientifically in the 1980s, and the department's contributions to this science in collaboration with the Edinburgh Institute of Occupational Medicine were influential internationally. Other research results contributed to regulation, for example work on passive smoking to prohibition of smoking in public buildings, the dietary work to recommendations of diet in pregnancy and removal of the advice not to eat nuts, the diving work on guidelines for medical examination of divers. From the staff's point of view, 20 achieved doctorates and three obtained professorial chairs. And from the Medical School's point of view, the department ended with among the highest citation rates and grant income in the University. But there it did end. In 2015 it was subsumed into a larger university body and the key staff migrated to other universities.

From my first consultant appointment in Cardiff in 1970 (when I joined the Hospital Consultants and Specialists Association) until 2013, 10 years after retirement, I taught medical students in lectures and at the bedside on the relationship between our physical and mental health, illness, and the environment in which we live – the air we breathe, the food and drink we take, our activities, and our competitors, the micro-organisms. From 1998, my later years in Aberdeen, until today I have been lecturing on the risks of climate change and how we need to adapt to the rapidly changing environment. Both these environmental themes have come very much into public awareness over the period of the pandemic. The doctor who practises environmental medicine, whichever specialty you are in, is better able to advise patients on how to address such problems, how to protect themselves and others. I have been privileged to work with many colleagues who shared this ethos and who did most of the work I have quoted.

In short, environmental medicine is simply what every doctor in every specialty should practice. It starts with the social and personal history and leads you to ask how well- or ill-adapted your patient is to the environment in which he or she lives. It is just good medicine. Ask questions of yourself and look for answers. It is what Nye Bevan, knowing of the social and workplace conditions of miners in South Wales, asked of us when he founded the NHS.

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Interested in writing for the newsletter?

This newsletter goes out to all our members and is also on our website. Contributions are welcome. If you have any ideas for an article please contact the Managing Editor, Alan Taman: healthjournos@gmail.com

More funding, training and recruitment? Our NHS staffing needs far more than this

Increasing money and training to refuel our weakening and unstable NHS healthcarers workforce may be necessary, but it is certainly not sufficient. Executive Member David Zigmond offer some thoughts on why.

There is growing darkness at the (imagined) light at the end of the Covid tunnel.

We have many reports of the pandemic's legacy of damage and cost to our healthcare: not just delays and interruptions of sometimes vital treatments, but of increasing staff burn-out, drop-out and opt-out. And many of those that remain seem like heroically-motivated runners staggering towards the end of a gruelling marathon – painfully determined to continue, yet collapsing into the arms of supportive and restorative care in order to recover.

Thankfully, this is at least now recognised and stated recently by the erstwhile Health Secretary, Jeremy Hunt, and the recently appointed Chief Executive of NHS England, Amanda Pritchard. Both are agreed that this is a serious problem which will be neglected at our peril. Their remedy? Adequate funding for greater training and recruitment of staff. In a post-Covid post-austerity era this may sound encouraging, but it raises many other questions, some very quotidian, others more fundamental yet obscure. How much funding is 'adequate'? How will this be raised, distributed and secured? If we recruit medical and nursing staff from other (often much poorer) countries – as Amanda Pritchard breezily suggested – what are the ethical and practical (elsewhere) consequences of this?

But there are much greater and deeper rooted problems that threaten our NHS workforce than this Covid-induced concussion: the insidious and cumulative demoralisation and depersonalisation of healthcarers who have lost a sense of vocational pride and satisfaction, and colleagueial trust and belonging in their work. This deep and widespread dissatisfaction amongst so many nurses and doctors far precedes the superadded – albeit far more dramatic – Covid-crisis. Perhaps because this erosion of spirit and morale has been more gradual and incremental, its substantial damage has received little sustained attention from governing and managing authorities. Despite many years of growing evidence – for example falling recruitment, failing health, increased early retirement and career abandonment amongst primary and mental healthcare workers – little attention has been paid to the human meaning of this. This inattention is highly selective and thus tells us much about the nature of our problems.

