

# this week

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## “End shameful maternal mortality”

The government underestimates the extent of racism's role in the “appalling” inequalities in maternity care that mean black women are almost four times as likely to die from childbirth as white women, MPs have said.

The Commons Women and Equalities Committee's report said ministers had not done enough to reduce the differences and the taskforce set up to tackle the issue had not met in nine months, despite intentions to meet every two months. Additionally, its terms of reference did not mention racism.

“The causes of the appalling disparity in maternal deaths are multiple, complex, and still not fully understood. Fixating on any one cause risks oversimplifying the problem and placing blame on the very women who are most at risk,” the report said. “Too many black women have experienced treatment that falls short of acceptable standards, and we are concerned that the government and NHS leadership have underestimated the extent to which racism plays a role.”

Despite a promise to reduce numbers of stillbirths, neonatal and maternal deaths, and neonatal brain injuries by 50% by 2025, the government has made little progress, and maternal deaths (excluding those from covid) rose by 3% between 2018 and 2020. Women in the poorest areas also face worse

outcomes, being 2.5 times as likely to die as women in the least deprived areas.

A fully staffed and funded maternity workforce is needed to make progress in reducing these inequalities, the committee said. Currently, funding falls short of the £200m to £350m a year recommended by the Commons Health and Social Care Committee and endorsed by the Ockenden report, which looked at the cases of nearly 1500 families who experienced maternal or neonatal harm, mainly from 2000 to 2019.

The report also highlighted gaps in ethnicity data and called for ministers and the NHS to prioritise capture of ethnicity data and for the taskforce to focus on representation of black women in maternal health research.

The committee's chair, Caroline Nokes, said, “It is frankly shameful that we have known about these disparities for at least 20 years. It cannot take another 20 to resolve.”

A Department of Health spokesperson said, “We've invested £165m since 2021 to grow the maternity workforce and are promoting careers in midwifery with an extra 3650 training places a year, while every local NHS maternity system has a plan in place to tackle disparities on a local level.”

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2023;381:p865

**The government has underestimated the extent to which racism plays a role, said the MPs' report**

### LATEST ONLINE

- Doctor imprisoned for patient's death after botched biopsy is struck off
- Despite bans, South Asia still struggles with pesticide suicides
- E-cigarette maker Juul to pay \$462m to settle deceptive marketing cases in six US states



# SEVEN DAYS IN



ALEX SEGRE / ALAMY

## Diabetes cases reach all time high, charity warns

The UK is in the “grip of a rapidly escalating diabetes crisis,” with the number of people affected topping five million for the first time, the charity Diabetes UK has said. It is calling on the government to make the condition central to its strategy on major conditions and to push ahead with its stalled strategy on obesity, including limiting advertising of junk food to children.

Across the UK 4.3 million people have a diabetes diagnosis, and the charity estimates 850 000 are undiagnosed, while 2.4 million people are at high risk of developing type 2 diabetes. There were 148 951 more people registered with diabetes in 2021-22 than the year before, the charity said. Around 90% of diagnoses are type 2, one of the risk factors for which is obesity. Currently 64% of adults in England are overweight or obese.

Last year the charity found that 148 000 people under the age of 40 have diabetes—an increase of 23% in the past five years—and could hit 200 000 by 2027.

Diabetes UK is calling for a continued focus on people who are at high risk of developing type 2 diabetes and ensuring they are referred to the NHS Diabetes Prevention Programme. It said integrated care systems must put diabetes at the heart of action plans to reduce health inequalities and target communities with a high prevalence of the disease.

Jacqui Wise, Kent [Cite this as: BMJ 2023;381:p848](#)

## Cancer

### NICE U turns on olaparib after manufacturer's deal

The National Institute for Health and Care Excellence has recommended olaparib for some types of early breast cancer and advanced prostate cancer in new draft guidelines, after a deal was negotiated between NHS England and the manufacturer AstraZeneca to provide the drug at a lower price. Given as a tablet, olaparib works by inhibiting the enzyme poly adenosine diphosphate-ribose polymerase (PARP) to prevent the DNA of cancer cells being repaired, stopping them from growing and spreading.

## Asylum seekers

### Lack of technology “is limiting access to care”

People seeking asylum in England are at risk of missing out on basic healthcare because of the cost of devices and mobile data, a lack of wi-fi networks in asylum accommodation, and a lack of confidence in navigating websites in English, the British Red Cross warned. The charity's head of health and resilience policy, Olivia Field, said, “Providing wi-fi in asylum accommodation, improving

digital literacy training, and making sure people have non-digital ways of accessing healthcare services are just some of the small steps the government and NHS can take to make sure everyone can get the care they need when they need it.”

## Talc

### J&J bids to end litigation with \$8.9bn offer



Johnson & Johnson offered a raised sum of \$8.9bn (£7.18bn) to litigants in the US who say that its talcum based baby powder caused ovarian cancers or mesothelioma, to be paid out over 25 years. This offer aims to resolve all North

American talcum powder claims made against J&J, including about 38 000 already filed and any future cases. The company abandoned its previous offer of \$2bn after a US appeal court upheld a lower court's rejection of J&J's proposal to pay its settlement through a specially created subsidiary that would take on the parent company's liability and then declare bankruptcy.



## NHS

### Labour pledges to train 15 000 doctors a year

Research by the Labour Party has found that 2.8 million patients saw their general practice close down or merge in the past five years, forcing them to find a new GP often miles from where they lived. There are 1200 fewer general practices today than in 2015: the average number of patients per practice was 9722 in February, up from 7465 in 2015, and each GP has to look after 348 more patients today than in 2015. Labour said that it would train 15 000 doctors a year and double medical school places, to be funded by abolishing the “non-dom” tax status.

### Service “was allowed to deteriorate” from 2010

Multiyear funding increases and various reforms led to improvements in NHS performance in England from 2000 to 2010, but performance has been in decline since 2010 because of lower increases in funding, limited funds for capital investment, and neglect of workforce planning, said a report from the King's Fund's former chief executive Chris Ham (left).

The failure to publish a credible workforce plan in the 2010s had

negative consequences, the report said, given that improvements in NHS performance from 2000 to 2010 had partly resulted from substantial increases in staffing and pay.

## Bird flu

### China records first human death from H3N8 avian flu



A woman in China has died from H3N8 avian flu—the first person to die from this subtype, the World Health Organization reported. “The likelihood of human-to-human spread is low,” it said, while emphasising the importance of global surveillance because of the constantly evolving nature of flu viruses. The woman had multiple underlying conditions, WHO added. Samples collected from a live poultry market visited by the woman before she became ill were positive for influenza A (H3N8), indicating that this may have been the source of infection. No other cases have been found among close contacts of the woman.



# MEDICINE

## Covid-19

### Virus was Australia's third main cause of death in 2022

Covid-19 was Australia's third leading cause of death last year—after ischaemic heart disease and dementia—with more than 20 200 more deaths than would have been expected without the pandemic and a total excess mortality of 12%, Australia's Actuaries Institute found. Most excess deaths occurred in people over 65, although excess mortality was at least 5% in all age groups in 2022.

