Exploring the Challenges of Funding and Compassion in Modern Medicine with Sir David Haslam Transcript

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Introduction and career journey

You mean it's an absolute privilege to be joined today by Sir David Haslam, who is a writer and health care policy consultant and a former president and chairman of the Council of Royal College of GP's.

And he's also been chair of Nice, the National Institute for Health and Care Excellence, president of the BMA and former vice chair of the Academy of Medical Royal Colleges.

He's currently Professor of Royal of General Practice at the University of Nicosia in Cyprus. He was a GP in Ramsey in Cambridgeshire for over 35 years, and an expert member of the NHS National Quality Board.

Absolute privilege to have you on the show today, Sir Haslam. Thank you so much for coming. How are you today? I'm very good. Thank you. Good to be with you. Amazing.

Can you share with us today a bit about your journey in healthcare field, and how you came to be in the position that you are in today? Well, I can try.

I mean, it was a bit of an accident, to be absolutely honest. I didn't I don't think anything in my career was what I'd planned apart from being a GP.

I started off I mean, I came from a family of doctors. My dad was a GP, my brother was a GP, my brother in law was a GP, my nurse, my sisters were both nurses, so career was a bit predictable.

I became a GP in rural Cambridgeshire and then, a sequence of events, happened. I became an examiner for the Royal College of GP's and a member of that council.

And he ultimately was elected to be chairman of council back in 2001. Quite a long time ago now, did that role subsequently was president. Monaghan was doing one of those roles I was at.

And any questions on all that? The labor Party spring meeting somewhere and the panel members apart from me was, the then Secretary of State for health and a guy called Simeon Kennedy.

And at the end of the session, he turned to me and he said, well, you talk sense. I'm about to set up, a new inspectorate for health care in the health care system called the Health Care Commission.

Would I join in as advisers? So I absolutely wasn't. So I didn't even know about the existence of the organization, let alone had any plans to join it. But it seemed interesting.

So I joined the that subsequently morphed into CQ. C and then I was asked to again, my total surprise to put my name forward for chair of nice. And one of I, it was mentioned to me, I thought it was a ridiculous idea, the previous chair.

So my role in this was a professor of clinical pharmacology and, you know, brain the size of a planet. And I was a working GP. And then I thought, hang on a minute, who does most of the work in the health service?

And and particularly because, social care was being taken up by CTC and I, I thought actually what that needs of a generalist. And so after a long appointment process, I and I as chair of nice, for six years and in the middle of all that I developed through, tonsil cancer, which was something that nightmare, and needed five sessions of chemotherapy and 35 sessions of radiotherapy.

So when I came to the end of, my time with nice, I became chair of the cancer charity Young Lives Versus Cancer, which I'm still chair the board of, because I felt it really important to try and give something back to the cancer field.

I realized that, I once calculated I've done about a quarter of a million consultations, and it's, it's only really when you get something like cancer that you understand what that degree of illness is really like.

And I'm also, my wife keeps reminding me that I'm retired, but I'm also a non-executive director. Just. And I just trust. So it's interesting. It's been been fascinating.

But but as I said, Marianne, I do it all make sense in retrospect. Yeah. Yes, yes.

Compassion fatigue and supporting clinicians

And what I love about about your work and your career and your personality is that you have always managed to attain leadership roles in areas that you were so passionate about, and you create so much positive change.

And yet you retain that the humbleness and, and that sincerity and that just you don't even need to show how great you are as a person. It just comes through, in the work that you do.

So that's something that I really admire you for. I know throughout your career you have always been, actively involved in advocating for prioritizing wellbeing and mental health support for healthcare professionals.

You've written about compassion fatigue and how harmful it can be. Can we start off with what is compassion fatigue? I think if everyone involved in health care starts out with their career wanting to be supportive and caring and, patient centered and patient focused.

But to be honest, I think sometimes just exhaustion, relentless demand, the sense that however hard you try, there's a waiting room full or a clinic full of more and more and more people becomes incredibly difficult to deal with at times.

And I think people just get drained. And one of the things the NHS isn't good about is supporting their stuff is providing, just just a bit of human kindness some of the time.

For me, it's it's such an important part of the role of leaders in the health services to support their staff. I remember when I was a junior hospital doctor, a very, very long time ago, two in past, two in the morning, the first cardiac arrest I was called to.

And, and it didn't work like most cardiac arrests, I couldn't resuscitate. But I was very upset. And a member of a ward clock somebody was helping on the ward at the time, came up and put her arm around me and said, come on, you did your best.