For the last 30 years there have been successive NHS reforms that may be seen as shifting attention, with increasing resources and precision, to money and metrics. The pioneering neoliberal agenda of the Thatcher era converged with the excited early development of digital technology: this enabled the mass-management and commodification of healthcare, and thence to marketised commissioning, monitored performance and regulated compliance – together these are most compatible with corporate tendering and contractual negotiation. All this was much less possible in a previous world informed by mere ledger-books and managed by variable human good faith and judgement. The combination of computerisation and the new economics could then reform healthcare to become more and more

like competitive commercialised manufacturing industries – like a giant web of siloed factories.

Before such serial reforms the NHS functioned more like a relatively informal network of families than such a system of contracted factories. This analogy can tell us much about the pre-1990s NHS and its strengths and weaknesses. As with real-life families there was much variation: there were those that were dysfunctional, even hazardous; but most resembled happier families that functioned well with flexibly adapted bonds of convivial trust that grew from personal familiarity, shared experiences and bespoke understandings. These bonds of personal identifications were shared between the healthcarers and their staff, and then with their patients – a professional community caring for a wider community. This sense of belonging nurtured deeper senses of shared context, meaning, motivation and purpose. This was exemplified by how we looked after and looked out for others: the bedrock of personal continuity of care – the Family Doctor.

It was such 'organic' growth of familiarity, community and care that sustained the practitioners' deep work satisfactions and thus the mostly buoyant morale, excellent recruitment and staffing endurance and stability of pre-1990s general practice. GPs liked their work: despite working hours being longer and the pay no better: they usually retired late with poignant reluctance and reciprocated affectionate gratitude.

There is a German word – *Verschlimmbesserung* – which means trying to fix things, but making them worse. This accurately describes much of the legacy of those serial reforms that did not see, heed or understand the organic nature of healthcare's complex human ecosystems and thought short-circuiting these to inorganic industrialised systems would be more 'efficient' and cost-effective. This often draconian process – from Family to Factory – was often answered with protest, argument and mounting evidence of its unpopularity, inefficiency and damage. But such reforms, once rolled out, are very difficult to roll back.

The tragic portents of the consequently dispirited and sickening NHS workforce – wrought by its no-one-knows-anyone-but-just-do-as-you're-told culture – have been very evident well before the pummelling of Covid. But that ethos, in its zealed mission, blinded those who designed and managed it.

Now we face the post-Covid denouement. What will 'building back better' mean? It will be another extravagant folly to train and recruit a larger tranche of healthcarers if they do not want to stay with us, and for us, for a long working lifetime. And yet they are only likely to do this if their working milieu is one of greater belonging, trust and satisfactions that can dovetail with personal vocation and identification … as so often happened before our serial reforms. How can an industrialised system, particularly one yoked to corporate and commercial interests, ever fulfil these conditions?

[*Many articles exploring similar themes are available on David Zigmond's Home Page* https://bit.ly/32N4jcd]

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Social justice and the 'failing' NHS

With the many likely attacks on the NHS we can expect this year, the charge that it is 'not fit for purpose' seems to be gaining ground. Communications Manager Alan Taman examines how.

We face an existential crisis on a global scale. Civilisation is at stake unless drastic action is taken. So, many argue, is the NHS. It has always faced threats.

But there has never been a combination of factors like those we currently have. Workforce levels perilously close to collapse. NHS staff taking time off through sickness at record levels. Doctors saying they intend to retire early (or have done so) in unprecedented numbers. Decades of dropping funding, in real terms. And, of course, the multiple threats facing the NHS from continued privatisation, as the Health & Care Bill could still easily herald an era of cherry-picking by private companies under the guise of service integration. DFNHS has commented on these, and supported other organisations committed to oppose them.

A further threat, perhaps not as often realised, is that posed by the belief that the NHS cannot do its job any more. That it is, despite being with us since 1948, somehow 'not fit for purpose' in the light of all of the above. Beliefs are powerful forces for change. A belief that something better could be made for healthcare in the UK is what drove the political will to establish the NHS. Believing in it has sustained it since. In the early stages of the pandemic, the government tapped into that, lionising the NHS as the greatest single reason to warrant lockdown and furlough on a massive scale. DFNHS took a sanguine view, fully aware that decades of under-funding and waves of legislation had weakened the NHS: it was not 'match fit' to withstand the pandemic. Despite which, staff did their jobs above and beyond. Some paid with their lives. We also know that the counter-belief, that the NHS is not the best way of offering healthcare, has always been there and seems to be growing.