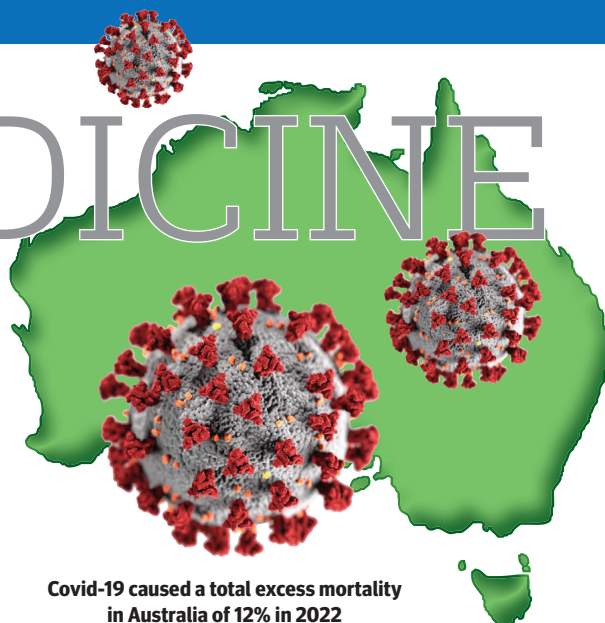
### "Pandemic hoax" surgeon loses suspension appeal

The High Court upheld a decision to suspend a senior surgeon from the UK medical register for six months for airing conspiracy theories on YouTube denying the existence of covid-19. Mohammad Adil appealed against the decision made last June by a medical practitioners tribunal, arguing that it infringed his right to free speech under the European Convention on Human Rights. But the judge noted that the convention may be restricted in the interests of public safety, to protect public health, and to protect the rights of others.

## Malaria

### Ghana approves vaccine for young children

Ghana's Food and Drugs Authority has approved a malaria vaccine developed by Oxford University for use in children aged 5 months to 3 years. The vaccine is being tested in a phase 3 trial, but phase 2 results suggest it is safe and effective. In 2021 it became the first malaria vaccine candidate to meet WHO's 75% efficacy target. Adrian



Covid-19 caused a total excess mortality in Australia of 12% in 2022

Hill, the vaccine programme's chief investigator, said, "This marks a culmination of 30 years of malaria vaccine research at Oxford with the design and provision of a high efficacy vaccine that can be supplied at adequate scale to the countries that need it most."

## Research news

### Teens who vape may become heavier smokers

Young teenage smokers who also vape may have a higher risk of persistent and heavier smoking in their late teens, showed two nationally representative UK and US studies published in *Tobacco Control*. The findings show that e-cigarettes may deepen early patterns of smoking, known as the entrenchment hypothesis, concluded the researchers. They did not find any evidence that e-cigarettes encouraged adolescents away from tobacco.

### Menu calorie counts have health benefits

Specifying the number of calories in each item on restaurant menus could prevent 28 000 new cancer cases and 16 700 cancer deaths among 235 million US adults aged over 20 in a 34 year period starting from 2015, suggested a modelling study published in *BMJ Open*. This would include 111 000 extra years of life lived in good health (QALYs) and \$1.48bn (£1.19bn) saved in related medical costs.

Cite this as: *BMJ* 2023;381:p857

## MENTAL HEALTH

Young people in the UK are waiting

between 10 days and 3 years for an appointment with CAMHS, with an average wait of 16 weeks

[*"The House" MPs' magazine*]



## SIXTY SECONDS ON... HAY FEVER



### BLESS YOU

Quite. Japan has seen a 20% rise in hay fever over the past 20 years. The amount of pollen wafting around is the highest in a decade, with last summer notable for being particularly dry, with more sunlight.

### NOT TO BE SNIFFED AT

Indeed. With about 40% of Japanese people getting hay fever, the effect on the economy is dire, with an estimated loss of 222bn yen (£1.3bn) a day, a 2020 analysis calculated.

### THAT'S EYE WATERING

It's nothing compared with sales of antihistamine nasal sprays and eye drops, which have risen by more than 200% in recent weeks, after warnings that cedar pollen counts could be 2.7 times up on last year. Some companies are offering to cover workers' medical fees and prescriptions and provide free eye drops and tissues.

### DON'T GO DOWN TO THE WOODS

Maybe not today, because a massive postwar reforestation programme aimed at preventing floods and landslides meant cedar is now the commonest tree in Japan. But if the Japan Forestry Agency has its way, woodlands could soon be a place of refuge for those afflicted with hay fever.

### HOW SOW?

Since the first pollen-free cedar variety was discovered at a Japanese shrine in 1992 scientists have been trying to produce cultivars more suitable for forestry while keeping pollen-free properties. By 2019 12.1 million low pollen or pollen-free cedars had been grown, roughly half of total seedlings, and it is hoped that will rise to 70% by 2032.

### THAT'S TREE-MENDOUS

A further breakthrough was made last month when researchers published the genetic sequence of cedar's 11 chromosomes—no mean feat given that its genome is 20 times bigger than that of rice and far more complex. This should speed up the development of pollen-free tree cultivars and also help predict how cedar might evolve.

### WHAT A RE-LEAF?

Sadly, given that hay fever is caused by all manner of plant pollens, sniffles are set to get worse—largely because higher temperatures and CO<sub>2</sub> levels are likely to create larger plants with more leaves.

Mun-Keat Looi, *The BMJ*

Cite this as: *BMJ* 2023;381:p847

## Ministers' plans will not make England smoke free in seven years, warn experts

The latest government plans to cut smoking rates are a "step forward" but are only around a third of the investment needed to deliver the ambition to make England smoke free by 2030, leading doctors, academics, and charities have warned.

On 11 April the health minister Neil O'Brien announced new measures in response to Javed Khan's independent smoking review. These included a "swap to stop" scheme with up to a million smokers

**On current trends we will be nearly a decade late in reaching a smokefree 2030**  
Open letter

offered a free vaping kit and a programme to offer pregnant women up to £400 to quit.

In an letter to *The BMJ* Nicholas Hopkinson, chair of Action on Smoking and Health, and other signatories said the plans were not nearly enough and called on ministers to invest £125m a year

in tobacco control, as Khan recommended.

This year real terms spending on tobacco control will be 45% down on 2015 levels, the letter said. "On current trends we will be nearly a decade late in reaching a smokefree 2030," it warned.

The letter said the latest announcements represented only about a third of the investment needed and were a reallocation of existing health department funds to public health, not new money. If the government invested £125m a year from the public purse there would be a net benefit to public finances, the signatories pointed out.

Hopkinson, professor of respiratory medicine at the National Heart and Lung Institute, Imperial College, said, "If the money can't be found from the public purse, a polluter pays levy that caps the tobacco industry's ill gotten profits must be introduced—an approach supported not just by health experts but by three quarters of the public."