Can I make you a bacon sandwich? And she went off and make me a bacon sandwich. And it was such a simple, human, thoughtful thing to do. And then a generation later, my daughter was a junior hospital doctor and had a similar thing happen, except there was only a broken microwave and, nobody to care for.

The more I talked to people in early phases of training, the thought that someone would be there for them in a supportive, caring way is all too rare and you can't expect people to give compassion if they don't receive compassion.

So you've spoken passionately in your career, emphasizing the role of leadership in fostering compassionate care. What are some specific actions that leaders in healthcare can take to create a culture that values and supports compassionate care?

Oh gosh, that's such a such a good question. And the the critical bit constantly is putting yourself in the patient's shoes. One of the things that fascinates me when talking to to to to doctors who, who themselves find it very

difficult to provide the sort of quality of care that they like to when they go with, say, an elderly parent to a hospital or whatever, and see it from a different perspective.

Sometimes it's a real eye opener in some of these things, some of some of the things that we can sort out can be can come from just looking at the world from a patient's perspective.

Just take this the crazy system where so many clinics have a block booking system. So everybody who's going to be seen by the respiratory medicines specialist is asked to come at 9:00, even though, you know, some of them are missing for a couple of hours now, that can feel very efficient from the hospital's point of view and from the doctor's point of view.

It's it's terrible for the patient from the relatives point of view. Put yourself put their head in the position of the patient or their relative when planning things, when if you're given any form of leader, look at what you're doing from the perspective of the people you're there to serve, and that can fundamentally make a difference.

So putting ourselves into the patient's shoes, because it won't be long to where patients ourselves of all we all know as doctors that stuff happens that, people who were perfectly fit yesterday can be seriously needing care today.

It could be any of us. And teamwork and passports are crucial. I was wondering if we could discuss some practical strategies for health care teams to be able to sort of hold each other accountable and encourage that sort of compassionate behavior.

Yeah, well, the key word you said there is teams. And I do think, I think working with people in a team does make a huge difference where you actually know the people you're working with as human beings.

And it's not just, from afar too much of health care at the moment. I sound like an old man complaining about, you know, everything's not like it used to be.

But I do feel that the the loss of a team where you feel there's a group of people who work together and get to know each other can make an enormous difference.

And I think we need to try and aspire to getting back to that again. It's one of these things I don't think anybody deliberately destroyed teams. It was part of things like European Working Time Directive, and so all brought in for the best possible reasons, meant that that the relationships broke down immense.

The however scientific, however collaborative medicine to a relationship business relationship with patients, relationships with each other. So so finding a way to support one's team members muscles versus so much having that camaraderie.

And I really believe, in that quote, a burden shared is a burden. Absolutely. Right.

Leadership, patient perspective, and teamwork

So being able to communicate, about about the positives, but also the trials and tribulations of working, in patient care to be able to, to better manage, the workload.

Absolutely. Right. Absolutely right. So, David, you spoke for a side effect, tackle some of the big questions about the future of health care. I want to ask what initially motivated you to write the book?

Well, it had been it had been bugging me for years. Was was the the idea that we weren't really clear what we were trying to achieve? And I and I watched well, particularly when I've been a leader in general practice and I, and I was meeting senior politicians all the time, and I, I got this sense that what really drove the political agenda was the, the, the conflicts, the exciting, the, the arrival of new technologies and so on.

And there was a complete undervaluing of things that we know make a difference. Things like continuity of care, things like, access and so on. In primary care, we know that the high quality primary care in global research produces really infinitely better sort of outcomes for patients.

And yet most of the funding, most of the staffing goes into the other bits of the health service, which might be wonder why on earth that was, what what's what's what's what's driving that.

And so it really was trying to look at that whole issue. It was clear to me that politicians didn't know what they were trying to achieve, apart from maybe to keep that bad news stories out of the newspapers, because if they if they wanted to reduce health inequalities and they wanted to improve health outcomes, they'd invest in primary care.

But what did they do? They do the opposite. Indeed. I have the privilege of, addressing the World Health Assembly in Geneva, which is the set of the parliaments of the World Health Organization.

But I recognize this is not just an NHS thing. It's a global thing that the the more exciting high tech bits of medicine get, the funding, get the stuff, the more human bits get seen as optional extras.

Nice to have when actually the value is the opposite way around, right? So it's the is the headline grabbers that get the most funding thrown at them.

Totally worth the community orientated care is what's left out. I remember having a completely, ridiculous conversation with a very senior politician, who was telling me how how proud he was of the, the, the new coronary care unit that there was in his local hospital.