It is useful to exam that belief, that the NHS 'doesn't work any more', given what we stand for, to reaffirm by questioning that our beliefs, in and for the NHS, are well founded and can withstand what the NHS now faces while also agreeing that the NHS is far from perfect.

The NHS cannot do its job because...

1 To do so needs limitless resources

This seems to be a growing voice in the clamour over the NHS and the crisis it faces. This argument is based on the assumption that the NHS has to meet all healthcare demand, and that this is growing to the point where the public finances to pay for this cannot be afforded. More so since the pandemic, with the sheer numbers of people whose treatment was delayed because of Covid. But it's an argument that has also been raised in step with advances in medicine. More ability to treat means more can be spent treating. So this must ultimately be unaffordable. In which case, should the NHS be replaced with something else?

But this argument misses a key point. The NHS was not founded to meet all healthcare demand. DFNHS has never set out to advocate that it does so. This hinges on how 'comprehensive healthcare' is defined. Does it mean 'treat everything'? or does it mean 'meet the needs of treatment to a degree agreed upon'? Ever since it was founded, the degree to which the NHS meets healthcare demand has always been an arbitrary matter,

decided upon by politicians and NHS managers who in turn have been given their authority to decide through political consent. It's a moving line and always has been.

A more useful way of looking at this is to ask, 'what model of social justice do we judge this by?' What level of healthcare should this society regard as acceptable, and to what degree should public money raised through taxation pay for it? At its heart, this hinges on the idea of fairness. Which way of delivering healthcare is fair? And what amount of tax should be levied to pay for that? Which in turn raises other questions about what cannot then be paid for with public funds, such as education. What kind of society do we want? Do we want a society where people have to find the financial means for nearly all healthcare throughout their lives on an individual basis? (USA) Or a system of taking money off people as they earn an income, proportionately, then deciding how much of that goes to healthcare for everyone irrespective of that individual's likely need over their life? (UK, and others) In which case, how much and where to spend are the key questions.

To say that system is unsustainable because it cannot meet an arbitrary level of need – absolutely everything – is as invalid as saying it is unsustainable because it does not meet another arbitrary level of need. Re-draw the line. What's still fair? And who is judging that? The NHS can deliver any possible healthcare we choose, but that is always at the expense of something else. Political, arbitrary choices. Not the pursuit of a never-ending ideal. 'The NHS is an ideal which cannot ever be achieved in practice' is a similar argument, which similarly misses this point.

"Re-draw the line. What's still fair?...The NHS can deliver any possible healthcare we choose, but that is always at the expense of something else. Political, arbitrary choices. Not the pursuit of a never-ending ideal. "

2 Private companies can do it better

Gauging the evidence for this in entire healthcare systems is complex, for several reasons. Here are just two. First, if you are comparing NHS with private, you have to consider outcomes for the whole population (look at the USA for reliable data on that, again) and not just those who can afford to pay or whose health insurance covers their treatment (USA, wealthy people). How many private companies even attempt to serve whole populations over such a range of services as the NHS? None. Second, although there are hybrid models that show better outcomes (as in parts of the EU) for some measures of healthcare (such as survival for some cancers), levels of funding are greater to start with per head, as gauged by percentage of GDP. If you're going to compare, compare like with like. Once that's done, the case for handing over services to private companies becomes far less reliable, and just as much a stance taken for ideological reasons ('private is best') as organisations like DFNHS are often accused of taking in favour of the NHS. The apparently 'superior' performance of hybrid models, such as in some EU countries, becomes far more questionable. Our data is robust, though admittedly the complexity of gauging it leaves room for honest debate. Admitting you cannot compare health systems easily would be a good place to start, then go on to pose questions about fairness, as much as outcome. How do you gauge what is fair? By outcome, by ease of access, by level of funding? If that is done, the case for the NHS is much clearer, as is the inherent unfairness of gauging performance simply on outcome alone.