Jacqui Wise, Kent [Cite this as: BMJ 2023;381:p863](#)



In 2022 the costs of smoking to health, social care, and the benefits system were **£22bn**, nearly double tobacco tax revenues, and the cost to the economy as a whole, including lost productivity and premature death, totalled **£173bn**

## "Government must drop nonsensical demands to avoid more strikes"

Junior doctors' leaders have vowed to focus on seeking a settlement with the government over their pay to try to avoid further strike action. But Vivek Trivedi, co-chair of the BMA's Junior Doctors Committee, told *The BMJ* that ministers were not approaching negotiations in the way that would usually be expected and that it was blocking any path to a deal.

"What they've asked us to do is to move our opening position, which is completely nonsensical," Trivedi said. "Anyone who has ever negotiated with anyone knows that one side puts their case forward and then the other side puts their case forward, and then after a period of negotiation you come to a mutually agreeable solution. But we haven't yet had the other side. The government has yet to put anything on the table at all, so it is completely unreasonable for them to expect us to move right now."

Junior doctors are asking for a 35.3% pay rise to reverse an estimated 26% real terms cut since 2008-09.

Speaking to *The BMJ* on 17 April, two days after the four days of strike

action in England had ended, Trivedi hinted that the Junior Doctors Committee would be willing to discuss settlements that differed from its initial demands, as is standard practice in any negotiation process.

He told *The BMJ*, "I don't think anyone would have ever expected a final deal agreeable to both sides to be presented on the very first day. That just doesn't happen. But we were hoping to have honest conversations to get to that point."

On the same day, Steve Barclay, England's health secretary, made a statement to MPs on what steps he was taking to prevent more strikes in the NHS.

He said, "I recognise there are significant pressures on junior doctors both from the period of the pandemic

and from dealing with the backlogs that has caused. And I do want to see a deal that increases junior doctors' pay and a deal that fixes many of the non-pay frustrations that they articulate. But the Junior Doctors Committee co-chairs have still not indicated they will move substantially from their 35% pay demand, which is not affordable."

**£15 BILLION ON USELESS PPE BUT NO CASH TO PAY DOCTORS FAIRLY**

## NHS forced to postpone 195 000 appointments during latest action

The NHS in England saw 195 000 appointments postponed during the four days of strike action by junior doctors last week, official data show.

NHS England said 27 361 staff weren't at work at the peak of the 96 hour walkout, which ended at 7 am on 15 April. But it said that was not the full picture, as a high number of entries from workforce data were missing.

March's strike caused 175 000 postponements across three days.

The NHS's national medical director, Stephen Powis, said the figures laid

bare the "colossal impact" of industrial action on planned care in the NHS.

He said, "Each of the 195 000 appointments postponed has an impact on the lives of individuals and their families and creates further pressure on services and on a tired workforce—and this is likely to be an underestimate of the impact as some areas provisionally avoided scheduling appointments for these strike days.

"Our staff now have an immense amount of work to catch up on hundreds of thousands of



But the Junior Doctors Committee rejected Barclay's description of its position. In a joint statement Trivedi and his co-chair Robert Laurenson said, "While we have said we are happy to talk any time, anywhere, Mr Barclay continues to demand that we drop our opening position of calling for a reversal of the pay erosion before he will even enter discussions. This does not sound like someone who understands the pay pressures junior doctors are under, nor someone who wants to sit down with us."

"So once again we urge them to drop their barriers to talks and meet with us in good faith, whether that is through the conciliation service Acas or directly, so that we can solve this dispute for the good of junior doctors, patients, and the NHS."

#### Little choice but to escalate

Trivedi told *The BMJ* that unless the government was willing to shift from its current stance the committee would be left with little choice but to escalate the dispute. He added, "We want him to come to the table without any further strikes being called. Right now, what our members, what the public and patients want is for us to try to get round the table. So that is where we're going to be putting all of our efforts, and we hope that Mr



Barclay reciprocates and does come in good faith."

During the industrial action last week the BMA and the NHS Confederation called on the government to agree to the Advisory, Conciliation and Arbitration Service (Acas) facilitating or initiating talks on junior doctors' pay. But as at 17 April the health department continued to maintain it would enter talks—with or without the help of Acas—only if this demand was lowered and strike action was paused.

When asked by *The BMJ* whether the department would agree to Acas, a spokesperson said, "The health and social care secretary has been clear that his door is open, and he remains willing to engage constructively, but that a demand of 35%, which would involve some junior doctors receiving a £20 000 pay rise, is unreasonable in the current economic context."

"But our position remains that the Junior Doctors Committee needs to



**We want to try to get round the table. So that is where we're going to be putting all of our efforts**

Vivek Trivedi

significantly reduce its demands and pause strike action for formal talks to begin—and that will not change."

#### No coordination with nurses... yet

Meanwhile, members of the Royal College of Nursing in England have rejected a pay offer and will go on strike between 30 April and 2 May.

Amid reports that healthcare unions may seek to coordinate strike action in the future, Trivedi said that junior doctors would not be coordinating with nurses in two weeks' time, because that was too soon to give the required notification period to employers. But he did not rule out coordinating industrial action in the future.

He said, "We fully support our nursing colleagues, and the 5% pay offer that was recommended to them is obviously a real terms pay cut this year, so it goes completely against their fight for fair pay and similarly our fight to restore pay against those subinflationary pay rises. In terms of coordinating action in the future, it's not something that we have ruled in or out so would be open to consider."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;381:p877

**A DEMAND** of 35% would mean some doctors receiving a **£20 000** pay rise, which is unreasonable in the current economic context, says the government

appointments, all the while continuing to make progress on tackling the backlog of people who have been waiting the longest for treatment. We have now seen nearly half a million appointments rescheduled over the last five months. While our staff are doing all they possibly can to manage the disruption, it is becoming increasingly difficult, and the impact on patients and staff will unfortunately continue to worsen."

Matthew Taylor, chief executive of the NHS Confederation, said that although NHS leaders and staff had planned well for the strikes and worked closely with local union representatives to deliver safe care and

**Local services have been greatly stretched at a cost to patients and families**

Matthew Taylor

minimise disruption to patients, the action was hampering efforts to bring down waiting lists.

"Local services have been greatly stretched, and a laser-like focus on maintaining patient safety in emergency and critical care and other areas has come at a cost to patients and families on elective and diagnostic waiting lists," Taylor warned.

In a joint statement Vivek Trivedi and Robert Laurenson, co-chairs of the BMA's Junior Doctors Committee, said, "Junior doctors know all too well the frustration of patients waiting too long for care, and with a waiting list of 7.2 million in England we are facing difficult conversations

with them every single day. These millions of patients are not in this position because of strikes, though. Persistent under-resourcing of the health service and undervaluing staff—exacerbated by a pandemic—mean we simply don't have the workforce and capacity to provide the high quality and timely care that patients need and deserve.