A friend of his had been admitted and, been treated wonderfully. I mean, within, you know, within 24 hours was in the gym is an all the right treatments followed all the right guidelines, fantastic success.

And I remember saying to him, it is it's hugely impressive, but what would you what would you prefer. Would you prefer a heart attack treated like that or not having a heart attack in the first place?

Because if you know. And he looked at me as if I was completely mad, as if those weren't comparable. But I said, but if you invest in primary care, if you invest in prevention, if you know, blood pressure, control, smoking, obesity, lipids, all the rest, you can avoid the heart attack.

But the trouble of course, with that story is that there's no story. There's no story from pensioners. And even the person who doesn't have the heart attack didn't know they didn't have a heart attack.

So there's no story to to to say to the press, there's no there's no political that's it's incredibly frustrating. But it totally explains. And I'm not knocking the coronary care unit.

You know, one day I might need one. I think that's fantastic. But but be that logically, does anyone in the world of public health or prevention knows if you put your bang for your bucks there, ultimately you will get much better results, but there's just no story.

Or if there is a story statistically and it happens 50 years later, so there's no one to take the credit of it. That's the other problem. It's a shame that we have it so backwards that the financing of a health care systems are more motivated by headline grabbers, and by cutting edge technology rather than promoting long term community based care that's preventative.

And, and provides longer term benefit to patients. Totally. And for me, that was observing that that was what was happening. Really what made me write my book is to try and explore the saying, what what that's going on? Why?

Why do politicians talk when we when we believe in prevention and then they cut the budget, and and all the excitement, all the newspaper stories where the, the drama comes, which just said to me there wasn't any clarity about what we're trying to get to, because if there was, I mean, if you got almost infinite demand, restricted

budgets, and lack of clarity about where you want to get to, that's not really a recipe for a well-run business. No.

This follows on quite nicely to my next question. Your book argued that simply throwing money at health care just isn't the answer.

Why healthcare priorities are misaligned

So I wondered if you could elaborate on this concept and offer some alternative approaches. Consider. That's not the same as saying that we don't need more money.

I think it's very, very clear to me what austerity has done to the NHS, who we think the level of funding that it's received over the last ten, 40 years has not been sufficient to keep up with demand.

But that's not the same thing as saying that the answer to all problems is to pour money in. You only have to look at the United States to see this. The United States, which spends double, the proportion of GDP on health care that we do and has worse results for most of the population.

Or you can look at the opposite extreme, look at the Cuban health care system, which is really very poor in terms of finance. But in some of their areas, like perinatal and maternal mortality, they're ahead of most of the United States with a very much smaller budget, because they focused on areas of prevention and hygiene and such like, so it's getting your focus right, be clear about what you're trying to achieve and, and fund that appropriately.

And don't let yourself be over swayed by the dramatic and the new. Some of the new cancer drugs that come along at enormous expense, at enormous expense, have very little benefit compared to the predecessor drugs.

Yet we have issues, like I mentioned this a few minutes ago, continuity of care in general practices where there is really good international evidence now about reduction in mortality, improved, you know, benefits across the board, but that's not seen as something that matters by our political most is and it's and it's there's a prejudice there or prejudice against the human.

It feels like as opposed to the, the technical. Yes. And this is something that I can relate with. As a GP registrar in my first year, at the moment I'm having 30 minute consultations and the benefits that not only I feel and I experience, as well as the patients that I provide care for with the 30 minute consultations, versus some of the 20 minute consultations that I've had to, move into old, for me, it's been drastic.

So with the 30 minute consultations at the end of it, I felt that I provided, truly, truly holistic care towards my patients. And I found that I found a lot of good feedback from patients telling me that they felt listened to, that we came to that, management plan together, and they felt much better at the end of that consultation, and they're less likely to come back, because we've come to that plan together and they are more likely to benefit from that moving forwards.

Whereas with even a 20 minute consultation, which is which is not even the, the allotted time for a standard GP, it's 15 minutes. I started notice I was looking at the computer more and I wasn't maintaining the eye contact with the patient so that human to human interaction was getting lost.

That face to face was getting lost. And by the end of it, because I'm just a data monkey and the patient is trying to it's trying to get some sort of human connection with me whilst I'm trying to, get some data for from the computer for them.

There's so much of that therapeutic benefit of that interaction that was lost. And that's something that's something of a personal experience that I can that I can, offer to, to the, the point that you just made to totally agree with you and I'm not I don't think either of us are kidding ourselves that we're going to get 30 minute consultations as a routine, but but the what you did talk about there was the importance of listening or being listened to.