3 It is wasteful

This argument takes the view that the NHS needs to be replaced (usually with systems that rely on or encourage private health insurance) because it has become too 'inefficient'. The first problem with this argument is how massive and complex the NHS is. How then, to judge how 'wasteful' something that size is? There is waste. But what is acceptable, on this scale? It would be foolish to say that the NHS does not need improving, and to deny that in some areas performance has gotten worse. A far more useful approach is to realise that the NHS always has room for improvement, and those working in it by and large want to do their jobs as well as they can. So how can improvements be made? Why have some areas fallen behind – are funding levels dropping or have staff levels dropped dangerously low? If funding and workforce levels have dropped, wouldn't you expect any system to start to fail? If more was spent, what is the best way of gauging how much this improves things?

What the NHS means and what it needs

The NHS is not a discrete, easily measured entity, though many metrics used to gauge what it does have to use some standard. It is an idea, a way of doing things, a political construct fashioned from governing principles tempered by pragmatism and enacted through political will, and founded on a set of principles with ideas of social justice at their heart. Limits on what it does, and what it can do, and what it should do, have always needed to be set and have always been modified by political agendas, difficult choices over spending and taxation, and, at times, sheer expediency. Which is the case now. The NHS does not 'need replacing'. It will need massive investment, after years of neglect grounded in a hostile ideology which encourages the view that publicly funded healthcare was somehow less desirable than models relying on privately funded healthcare. That

view prevails far stronger than it has before, as wave after wave of weakening legislation has made the NHS increasingly vulnerable to fragmentation and commercialisation. For the NHS there are still, to quote a remark often attributed to Bevan though contested by some, 'folk left with faith to fight for it' but they are beset and beguiled on all sides by voices of doubt and denial. Voices which speak to individual fear, and blame: exactly what the NHS was set up to combat. Now is the time to rally to the NHS as a socially just way of delivering healthcare, not deny it can continue to serve us as the best choice.

Nowhere in our aims or constitution does DFNHS advocate universal healthcare sufficient to meet all demand. But we do say that 'only the NHS can provide comprehensive clinical cover and health protection for the whole population' and demand that the NHS is restored 'as a publicly funded, publicly provided and publicly accountable service'. And that is as true now as it was in 1948.

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The Peter Fisher Essay 2021: Winner and first runner-up

The winning essay and runner-up to the first Peter Fisher Essay Prize show a remarkable insight into the essay subject. We will be publishing further runners-up in future issues

WINNING ENTRY:
The COVID-19 pandemic and the lessons of ignorance

The pandemic has been a period of great discovery and learning; the cross-boundaries potential for collaborative working, a renewed sense that kindness is more valuable than material objects, the laying down of roots of human connections in a disconnected, digital world and a timely reminder that we are mortal and human after all.

However, in an era of reflective practice, quality improvement and patient safety it could be said that what we should actually learn from the pandemic is that, in fact, we have learnt nothing at all. Inequality exists and is allowed to continue with a government that is ambivalent to change [1]. Racism is endemic within a society that permits it to have a voice whilst undermining the experience of minority groups [2] and these both feed into a propagation of institutional moral injury within our NHS [3].

These lessons are not new and have been revealed time and again after pandemics and scandals.

> No sustainable development, environmental harmony or lasting security will happen if we are unable to eradicate hunger and extreme inequality

As the world joined hands in solidarity over the devastating effects of COVID-19 [4] with heart-warming acts of kindness inspiring hope in millions, the virus once hailed as "the great equaliser" revealed deep uncomfortable truths about the inequalities that exist in the fault lines of society [5]. Marginalised and socio-economically disadvantaged groups have carried the burdens of this pandemic; mortality rates are twice as high in high-poverty countries compared to more affluent states. Lower income families were more likely to spend their savings, making them vulnerable to problem debt, whilst higher income households added to their savings [6]. These same families are often dependent on a single-earner to pay for the extra heating and food required during lockdown, negatively affecting their ability to socially distance, seek healthcare, quarantine from work and address their underlying comorbidities that contribute to worse outcomes once COVID is contracted [5-7]. The effect is not limited to this generation. The effect of lost education disproportionately affects the children from lower income families; it is estimated that losing half a year of schooling for these individuals will result in a £40,000 loss in lifetime earnings [8]. This only serves to embed wealth disparities for future generations.