"This is why we have been led to strike, and while we are of course sorry to anyone who had their care disrupted this is the same apology we're already having to give to patients on a daily basis because the NHS cannot cope."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2023;381:p873



# Health professionals demand action on climate to protect people and planet

One of the UK's biggest climate protests is taking place in London this weekend. **Matthew Limb** asks medical participants what prompted them to join the demonstration



**We know that the climate and ecological crisis is the biggest determinant of our health now and in the future**

Aarti Bansal

Organisers of the Planetary Health Hub event in London on 21-24 April say 26 groups representing thousands of health professionals—including many new to climate protests—are supporting the action taking place outside parliament.

Campaigners were due to picket the Department of Health and Social Care to call for a public health campaign on climate change and to voice demands such as phasing out of oil and gas and ensuring clean air for all.

"We also have requests of government that are completely in keeping with what the Royal College of Physicians, the UK Health Alliance, and others have been asking for a few years now—which is for a moratorium on new fossil fuel projects, licensing, and subsidies," said Chris Newman, a GP and hub co-organiser.

"Two or three years ago it was quite hard to explain why climate and health are linked," said Anna Moore, a respiratory doctor who is joint vice chair of the voluntary staff network

Green at Barts Health, which promotes action, advocacy, and education. Since then the trust's Whipps Cross Hospital was flooded, and last year's heatwave led to operations being cancelled—both events more likely to reoccur with climate breakdown.

"We are in Tower Hamlets, one of the most polluted boroughs in London—children are born with smaller lungs, it's right on our doorstep. It's clear to our members that the ecological crisis that we're living through is affecting people's health and people want action," said Moore.

## Sustainable clinical models

Moore said many group members were working on initiatives to reduce waste, including in operating theatres, and to promote low carbon use across hospital sites, while also looking to develop more sustainable clinical models and preventive healthcare initiatives.

"A lot of what I hear is, 'I can't do anything about this, I feel powerless.' But people say that being part of a group that's acting is empowering.

This is a nice opportunity to be able to join lots of other health promoting organisations."

The Association of Clinical Psychologists has already declared a climate emergency. Its members will be among those hosting climate cafes—spaces where the public can come and speak about their reaction to the crisis—and giving talks on "an approach to making sense of climate distress," said Gareth Morgan, co-lead of its Climate Action Network.

The Greener Practice network has some 30 local groups across the UK working to make primary care more environmentally sustainable.

Aarti Bansal, a GP and founder of the network, told *The BMJ*, "Some of my colleagues are cycling from Sheffield to London to raise awareness, and others are coming from all over the country to add to our voices. We hope it will be huge, will pierce the public consciousness, and will offer that positive message of how climate action is good for our health, which everyone connects to," she said.

"We know the climate and

## Lack of specialist help leaves A&E staff at risk of missing child abuse cases

Emergency department doctors risk missing non-accidental injuries in babies because of a lack of specific guidance, multiagency information, and specialist safeguarding help, the Healthcare Safety Investigation Branch has found.

HSIB analysed 10 serious incident reports from NHS trusts in cases where non-accidental injuries were missed, and it

interviewed staff at three acute care trusts. Staff pointed to the high workload and time pressures in emergency departments, along with the sensitivity of raising the matter, as barriers to a diagnosis of non-accidental injury.

The investigation found that, although there was guidance on child abuse from NICE and from the Royal College of Paediatrics and Child Health, there was no

specific emergency department guide on the identification of suspected non-accidental injuries and how to act on a suspicion.

Serious incident reports tended to focus on individuals rather than systems, the investigation team found. A key factor was a "lack of professional curiosity" among clinicians, who might take what parents said at face value and



might not fully explore the way the injury occurred or whether the explanation offered fitted with the developmental stage the infant had reached.

A parent's explanation, for example, that a baby had caught his leg in the bars of his cot was accepted even though the 12 week old infant would not have been able to roll. Clinicians, particularly those with less experience of child abuse, tended to focus on treating the injury.

Access to information about a baby's or parent's previous involvement with social services was patchy, and only certain





ecological crisis is the biggest determinant of our health now and in the future and recognise that action on the climate crisis is our greatest health opportunity.”

Matthew Lee, sustainability lead for Doctors Association UK (DAUK), a non-profit advocacy group of doctors and medical students, believes it’s “our duty of care to campaign for stronger action on climate change for the sake of human health.”

#### Cultural shift

At the protest DAUK members were expected to explain the ethos of a “learn not blame culture” and why that’s applicable to climate and health.

They will ask people to sign an open letter calling on England’s health secretary, Stephen Barclay, to back the Climate and Ecology Bill now going through parliament, which proposes tackling the interconnected climate and nature crises that pose threats to mental and physical health and to halt and reverse biodiversity loss back to 2020 levels by 2030.

Rob Abrams is climate lead for

Medact, which campaigns for solutions to the social, political, and economic conditions that damage health, deepen health inequalities, and threaten peace and security. He said Medact had collaborated with Doctors for Extinction Rebellion on mobilising health workers to march during the COP26 and COP27 climate talks and that this led to the group’s involvement in the Planetary Health Hub.

“We’re always trying to push health institutions to take further, more concrete actions on climate. We’re also part of this bigger movement—ultimately action is needed at a national and global level.”

Abrams said that the UK’s commitment to achieve net zero emissions by 2050 didn’t go far enough and that he backed a “real zero” approach that stops emissions completely, “rather than this fantasy scenario where we’re going to suck emissions out of the air after the fact through unproven carbon capture technologies.”

Matthew Limb, London

Cite this as: *BMJ* 2023;381:p851

children who met defined thresholds were included in information sharing. Contacting social services or GPs for information was time consuming and difficult, the investigators were told. In addition, although clinicians can refer to the trust’s safeguarding team, they typically work office hours, with no on-call arrangements.

The Emergency Care Data Set (ECDS) gathers information about emergency department attendances and includes a field for when visits are related to safeguarding.

But the information is not currently used in the NHS, and quality assurance to ensure its reliability is minimal, the report said.

In one of two safety recommendations HSIB suggested that NHS England review the utility of the safeguarding data in the ECDS and agree a process for assuring the quality of data.

Its second recommendation was for the Royal College of Emergency Medicine to develop guidance.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2023;381:p835

**Clinicians can refer to safeguarding teams, but they typically work office hours, with no on-call arrangements**

HSIB report

## Reusable gowns and drapes could reduce carbon footprint

Laundering surgical gowns, drapes, and instrument table drapes rather than throwing away single use versions could go a long way to reducing the carbon footprint of surgery, researchers have said after finding that more than two thirds of emissions in five common operations came from disposable items.

For their analysis researchers from Brighton and Sussex Medical School and the University of Warwick observed the five most commonly performed operations in NHS theatres and counted all the instruments, drapes, devices, and other items that surgeons typically used. They then calculated the carbon footprint of all the items from their production to disposal, or the energy used for their sterilisation.