And, and, I've experienced this as a patient as well as a doctor. The difference it makes when your clinician gives

you eye contact, I mean, I, I think many times I've said that the secret to good consulting is very straightforward.

It's shut up. Listen, care and know something. And shut up and listen to a vital, there's lots and lots of evidence that the clinicians interrupt very, very quickly.

And I've experiences, you know, again, as a patient myself. But the care bit it's not soft and fluffy Californian psychobabble. What I'm talking about is just being interested in the person you're with.

And, and recognizing them as a, as a, as a human being and knowing something that's up to professional responsibility. Now, what we've managed to do is set up systems that get in the way of most of those.

So I love your phrase about being a data monkey. So the development of computerized systems that allow us to record this really important data and to be able to access it is fine, but we need to look at the ergonomics of this.

How does it how does it affect the time and the way the doctor spends with the patient? Maybe artificial intelligence will be able to help us with some of this, with some more remote collection of some of the information.

But, but I've, I've witnessed consultations with members of my own family where, a doctor has not once looked at a patient. They've spent the whole time looking at a screen and reading stuff that is no way to feel cared for.

And this, this stuff, again, matters. You emphasize the prioritizing of treatments and cost effectiveness, in your book Side Effects. So how do we strike that balance between cutting edge treatments that offer an enormous benefit to the few and essential care for everyone?

Well, I think I think nice does a remarkable job, and having been chair for six years and having the, you know, the privilege of looking at it, it's all it's it's modeling and so on, it answers the question that it's asked fantastically well.

And the question that nice is asked is, is this is the extra cost of this new treatment justified by its benefit over the previous treatment? But what nobody asks is what the alternative ways of spending that fixed amount of health service money is.

No one has ever asked, why do we put all this money into this bits of technical medicine and completely under support. I keep coming back to general practice, but I'm passionate about this.

Why? Why? If we allow general practice to wither away the number of GP's to weather away the funding for general practice to wither away whilst we have poured in millions and millions of pounds into other bits of the system.

Was that a conscious decision or just a mistake? And actually I think it's a mistake. I think is, I think it was just, well, this bit it would be unethical to deprive patients of this very expensive drug.

Well, it's actually unethical, probably to deprive people of a relationship with a known doctor or clinician.

Prevention, primary care, and smarter spending

But that question never gets asked. So somewhere in the system we're missing that that overview. So the nice model is fine for what it's asked to do, but it's not asked to do the right question.

And it would be very difficult question to ask. But it's just one that is allowed the, the the difficult to measure to wither away. And that for me is a problem.

Yes, it seems to be following the path of least resistance, if you will. And almost heading towards the US practice of defensive medicine. Yeah, I have have stated the, the unethical myths, if that's the word of not providing the expensive, anti-cancer drug as opposed to, preventative care, which is a bit wishy washy.

So we're not going to worry about that so much. So totally. But you'll never use as I said earlier, that the problem with preventive care is, is there's no story.

There's no individual who can say that that had I not received preventive care, I would have died of such and such. Because you don't know, you know, the people who've had their blood pressure controlled and didn't know there is no story. Yeah.

There's no story. And the stats are so hard to find because we may have prevented that individual from starting to get heart disease. In any case. That's absolutely right.

And the challenge is that the, the, the patient with, with cancer has a name and the photograph and can appear as a news story about the tragedy of them not receiving the drug that they think they should receive.

Whereas the, you know, these, these other issues in health care, there's no name, there's no story. Now, again, you know, having received radiotherapy and chemotherapy myself, I'm not knocking cancer care, but I'm just knocking the prioritization of areas of, of of decision making and funding where I think there is a real problem.

Yes. Would you say that there is a solution, to being able to dissociate something as important as a health care system from sensationalism driven finance provision?

I do, I it would be an absolute, you know, if I didn't feel there was a solution, it would be it would be a desperate situation. I think there's so many things that we can do.

We can look at issues like over medicalization, we can look at things like the impact of the pharmaceutical industry in terms of determining where the next area of treatable need is, rather than looking at, you know, from a patient centered perspective, what, what what's the most effective, use of our funding, over medicalization, as I say, over treatment, some of the the care of, when I see patients in care homes who are near the end of their life, rushed into hospital and receiving CPR, and you wonder, where's the kindness in that?