This lesson is not new. COVID-19 arrived during a prolonged period of austerity, cuts in government spending, growing child poverty and stalling life expectancy[9]. Similar lessons have been revealed during the 2009 H1N1 pandemic and, similarly, during the 1918 Spanish influenza

[10,11]. Significant economic contraction was seen following 'The Great Influenza Pandemic of 1918-1920' with a 6 percent decline in GDP [12] and increase in poorhouse rates [13]; for every death there were four new attendances at poorhouses.

However, if a conscious effort is made to redistribute wealth, as witnessed in the 'Black Death', it is possible to reduce poverty and inequality [14]. Here, wages were increased and the poorer strata of society were given greater negotiating powers [14], resulting in many acquiring properties for the first time.

Yet, this requires co-ordinated governmental action that is proportionate to the scale of the problem [15]. Rather than begrudgingly responding to non-governmental organisations and civil society to support the most vulnerable in society, such as witnessed in response to childhood food insecurity in the UK [16], the Government must recognise that mitigating against these symptoms of economic insecurity is critical to social justice as we emerge from the COVID-19 crisis into a socio-economic one that has followed the pandemics of the past [14]. This requires sustainable policies that are equity-focussed and recognises the complex interplay between health and economy [15]. Otherwise, the health and economic burdens will disproportionately weigh on the poorest in society [15-17] and the landscape of suffering is set to grow if the social security of the country is not addressed. The lessons are there; we just need to reflect on them.

"Prejudice is a burden that confuses the past, threatens the future, and renders the present inaccessible" – Maya Angelo

"Black communities are still traumatised by historical abuses... and so mistrust of the medical commuity persists. This matters in a time where BAME groups carry the burden of morbidity and mortality from Covid-19"

Just as COVID-19 has exposed the fracture lines of wealth in society, so too has it dug up the deep-rooted foundations of xenophobia and discrimination in the UK. This has only been reinforced by the World's political leaders through anti-migrant rhetoric and microagressions from border policies to derogatory language [18]. This discriminatory 'otherness' that our leaders sanction has been observed throughout history; the LGBTQ community and HIV, the Ebola crisis and people of West African background, the Black Death and scapegoating of the Jewish community. The observed 'tsunami of hate' [19,20] levelled against people from ethnic minorities has been met with relative silence from governments [21] that permits intolerance to grow. Such ambivalence ignited a wave of protests organised by the 'Black Lives Matter' movement that condemned the ingrained systemic racism that perpetuates ethnic inequities in society today [22]. Furthermore, public gestures such as taking the knee during the Euros 2020 catapulted the need for social justice into a wider public consciousness [23].

This matters in an age where Black communities are still traumatised by historical abuses, such as the Tuskegee trial whereby vulnerable Black individuals were not allowed access to a cure for syphilis leading to their deaths, and so mistrust of the medical community persists [24]. This matters in a time where Black, Asian and minority ethnic (BAME) groups carry the burden of morbidity and mortality from COVID-19 that is independent of baseline health, lifestyle and wealth [15,22,25]. This matters as vaccine hesitancy is greatest in BAME populations and risks marginalising these groups further [26]. It matters.

However, it also matters that the lived experience of BAME individuals continue to be minimised and dismissed, such as seen in the Commission on Race and Ethnic Disparities Report [27], or when the anti-racist movement has been compared to 'gesture politics' [28].

In contrast, there is a need for understanding the legitimate concerns of these communities, engaging with BAME leaders and investing trust in their lived experience which matters as much as their lives matter. This lesson is also not new. Collaborative working that offers proactive communication that is accessible and non-stigmatising is long overdue and is a step towards the advocacy needed to tackle the health injustices these individuals have faced through this pandemic.