Single use items accounted for 68% of the total carbon footprint, whereas reusable items accounted for just 32%, they reported in the *Journal of the Royal Society of Medicine*.

Of the operations studied, knee replacement surgery had the highest product carbon footprint at 85.5 kg CO<sub>2</sub> equivalent (CO<sub>2</sub>e), similar to driving more than 300 miles in an average car. The next highest

**MEDICAL** equipment, such as that analysed in this study, accounts for **10%** of the NHS’s carbon footprint, the NHS has said



MARK THOMAS

were gall bladder removal (20.3 kg CO<sub>2</sub>e) and carpal tunnel decompression surgery (12 kg CO<sub>2</sub>e).

The health services in England and Wales have pledged to reach a net zero carbon footprint in all their operations by 2045. Medical equipment, such as that analysed in this study, accounts for 10% of the NHS’s carbon footprint, the NHS has said.

As well as replacing non-sterile gloves with handwashing where appropriate, the researchers suggested swab packs should not be opened unless they were needed and that suppliers could remove rarely used items from single use pre-prepared packs.

They also found no evidence that reusable surgical textiles were clinically inferior to single use gowns, patient drapes, or instrument table drapes and that a switch to reusables would lead to significant carbon reductions.

Florence Wedmore, *The BMJ*

Cite this as: *BMJ* 2023;381:p853

## THE BIG PICTURE

# Blue plaque honours pioneering GP

More than 50 years after his death, the life of the influential GP Cecil Belfield Clarke has been marked by a blue plaque near the site of his medical practice in south London.

Clarke was born in Barbados in 1894. After winning a scholarship he travelled to England in 1914, just after the outbreak of the first world war, to study medicine at Cambridge University.

After completing his training at University College Hospital, in 1923 Clarke opened a medical practice near Elephant and Castle, where he worked for nearly 50 years, including during the Blitz, when most of the neighbourhood was bombed. In 1936 Clarke became a district medical officer.

In 1954 Clarke was elected to the BMA council as representative for the West Indies and served until 1967, two years after he retired from practice.

As well as his medical practice, Clarke was a leading figure in race relations in London and internationally from the early 1930s onwards. He was a founding member and benefactor of the League of Coloured Peoples.

*Alison Shepherd, The BMJ*

[Cite this as: BMJ 2023;381:p869](#)







1. Clarke with a patient at his south London surgery in 1949
2. The blue plaque unveiled on 12 April
3. Latifa Patel, BMA chair, and
4. Kamran Abassi, The BMJ's editor in chief, speak at the unveiling ceremony
5. Members of the the Nubian Jak Community Trust, which arranges blue plaques for ethnic minority people, and speakers at the event

# Patricia Hewitt's review of the latest NHS reforms

A mixed bag of proposals on some very familiar themes

Last week, the UK government published the findings of an independent review into the latest NHS reforms in England,<sup>1</sup> led by Patricia Hewitt, Labour health secretary between 2005 and 2007 and now chair of one of the NHS's new integrated care systems. The review was established in November 2022 to consider changes to the governance and oversight of integrated care systems—42 regional bodies responsible for planning services to improve health and reduce health inequalities—less than six months after they were created.<sup>2</sup>

Hewitt's report and recommendations are wide ranging. The main themes are achingly familiar: a greater focus on preventing ill health and reducing health inequalities, stronger collaboration across the NHS and other services, more local control over decision making, and less reliance on top-down performance management to stimulate improvement.

## Towards prevention

The review calls for a shift in NHS spending towards prevention. Hewitt proposes a working group to define what this means in practice, an audit of local spending, and a 1% increase in the share of local NHS budgets spent on prevention over five years.

More investment is no doubt needed in primary and community care and wider public services that shape health. But the target might become an exercise in (re) categorising NHS budget lines rather than a meaningful way to boost spending on evidence based preventive interventions.

Déjà vu? As health secretary, Hewitt published a white paper in 2006—*Our Health, Our Care, Our Say*—that made similar proposals to shift the balance of NHS spending towards prevention.<sup>3</sup> Yet over the past 20 years there has been a major shift in the composition of NHS spending towards hospital care



**Without political support the NHS is being sent upstream against a strong tide**

and away from other areas, including primary and community services.<sup>4</sup>

Improving health and reducing inequalities depends on policy action well beyond the NHS. Hewitt rightly calls on government to develop a coordinated strategy for doing just that—a “national mission for health improvement”—as well as boost investment in local government public health services (although, rather timidly, only “as public finances allow”). The public health grant has been cut by 26% per person in real terms since 2015-16, with funding falling furthest in poorer areas.<sup>5,6</sup> Growing evidence indicates that England's last national health inequalities strategy, from 1997 to 2010—which involved a mix of investment in public services and new social programmes, such as Sure Start—helped narrow health inequalities.<sup>7,8</sup> Without a similar political approach, the NHS is being sent upstream against a strong tide

## Greater autonomy

Hewitt wants NHS leaders in integrated care systems to be given greater autonomy: fewer national targets, more control over spending, less top-down intervention. Pruning the NHS's priority thickets makes sense.<sup>9</sup> The bigger question is whether integrated care systems have the capabilities to lead large scale improvements in services, and whether they will be supported to develop them.

Hewitt fudges the question of whether the Care Quality Commission should produce overall ratings for the new systems—summary judgments like “good” or “inadequate” that the regulator plans to produce in their new assessments.<sup>13</sup> Integrated care systems cover all NHS services and include collaboration with other sectors. Aggregate ratings would be overly simplistic, face multiple technical issues, and might have harmful effects, like gaming and distorting local priorities.<sup>14-16</sup> History suggests that they are also a sharp tool for top-down political control.

Integrated care systems are made up of many organisations and overlapping partnerships between them. Their relationships and roles—between NHS providers and integrated care boards, for example—are not always clear.<sup>17,18</sup> Hewitt's suggestion of yet more partnerships (a group of local areas called “high accountability and responsibility partnerships”) risks adding complexity.

Dotted throughout the review are a mix of worthy pointers for government. (Fittingly, the review was published on the same day that government announced plans to water down its limited commitments to support social care staff.<sup>19</sup>) More controversial recommendations, such as “radical reform” of the general practice contract to allow greater local control, are dangled briefly by Hewitt but pushed back to government with little detail.

The government's response to the review was lukewarm, at best—“ministers will review recommendations of this report in due course”<sup>20</sup>—and political attention seems more focused on short term issues ahead of a general election than systemic action on improving health and health equity.