Where's that now? Not trying to save money by not doing. I'm trying to do the right thing. But again, because of defensiveness, because of fear about compliance or legal action, you tend to get overtreatment, which can be hugely expensive.

But more than anything, hugely cruel. And so I think, again, this has resulted from a whole bunch of things from, from litigation, from fear of litigation, from, you know, the potential benefits, potential risks and so on that, that we've just got these out of kilter.

And I think it requires an ability to for the system to step back and look at what is the kind, sensible way of approaching some of these issues. And there's some great work goes on.

There's been really excellent work in Wales and Scotland. Too much medicine, food and medicine. I've forgotten the various terminologies, but, you know, there are people looking at some of these things, but it needs to be all brought together.

Thank you. So preventative measures, seem to be the cornerstone of your vision for sustainable health systems and what specific preventative strategies would you, suggest and that you find most promising?

It's not it's not just prevention. It's, I do believe in things like relationship medicine rather than transactional medicine so much you said yourself marrying about, you know, becoming a data monkey.

I'm going to keep using that phrase, but because I because it's spot on, I think relationship medicine is so, so important, and has an impact on the outcome of so many conditions and in terms of early diagnosis and honesty in relationships and so on.

The probably the biggest area that I do find often the most perfect exemplar of where we are at the moment is

weight is is diet and weight. So we have a food industry that's out of control and has so much influence on political parties providing poor quality, poor quality, very delicious food.

And I'm not knocking it, but, you know, the ultra high protein processed food issue and so on. And the way that medicine is now dealing with it is with expensive drugs to help people lose weight.

Now, if you step back from this for a moment, it's it's sheer madness. I absolutely get as an acute dealing with obesity as it exists now, there may well be a place for drugs, but it's a long term solution.

If what we're seriously saying is let's feed people rubbish and then give them drugs to counteract that. Where? Where on earth is the logic in this? The logic is in getting, the the balance between healthy and unhealthy eating, sort of far more, far more logical dealing with the ultra high processed foods, if necessary, subsidizing some of the healthy foods.

Why is it that in I mean, we could spend another hour talking about some little moments work around, the social determinants of health? So much of health benefit comes from outside medicine, outside the NHS, and we just need to recognize that.

But particularly, the Conservative Party sees this as, as nanny state stuff and therefore something we shouldn't go near. For me, it just feels like plain common sense.

But, but that's, maybe, maybe overly political for us to get into. Not. So, it's something I'm quite passionate about, passionate about as well. And it does feel like food.

The food industry is, very profit driven, and it seems like the ultra processed foods. Yeah, they're lobbying seems to be very effective, with the government, in terms of renting people from, from receiving good whole foods, good nutrition from fruit, vegetables, whole starches, carbohydrates, and that in itself would be so, so effective.

Mental health, burnout, and work-life balance

Weight management, rather than receiving these high calorie, empty foods that are highly addictive, it feels to me that the behavior of much of the food industry is very, very similar to that of the tobacco industry.

In the past, the tobacco industry in the past tended to sponsor sort of so-called signs that somehow played down the risks. And, and, and we're seeing exactly the same sort of thing in the food industry.

And it just needs tough governance. Yes. I think that was the example of Coca Cola, backing quite a bit of scientific research to show that exercise is an effective tool for weight loss, which isn't really the case.

Absolutely. But, it seems to be it seems to be, highlighted by, by fast food, food industries as the tool if you keep carrying on eating the, the ultra processed foods, but you just keep up with the exercise, you'll be fine.

Which isn't which isn't, the correct way to to live life. So my next question is, regarding the growing importance and awareness around mental health.

Your book acknowledged, how important it is, to, for health care systems to better address the needs of, patients with mental health conditions. How how would you suggest that the NHS goes about this?

Well, it's a question of prioritizing and prioritization yet again. The, the the the political noise tends to be mainly around acute hospital waiting list waiting times, which tends to allow mental health.

To, to drift off the off the agenda. Unless there's an absolute crisis, if there's a scandal arises, then it gets onto the agenda. But the particularly post-pandemic, for instance, the, provision of, of Camhs services for the young people, the waiting times, their, become nationally something of a disgrace.

And it is just come down to prioritization. It is always saying, I, I remember again when I was chair of nice that I think David Cameron was prime minister at the time, and it brought in a theme that because there had been so much, lobbying, against nice that we were at the time, not approving some very expensive cancer drugs.

And he brought in a new fund called the Cancer Drugs Fund. And I remember saying that the health Select Committee in the House of Commons, the thing is, you're just as dead from suicide as you are from cancer.