"We can't solve problems by using the same kind of thinking we used when we created them" – Albert Einstein

"The Covid-19 pandemic has revealed and unwillingness to confront the uncomfortable truths in our society and the unconcscious biases that exist...the NHS has had to navigate the last two years in a storm of fear and resentment"

The NHS is embedded within the social climate that surrounds it. If it exists within an ecosystem of fear, frustration and anger, the strength of the health system is not mutually excluded from that [18]. The moral injury that results "weigh down both people and institutions" [3]. This has been witnessed with the recent GMC survey exposing one-third of trainees in the UK feeling burnt out to a high degree and almost half finding their work emotionally exhausting [29]. These findings are not new or particularly surprising to those within the NHS but are the worst recorded. Furthermore, evidence suggests that this is intimately linked to a culture of bullying and undermining faced by individuals on a daily basis [30,31]. For example, 19% of staff experienced bullying and 98% reported incivility in the workplace in 2019 [32] and this is simply the tip of the iceberg [33] and symptomatic of lessons not learnt from Stafford, Bristol, Morecombe Bay, Gosport, and more recently, Shrewsbury where corrosive toxic workplaces led to morally distressing outcomes. The burnt-out, the bullied and the bullies are all victims of an institution that is crippled from understaffing and under-resourcing in a hostile environment where individuals are blamed but at the same time a 'no-blame' culture is tokenly promoted [34]. This requires sustainable investment into staff retention and resources so that the NHS has the organisational emotional capacity to address allegations of bullying in an empathic way. Until this happens, all the campaigns to "speak out" will fail as staff do not feel empowered or assured to raise concerns [35]. Until this happens, lessons cannot be learned.

"When you come out of the storm, you won't be the same person who walked in. That's what the storm's all about" – Haruki Murakami

The COVID-19 pandemic has revealed an unwillingness to confront the uncomfortable truths in our society and the unconscious biases that exist [36]. Consequently, the NHS has had to navigate the last 2 years in a storm of fear and resentment, cursed with scandals characterised by silo-working and division. In contrast, the Swedish prescribe to the concept of the 'Smultronstalle' or "Wild strawberry patch", which is defined as a place of refuge and great sentimental value. A place that needs attention, cultivation and kindness sown into

its soil. Some might say the NHS represents this shelter of safety, however it can only grow within an ecosystem of compassion, tolerance and trust. This requires responsive leadership at all levels if healing is to grow and solidarity is to blossom. However, this lesson is not new. What should we learn from COVID-19? Maybe the lesson is that we have learnt nothing at all.

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Catherine Huang

"What lessons should we learn from the Covid-19 pandemic?"

"What lessons should we learn from the Covid-19 pandemic?" There is no plural for what we should learn from the Covid-19 pandemic, only one lesson which is all-encompassing and should be prevailing. The lesson is compassion. The lesson we should learn from the Covid-19 pandemic is compassion.

Compassion for each other and compassion for ourselves. Compassion has always been important in healthcare with 'compassionate care' and 'compassionate leadership' becoming ubiquitous phrases (and the subject of many a conference presentation) but the last 17 months have been different: gruelling, unrelenting and at times, it has been almost impossible to see a way out. We, globally, have become vulnerable: having to journey together into unchartered waters and navigate many storms with little knowledge, save that gleaned from countries temporally ahead of us, in the United Kingdom (UK), in terms of rising cases. The "waves" we have sailed across have not been kindly waters but have been soaring, towering, crashing numbers of acutely deteriorating and dying patients resulting in wrecks of overwhelmed emergency and acute care services. Regardless of our position and grade, we are all leaders within healthcare: as we steer our vessels and steer each other into this uncertain future, we all require compassion to act as map, compass, and guiding light. As we strive to return to 'normality', we should not forget compassion in our behaviour towards others and ourselves.