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# Exposure to ionising radiation at work

Steps must be taken to ensure full protection of female healthworkers' breast tissue

**E**xposure to ionising radiation during image guided procedures has been associated with a higher incidence of breast cancer in female healthcare workers.<sup>1-6</sup> Lead or lead equivalent gowns are used to reduce radiation exposure during image guided procedures, but studies have shown that current gowns provide inadequate protection to breast tissue as they leave the upper outer quadrant and axilla exposed.<sup>7,8</sup>

Quantifying the risk of occupational radiation induced breast cancer in women working in healthcare is challenging because longitudinal data have not been widely collected. Data acquisition is complicated by the interval between exposure and development of disease, and the relatively small number of women working in image guided specialties.

At consultant level, women make up 7%, 12%, and 16% of the UK trauma and orthopaedic, interventional radiology, and cardiology workforces, respectively.<sup>12-15</sup> As the number of female trainees entering these specialties increases, it is essential that the risks are further investigated, available evidence is considered, and equipment provision improved to minimise this risk.<sup>12-15</sup>

## Increased prevalence

Studies of female US orthopaedic surgeons reported a 2.9-fold to 3.9-fold increase in the prevalence of breast cancer, compared with an age matched female population.<sup>1-3</sup> The risk persisted at double the expected level after sensitivity analysis to address selection bias. Female plastic



**We need clear guidelines on an acceptable dose of ionising radiation to the female breast**

and urological surgeons, who had similar lifestyles and pregnancy histories to the orthopaedic surgeons, did not share this increased risk.<sup>2</sup> A small Finnish study highlighted that breast cancer occurred at 1.7 fold the expected rate in radiologists, surgeons, and cardiologists compared with female physicians not working with radiation.<sup>4</sup>

Increased rates of breast cancer have also been found in cohorts of US and Chinese radiological technologists.<sup>5,6</sup> Male breast cancer is rare, accounting for 1% of total cases.<sup>10</sup> Diagnostic and therapeutic ionising radiation has been implicated in its development, but two literature reviews have not identified occupational radiation exposure as a risk factor.<sup>16,17</sup>

To quantify radiation exposure to the upper outer quadrant, researchers attached dosimeters to the upper outer quadrant of the breast of an artificial female torso that was wearing commonly used protective equipment.<sup>8</sup> Simulated intraoperative positioning showed a large variance in radiation exposure, inadequate protection of the upper outer quadrant, and no significant reduction in dose when a standard protective gown was compared with a torso without protection.<sup>7,8</sup>

A separate study that placed dosimeters over a standard protective gown worn by orthopaedic surgeons identified that the area adjacent to the axilla received the highest radiation

dose in the upper body.<sup>18</sup>

The International Commission on Radiation Protection revised its guidelines in 2007 to double the relative detriment of ionising radiation for breast cancer, due to a historical underestimation of the impact of ionising radiation on breast tissue.<sup>19</sup> Clear guidelines on an acceptable dose of ionising radiation to the female breast would facilitate improvements in governance of radiation exposure in the workplace.

## Better protection

The Ionising Radiation Regulations 2017 state that the radiation dose delivered to workers should be as low as reasonably achievable (the ALARA principle).<sup>11</sup> The most effective ways to accomplish this are reducing the duration of exposure, increasing the distance from the source, and shielding all workers with effective protective clothing.

Current standard gowns cover the torso, reproductive organs, and femurs, with additional thyroid protection available. Possible designs to protect the upper outer quadrant of the breast include axillary shields, sleeves that can be worn under standard gowns, gowns with capped sleeves, and axillary wings. The addition of axillary coverage or sleeves has been found to decrease intraoperative irradiation to the upper outer quadrant by 99%.<sup>8</sup> Each new design to the market should be tested rigorously before claiming that it protects the upper outer quadrant. The European Society for Vascular Surgery has already recommended that female operators consider adopting this additional protection.<sup>20</sup>

Employers worldwide have a duty of care to workers exposed to ionising radiation, and therefore should provide adequate protection to enhance the safety of all their staff.

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# How to save £20000 and 780 staff hours a year on a single ward, with one climate friendly change

Hospitals are finding that sustainable healthcare can bring triple wins—for the planet, for patients and staff, and for the bottom line. Involving staff and patients is key, **Florence Wedmore** found out at the Royal College of Physicians' conference last month

**G**areth Murcutt, a renal technical manager at the Royal Free Hospital in London, remembers his “eureka moment.” After the pandemic his clinical director had asked him to look at sustainability—but at first it wasn't his top priority, he told *Medicine 2023*, the Royal College of Physicians' annual conference, held in March.

“We were struggling with all sorts of things,” he explains. “And not because I didn't believe in the climate crisis, but I approached this from the idea that there is nothing we are going to do that is going to make the treatment worse for our patients, and thus I thought the gains would be fairly marginal.”

He then looked at how the renal team deliver acid concentrate to their dialysis machines: they load a new 5 L container of acid concentrate onto each machine for each patient. This is then lifted off each dialysis machine after each patient's treatment session, several times a day. The team did an audit of how much was left in the can at the end of each treatment session.

“It's fair to say the results shocked me immeasurably,” says Murcutt. “It turns out, on average, we're throwing away around one third of every single can that we buy.” This was the light bulb pinging on: there had to be a better way.

And there is. He realised that switching the trust's dialysis units (wards) to central delivery systems would immediately save a typical 30 bed dialysis unit £20 000 a year in acid concentrate. There were many other benefits, too. He calculated that staff in a typical dialysis unit were lifting a cumulative total of 1250 kg a day when they lifted the containers onto and off the machines, and getting rid of this task would give a unit at least 2.5 hours of staff time

back each day. A single dialysis unit could save 6188 kg CO<sub>2</sub> equivalent (CO<sub>2</sub>e) a year in concentrate and 22 299 kg CO<sub>2</sub>e from the difference in packaging. The switch will run as a trial on two units starting summer 2023.

This inspired Murcutt to see what other changes he could make, such as asking manufacturers to put tubing sets in packs of two instead of one, and calculating the emission savings from using physiological fluid produced by the dialysis machines instead of pre-packaged saline bags—which are, as Murcutt says, “plastic wrapped in plastic.” This switch in saline saves each dialysis unit 4000 kg CO<sub>2</sub>e a year from the weight of the plastic alone.

## Delivery by drone

Healthcare staff in Coventry have turned to the skies to save time and carbon. Sean James, operations lead at the Arden Tissue Bank based at University Hospital Coventry, worked with a local start-up to test whether it was feasible to use drones to transfer patient samples between Rugby and Coventry, two sites of the University Hospitals Coventry and Warwickshire NHS Trust.

Using a drone showed a more than 95% reduction in emissions when compared with road transport, and this remained more than 90% even when compared with an electric van, James told the conference. It also halves the journey time, which is crucial, for instance, if urgent blood or other equipment needs to be delivered between sites. James says that a drone was recently used to deliver a prosthesis from one site to the other, mid-operation. He explains, “If you have a patient in the

theatre [in the Hospital of St Cross, Rugby], and the prosthetic is at Coventry, you can still get it done: it can fly you a prosthetic there, and it has happened—it happened two weeks ago.”