So why does one get the funding and the other doesn't? And it's that sort of mismatch between priorities. That, that, I seem to keep picking on cancer.

It's because it's a, it's a, it's a, it's something I've suffered from. So I know about, but it's also, something where the, the, the, the, the balance of approaches across the system seem seem curious, which means it's not a question of downplaying cancer.

It's a question of supporting mental health issues much, much more than we do, but recognize the importance of it whilst avoiding mission creep, while avoiding, over medical izing the the normal emotions of of life.

It just seems that, one, disease process seems more lucrative than the other. That's that's a way of looking at it. Certainly. And I wanted to move away from, the work that you've been doing, and focus on you as a person.

I was wondering what challenges to your emotional wellbeing, have you experienced whilst you've been working? Are your various roles now it's a it's a very good question.

And the simple fact is that these sort of jobs are difficult. They can be quite lonely if you're in a leadership role. It's quite lonely. And I think it's really important that people build up a support network, with other people doing similar roles so that they can at least share their experience.

So let off steam occasionally. I remember when I was, I think chairman at the Royal College of GP's, and I suddenly realized I've been doing the job for a few months, and I suddenly realized it was impossible, that all the demands on my for my time, it was simply impossible.

There was no way I could do everything that needed doing. Once I realized it was impossible, that came as something of a relief. It meant I could actually focus on the things I could get on and do rather than beat myself up about the things I couldn't get on there.

So I think, I think being realistic about what you can achieve and focused is really quite important. I also remember one one particular spell when I, I, I could barely sleep.

I spent an entire week hardly able to sleep because I was so worried about one particular issue. And the thing that almost amuses me about this is about three months later, I could remember the not sleeping, but I couldn't remember what the issue was.

In other words, things can get completely out of the become. You almost become obsessed about them when actually they not quite as important as you feared.

And of course, there are other important points that come along in all our roles. But keeping things in perspective, I think is incredibly important. And for me, that's also a question making sure that the supportive bits of your life, are there.

I always tend to think of stress management as a bit like a pair of scales. On one side, you've got the the issues that are stressing you, the challenges of work, the busyness, the, you know, whatever it is, the other side, the things that keep you going.

And you just mustn't let that get out of balance. And it's when they do get out of balance, the scales tick. Dreadful that people we run into burnout and all those sort of issues.

Yes, there is a reason why they call it the work life balance. But also, I think that sort of, makes it okay for people to not enjoy their work. And I think it's so important to do what you love and to enjoy and be passionate about the work that you do.

So that's you have quality of life at the end of it. Really. And I think so. I mean, you mentioned work life balance. I've always felt it's, it's that if you absolutely see the two bits of your in one business work and the other business is life, it's, it's all life.

Yeah, it's all life. And it's critical that. Yeah, I'm not being Pollyanna. I'm not saying life's always, you know, work is always enjoyable and rewarding.

Sometimes it's just really hard, really stressful, you know, recognizing that life can is incredibly important. Yeah. I think it's almost, endemic in the NHS.

In our healthcare system for people to feel and to be overworked. And for the, the kindness to be taken for granted, to be abused because, because there is just not enough of a workforce, with the inadequate staffing, and the poor morale, I think that people don't enjoy their work.

So they see their life outside of work as life. And I'm really passionate about getting the NHS to a point where we are able to have quality of life whilst we're at work.

Absolutely, absolutely. And that that behooves leaders, those politicians, everyone planning the health service, to recognize and focus on the importance of the health and wellbeing of their staff.

This leads me on to, my question what has been the most difficult work environment you found yourself working in and how did you get through it? You've made me suddenly think about two days in my life on the Monday by got the blood test results on a patient of mine who was a good personal friend, which showed he got a fairly aggressive leukemia and going and explaining to him and his his wife what this meant and what the future was, was going to be like.

And on the next day, I had a, I think it was either 1 to 1, or there was a couple of us meeting the Prime Minister to talk about health policy issues.

Now, which of those do you think was the hardest to do by a long way? By a long way, it was talking to my friend about his illness. So I think the hardest bits of my career have all been related to patients rather than the other stuff.

So for me, it's, it's, it's it's the human bit with patients has been the really difficult part. And the worrying when you've got something, you know, if you think you've got something wrong or whatever, much harder than the, the, the leadership.

That's not to say they've not been challenging, but it's just to me they're in a different a different ballpark with each other. Thank you so much. Well, it's been a complete pleasure to have you with us today, sir David Haslam, thank you so much for sharing your invaluable insights.

And, and take care for the past.