Compassion evolved from our need and survival advantage to move away from self-preservation at all costs, to developing behaviours that offered mutual benefits including the propagation of our species [1]. As a result, we all instinctively recognise compassion to be a 'good thing'. However, it can be difficult to define: the Oxford English Dictionary defines compassion as both "suffering together with another" and the "emotion, when a person is moved by the suffering or distress of another, and by the desire to relieve it" [2]. We have certainly done the former: on the day I write this, there have been almost 153,000 deaths as a direct result of COVID-19 [3]. This figure, whilst in itself is devastating, is a vast underrepresentation of the suffering experienced since the start of the pandemic. This suffering has taken innumerable and previously unimaginable forms: the separation from loved ones in hospital and in institutional care as visiting was limited to reduce infection transmission [4], the delay on cancer diagnoses as routine diagnostic work was deferred [5] and the increases in loneliness and social isolation [6] which followed lockdown restrictions. Yet, all this suffering we have endured together and solely being moved by our collective distress is insufficient to be compassionate. Compassion is recognising and being sensitive to this suffering but also making changes to reduce or prevent it [7]. It is making others feel supported when they are desolate and feel accompanied when they feel deserted.

Compassionate behaviour is taking steps to stop people feeling desperate, isolated, and alone. It has evolved and is now not just about caring for our progeny to safeguard our descendants, but it is recognising that all of us, whether relation or not, grow and develop better when we feel safe, protected, and loved. Compassion is learning lessons from others as to how to avoid future suffering and distress by being the best version of ourselves. This compassion for others is the guiding light we hold aloft – providing hope to all

that there is help available and a way out of the darkness and despair.

In being the best version of ourselves though, self-compassion is important as being the best version of ourselves does not mean simply 'being the best' at everything. The constant, grumbling feelings of inadequacy for not spending lockdown and the Covid-19 pandemic 'achieving' weigh heavy on a number of us. It is a difficult confession to make but I have not been compassionate to myself due to my self-perceived lack of successes over the last 17 months. Making sourdough, taking up a craft hobby, learning a new language or becoming incredibly physically fit are all admirable but should not form the stick that we beat ourselves up with. Unfortunately, particularly in healthcare, we are competitive creatures and so continue to self-flagellate when we believe ourselves to have failed.

Feelings of failure have been amplified by the pandemic: in being restricted from seeing others in person or going about our daily routines, many have turned online and found inevitable comparisons with others apparently thriving in lockdown and providing evidence of their laurels on social media. We have forgotten that we are human. We have forgotten that the last 17 months were unprecedented. We do not make allowances for ourselves as we would for our loved ones or those under our care but instead hold ourselves to higher, often unattainable standards. It is critical for all of us to recognise this and take steps towards being self-compassionate.

Unfortunately, self-compassion has also become tied to rather negative 'buzzwords' like wellness which means we are at risk of failing to appreciate it's importance. Many ignore self-compassion, deleting the idea of it from our mental inboxes like the emails promoting mandatory e-learning on wellbeing [8] or the enforced free yoga session offered seemingly to tick a box. It is important to recognise that self-compassion is not self-pity or self-esteem but is accepting our limitations, flaws, and vulnerabilities (particularly in exceptional circumstances such as a pandemic) and not berating ourselves. In disregarding taking time to practice and develop self-compassion, we risk burnout. With burnout comes physical and mental ill-health, loss of ability to continue working or a desire to seek employment elsewhere [9] and at times, results in mortality [10]. Self-compassion is the map we hold for ourselves to indicate where we have been and where we are heading towards. It should involve reflecting on our past and present to direct and lead our futures. Without self-compassion and without treating ourselves as we would others, we run the risk of being unable to care for others or, potentially more catastrophic, snuffing out the compassion we have for each other too.

Compassion displayed towards healthcare professionals during the Covid-19 pandemic took many forms outside of the weekly doorstep claps [11]: generous gifts from individuals and companies flooded hospitals, discounts for NHS staff were in abundance and our 'heroes' were celebrated by many as hand drawn hearts and rainbows adorned windows of those forced to stay indoors [12] whilst we went to work. What has become increasingly apparent as the pandemic wears on however, is that we have all become weary: compassion fatigue is spreading, albeit at a lesser rate than coronavirus variants. There is no more clapping, no more donations and no more celebrated tales of 'heroes'. Goodwill extended towards healthcare professionals has dwindled resulting in protests outside of UK hospitals treating Covid-19 patients [13] and globally, to reports of staff being attacked by members of the public [14] as tensions over vaccines, healthcare resource allocation and lockdown restrictions erupted.