There are still some issues with this technology. One major factor for the UK is that the drones are not fond of rain, and the regulatory framework is still an area of active development. For James, however, the many potential benefits make this new technology difficult to ignore. He says, “The take home message is: massive reduction in carbon, drastic reduction in time taken, with caveats.”

Both James and Murcutt have delivered on the “triple bottom line,” an idea explained in the Centre for Sustainable Healthcare's sustainable value equation. It encourages considerations about value in healthcare to help balance outcomes for patients and populations against the financial, social, and environmental costs—in contrast with the more traditional balancing of individual patient outcomes against monetary cost. This framework allows sustainability to be added to any quality improvement work already under way.

Their projects also demonstrate the impact of involving different professional groups in the endeavour towards sustainable healthcare. Nick Watts, NHS chief sustainability officer, told the conference that there was broad support from NHS staff for tackling climate change. “When you go out and you ask NHS staff what do you want to see the NHS do more of, the response is thunderous... 92% want to see the NHS tackle climate change directly,” he says.

This need to engage all staff is endorsed by the Royal College of Physicians' position paper—launched at the conference—on healthcare sustainability and climate

**The first thing that we can all do in our work is talk about climate change**



change. It calls on the government to update the NHS constitution with the NHS's net zero targets and to "make it clear that this is a key responsibility for all staff."

Several trusts in England have invested in onsite generation of renewable energy, demonstrating the money that can be saved, says Watts. "We have seen the savings roll in... hundreds and hundreds of thousands of pounds reinvested back into healthcare," he says. "Every time we have tackled climate change, every single time, we have realised: number one, our patients love it; number two, our staff love it; and number three, it actually ends up saving money."

### Involving patients

Patients can be a part of the solution to more sustainable and resilient health systems. Kate Wylie, a GP in Australia and chair of Doctors for the Environment Australia, has already started to involve patients. "The first thing that we can all do in our work is talk about climate change,"

**Nick Watts (right) addresses the conference.**  
**Below: Sean James (right) and Gareth Murcutt (centre)**

she told the conference. Many may worry that this will feel uncomfortable, but Wylie says that, if we're allowed to talk about sexual health and drug use, "we're allowed to talk about the most pressing health problem of our time."

This involves pointing out where she sees climate change affecting her patients, such as in patients with allergy, or screening for concerns about climate change in those with anxiety or depression. "I meet a lot of elderly women who are very worried about their grandchildren's future," she says.

Her advice for anyone who is unsure

about discussing climate change in their consultations is, "Just start—just have a go. The first thing I did was to incorporate it into my care." This includes looking at possible climate risks in patients' care plans, such as ensuring that her patients with diabetes or cardiovascular disease know what to do in a heatwave.

She also talks to her patients about the health co-benefits of climate action, such as advising those with diabetes to "use your feet for transport, because that's good for the planet and good for yourself." She adds,

"I've not had a patient be angry with me



**Self-care is key to a sustainable healthcare system**  
Frances Mortimer



for bringing it up. Most people are very receptive to the message, and usually they're quite relieved that someone is talking about it."

### Self-care as climate action

Frances Mortimer, medical director of the Centre for Sustainable Healthcare, says that patient self-care is one of five core ways of working towards a sustainable healthcare system (alongside prevention, lean service delivery, operational resource use, and low carbon alternatives).

She explains, "Self-care is a shorthand, really. It's about patient empowerment in decisions about their care so that what we are doing is high value for them. And also supporting people to be much more active in managing their care, leading to better outcomes and more appropriate use of the system."

Mortimer told the conference about one example of this from an HIV service in Northamptonshire. The team realised that by adapting the care pathways for adherent and stable patients they could safely reduce their number of annual appointments. This meant switching from twice yearly face-to-face appointments and blood tests, to replacing one of these appointments with a phone call with a specialist nurse. For every patient there was a joint decision on whether to move to the stable pathway.

This reduced both the travel and equipment required for blood tests. It also freed up staff to spend more time with patients who had new diagnoses or needed more input. Over a year this saved the service £44 905 in costs and 25 958 kg CO<sub>2</sub>e—equivalent to driving 74 763 miles in a car.

Additionally, the team found that this change acted as an incentive for some patients to improve their adherence and move to the stable pathway. And for those on that pathway it not only saved them time in their visit but also around £9.20 in travelling costs each time, as well as any lost income from having to take time off work to come to the hospital.

William Stableforth, a consultant hepatologist in Cornwall, told the conference that not involving patients in discussions about individual changes "denies our patients potentially the benefits of sustainable healthcare." Eddie Kinsella, chair of the Royal College of Physicians' patient and carer network, added, "What strikes me in a very positive way are the examples where there's shared decision making and patient engagement, and where sensible conclusions are arrived at that are both better for the patient and also better for the planet."

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## PATIENT HEALTH RECORDS

# Access to records: Do open notes work for patients?

Since 2021, Americans have been guaranteed full and immediate access to their health records. Has this helped or hindered treatment, asks **Joanne Silberner**

**S**ome 15 years ago, a 67 year old New York City musician had a blood test as part of a routine check up. A few days later he was in intensive care.

His physician had gone on vacation before sharing the test results. Because she was away, no one reviewed the results, his condition worsened, and he wound up being admitted to hospital.

Fast forward to March 2023. The same patient—with a strong family history of early heart disease—had a scan to check his coronary arteries and booked an appointment for the next week. But over the weekend he got an email saying that, while most of his arteries were normal for his age, one showed "severe stenosis due to predominantly non-calcific plaque." The finding left him "stressed and beyond concerned," he tells *The BMJ*.

The man's story illustrates the double edged sword that is patient access to results.

Since April 2021, US medical practices and hospital systems have been required to provide free and immediate access to laboratory reports, exam notes, biopsy reports, and imaging details directly to patients, as a result of the 21st Century Cures Act, signed into law in December 2016. But,

while the value of full transparency had been hotly debated among doctors, no one really knew how patients felt.

Researchers at four medical centres across the US decided to ask. In the year after the act went into effect, they surveyed more than 43 000 people who had received results electronically after a medical exam. More than 8000 responded, with the results reported in *JAMA Network Open* on 20 March.

Tom Delbanco, professor of medicine at Harvard and a cofounder of Open Notes, a non-governmental organisation that has been advocating for healthcare transparency since 2010, expected that around 50% of the patients would be happy with immediate access to their records.

The survey showed that 95.7% of patients wanted to continue getting their results as soon as they were ready, without hearing from a doctor first. "I was amazed," Delbanco told *The BMJ*.

Catherine DesRoches, senior author of the report and associate professor at Harvard Medical School, was also surprised—especially by the 95.3% approval rating among patients who had received notes indicating that something might be awry. "I hope that this study can help tamp down some of the anxiety that clinicians seem to be feeling about this change," she says.

**I hope the study can help tamp down some of the anxiety that clinicians seem to be feeling about this change** Catherine DesRoches







## Patient anxiety

Under the act, health information has to be made available to patients electronically, upon request. Many healthcare providers have gone a step further, automatically sending results by email or other electronic notification; this, it turns out, is easier to do routinely for all patients rather than field individual requests.

Both before and soon after open records went into effect, the Association of American Cancer Institutes reported that three quarters of oncologists they surveyed had “negative perceptions” about the immediate release of clinical information. Most wanted to exclude biopsy and imaging reports, and believed that their patients would share their view.

Some state governments took pre-emptive action: Kentucky passed a law that specifically grants doctors a 72 hour window before their patients can see certain test results.

Chief among oncologists’ concerns was that the results, devoid of explanation and context from a

doctor, would cause unnecessary anxiety to the patient. This has some truth to it. According to the 2023 survey, 5% of respondents whose results were “normal” (not indicating illness or requiring further investigation) said that getting the results directly, rather than from their doctor, made them worry. That proportion was higher for those who received abnormal results (16.5%).

As DesRoches points out, however, getting the information over the phone from a healthcare provider might be just as worrisome, if not more so. Before the law went into effect, she and colleagues surveyed patients and clinicians from practices that supplied progress notes to their patients. Some 98% of patients said they liked it, but only 70% of clinicians thought it was a good idea.

## Workloads

In a Reddit discussion posted around the time the open records provision of the act went into law, a worried cardiologist in a group practice asked fellow physicians how they were



**I was amazed that 95.7% of patients wanted to get their results as soon as they were ready**

Tom Delbanco

dealing with anxious patients. “I’m concerned we will be spending more time educating people and more time discussing our notes than actually providing care.”

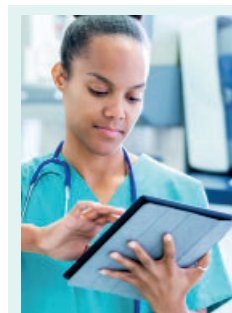
A guide for doctors and patients published in *The BMJ* in 2022 cited an NHS Digital report on 16 early adopter sites in England (general practices that offered patients full access to their medical records through an app, before a consultation, without being required to do so). The report notes that the practices “did not see an increase in workload”—some said it lessened their workload as they got fewer requests from patients for the information. The paper also noted a lack of evidence of emotional harm to patients in the US.

The Reddit discussion shows US doctors adjusting—several respondents said that if they order any tests now, they explicitly tell their patients that they may see results “before I have had a chance to review them,” telling them to try not to worry about the message they receive.

The American Medical Association broadly supports the intent of the open notes law, but would like to see clearer guidelines and more physician education. As for the concerned oncologists, open notes proponents hope they’ll come to appreciate that patients find access to information about their health helpful.

Joanne Silberner, freelance journalist, Bainbridge Island, Washington

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## UK OPEN RECORDS STILL STALLED

In England, where access to information for patients varies greatly across practices, efforts to institute a nationwide system for open notes are foundering.

Patient access to records was promised to start in 2020, then April 2022, and then November 2022—with one of the delays coming after the Royal College of General Practitioners asked for more time for training and preparation. The November 2022 request was postponed at the last minute after the BMA called for a rethink, saying in a statement that while it supports informing patients, practices around the country needed more time to ensure that records released would be in line with the Data Protection Act and safeguarding measures.

# “Helping people get back on their feet”—UK doctors in Turkey share their earthquake response stories

After parts of Turkey and Syria were devastated on 6 February, **The BMJ** speaks to British doctors who flew there and are still helping with the aftermath, about their experiences

Standing in a large tent with cardboard boxes of medical supplies piled up behind her, Nia Owens describes what she has seen since arriving in Turkey. “What you see on the news is...it’s pretty real. The places that have been destroyed are devastated and decimated,” says the Cardiff trained GP.

Around 50 000 people in Turkey died as a result of the earthquakes earlier this year, with tens of thousands more injured and more than 216 000 displaced. In Syria about 6000 people are believed to have been killed and more than 12 000 injured, and nearly 100 000 households have been displaced.

Landing in Turkey just over a week after two earthquakes hit the central and southern parts of the country within hours, Owens was first based in the Hatay province, working with Save the Children, and then transferred to work with the medical aid charity UK-Med in Türkoğlu. UK-Med has set up a field hospital in the grounds of an 80 bed community hospital that was severely damaged during the earthquakes and left unusable. The field hospital contains a triage, an emergency department, a maternity unit, and a pharmacy, with more than 30 staff from doctors to physiotherapists providing care for as many as 100 people every day.

Owens says, “We’re now kind of in a second phase of the disaster response. We’re trying to assist with people getting back on their feet.” Through mobile clinics she has been travelling out to communities to help them manage their chronic conditions, as well as treating the normal seasonal respiratory illnesses you would find in most GP waiting rooms in the UK.

“With people living in crowded tents, there’s lots of infectious diseases,” she says. “So, we see a lot of the things that you’d see in your regular NHS hospital in the middle of winter: coughs, colds, runny noses, there’s a lot of that going around. But then there’s also the other things like scabies, there’s lots of gastrointestinal illnesses, and just lots of



Owens and Lowsby spoke to The BMJ from their field hospital in Turkey



**Here, if you can help one or two people even a little bit, then it gives you a lot back** Nia Owens

people needing some assurance about their healthcare, really.”



## Challenging but rewarding

Richard Lowsby, an intensive care and emergency medicine consultant, arrived at the same site a few weeks after the earthquakes hit.

“We’re seeing a lot of people who had surgery initially after the earthquake, and now they’re coming back to the site to be reviewed, have dressings changed, that sort of thing,” he explains. “And we’re seeing musculoskeletal pain as a result of people working on sites that are being demolished, and also several patients are coming in with burns and things again, as a result of living in tents and having to use stoves.”

The field hospital has been set up right next to a Turkish aid facility, enabling the UK doctors to support their local colleagues.

“We’ve been working together. We are here to relieve some of the pressure from them,” says Lowsby. “Since the site has been established, I think between the two teams we’ve seen over 12 000 patients. So, there’s a huge demand.”

Lowsby will have spent a total of three weeks working at the base before he returns to Mid Cheshire Hospitals NHS Foundation Trust. He says, “It’s challenging work but also very rewarding. It gives you different skills and experience to what you’d get in the NHS, but also it’s an opportunity to contribute and build resilience to other healthcare systems. It’s not for everyone—the conditions are challenging—but you do have an opportunity to have a significant impact, which is very satisfying.”

The feeling of making a real difference is echoed by Owens, who has been living in Australia for the past 10 years. “[At home] sometimes you feel quite dejected,” she says. “You go home and you think, ‘Oh God, have I done anything useful today?’ Whereas I do feel here that if you can help one or two people even a little bit, then it gives you a lot back.”

“I think we get a lot out of it as well as giving. So, I don’t think it’s a purely selfless act, just coming out here to work. But it’s a very interesting environment to work in and really challenging at times.”

Elisabeth Mahase, *The BMJ*

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