However, as healthcare professionals, we are also at risk of compassion fatigue thereby losing empathy and connection with patients [15] and reducing quality care as a result. An example of this prior to the pandemic was in Mid-Staffordshire NHS Foundation Trust [16] now held up as a reminder of what happens when individuals lose

their compassion, empathy, and humanity. We are at risk of similar happening again up and down the UK. Self-compassion can defend against compassion fatigue and is the most important step in safeguarding against it. We need to recognise that we are all at risk and as we face potentially further waves, we should take steps now to recognise compassion fatigue in ourselves, and in each other. We need to act using compassion as our compass to guide the way. Take leave and rest including proper and regular breaks whilst at work, keep connected to loved ones and share feelings with colleagues. As we are all leaders, we should all encourage and support colleagues to take breaks, keep connected and share feelings. Open discourse on our good days (and bad days) and encouraging teams that celebrate success and share, and learn from, failures will all help mitigate against compassion fatigue and will preserve our compassion for each other and ourselves.

We are (allegedly) now in a period of reset and recovery in healthcare [17] though as I write this, daily Covid-19 cases continue to climb, and the UK Government plans for so-called "Freedom Day" next week despite concerns of rising infection rates. Through our telescope, it looks like we will encounter more waves and stormy waters. Recognition of the importance of compassion in our recovery extends beyond healthcare: Joe Biden in his first speech to the United States of America, after being projected to become president-elect following the 2020 election spoke of "getting COVID under control… (building) on a bedrock of science" and proposing action based on "compassion, empathy, and concern" [18]. Of these three, compassion is paramount: compassion for each other, for ourselves and as leaders in healthcare. The journey ahead may be uncertain, but we can be certain of this: with compassion as our instrument, armour, and the lesson we have learnt, we will reach our destination.

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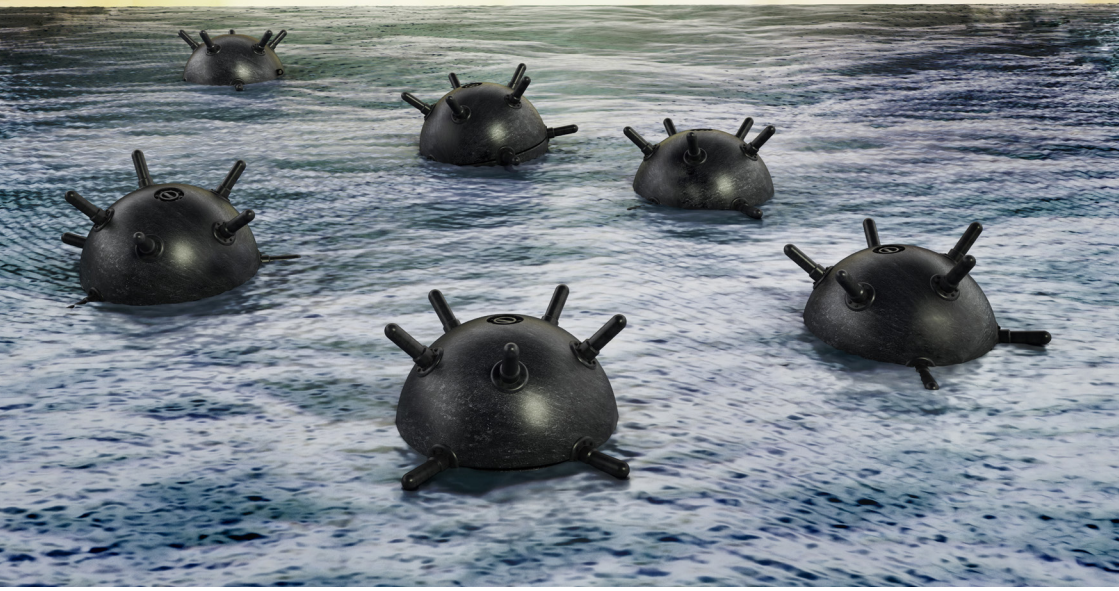
Interested in joining in more?

The Executive Committee welcomes new people who want to take a more active role in the group at any time and can co-opt members on to the EC. Please contact the Chair if you want to join.

Coronavirus is not the only threat...



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