

Insomnia and obesity

Obesity is a worldwide problem, mainly caused by excess calorie intake and physical inactivity. It is associated with CVD, stroke, T2D and psychological problems.

Experimental data reported an increased level of appetite-stimulating ghrelin, decreased level of appetite-inhibiting leptin and glucose intolerance in sleep-restricted individuals.¹² Many cohort, cross-sectional and longitudinal studies have determined an association between poor sleep and obesity.¹² However, the main limitation of these studies is the lack of objective sleep measurements. Studies on sleep and obesity have been summarised in a review by Tatjana Crönlein.¹²

In contrast to the large number of studies on other sleep disorders and obesity, limited studies have investigated the association between insomnia disorder and obesity. Huang et al.¹³ measured sleep using PSG in Chinese insomniac patients and healthy controls but found no significant difference in their BMI. Another study by Crönlein et al.¹⁴ found that German patients with severe chronic insomnia even had lower BMI than controls.

Conclusion

Self-reported sleep duration is sufficient for a diagnosis for insomnia disorder, however it clearly does not always correlate with objective sleep loss due in part to sleep state misperception. There is an increased risk of hypertension and diabetes in those with insomnia but ONLY if they have an objectively short sleep time as well, this is approximately 10% of those who suffer from insomnia.¹⁵ There is no clear link between obesity and insomnia.

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Taking the scenic route through training...

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In the words of a colleague, I am taking the 'scenic route' through Neurology training – mainly to develop my own professional interests, but also out of a recognition that, increasingly, being a Consultant requires more than just an ability to assess, diagnose and treat neurological conditions. Whilst the leadership and management aspect of the curriculum can be achieved through a weekend course and lectures on the topic, in real life, there is no substitute for experience in this area to prepare trainees for the 'add-on' roles increasingly demanded of Consultants; chairing meetings, writing business plans, supervising trainees, dealing with complaints, preparing for CQC inspections... and so the list goes on. Furthermore, the structure of Neurology training means that trainees typically spend their entire training in a hospital environment, sometimes with little understanding of how guidelines are developed, policy is implemented and funding decisions made in the wider NHS.

So...How can trainees pursue extra-curricular activities aligned with their career ?

I was initially a member of the BMA Junior Doctors Committee from 2008-2012, and sat on the executive committee for Education and Training. During this time I had the opportunity to chair meetings, as well as attend external meetings at the GMC and the Department of Health. This provided my first insight into the role of Arms Length Bodies (ALBs) in setting standards in healthcare, shaping health policy and training the future workforce.

The BMA and other ALBs provide opportunities for trainees to be engaged in policy development, organising conferences and writing articles (see page 23). Whilst most of these appointments are usually for voluntary roles, basic expenses are typically covered and food provided.

The networking opportunities available through such organisations are as valuable as the skills obtained; meeting with like-minded colleagues invariably provides opportunities for collaboration and a forum in which further opportunities are advertised. It was through colleagues at the BMA that I first learned about the MPTS, and the National Medical Director's Clinical Fellow Scheme.

Working for the Medical Practitioners Tribunal Service

In November 2014, I saw an advert in the BMJ for Fitness to Practice Tribunal Members at the MPTS. The advert – particularly welcoming applications from 'women, anyone under 40, anyone with a disability, and ethnic minorities' encouraged me to apply for a role that I had

assumed was reserved for senior Consultants. Following submission of a lengthy application form, I was invited to a selection centre in Manchester, where there was an interview, a written paper with questions on a scenario involving allegations against a doctor, and a critical reasoning test.

The MPTS holds recruitment rounds every 2-3 years. There were 350 applicants in the last round, and 50 were appointed. The appointment term is for four years, extendable for another four years. Appointed tribunal members are expected to commit to a minimum of 20 days per year.

I had support from my educational supervisor and training programme director, who both recognised that this experience does help develop competences allied to the curriculum. I am paid a fixed daily rate by MPTS and take unpaid leave from my NHS post for the weeks while I am away.

I typically spend a fortnight in Manchester every six months, but there are options for tribunal members to be listed for shorter review hearings lasting 1-3 days. Each tribunal has three members on the panel; a medical member, a lay member, and a chair who can be from a medical or lay background. In the absence of a legally qualified chair there is also a legal assessor present. We listen to the evidence presented by the barrister for the GMC, the doctor and their representative (if present), as well as consider written evidence from a variety of sources including police statements, performance reviews, testimonials from colleagues, and sometimes oral evidence from expert witnesses and patients.

The role of a fitness to practice panellist has been a challenging one; cases I have dealt with cover a range of misconduct including sexual and physical assaults, human trafficking, and theft of medications and property. I do not take it lightly that we suspend, and even erase doctors from the register, as I know full well the hurdles of medical school, training applications, postgraduate exams and unsociable working hours required to progress in a medical career. However, the public needs to have confidence in the reputation of the profession, and protection from the small minority of doctors who harm patients. To put this into context, there are approximately 270,000 doctors on the register, ~ 237 are referred to a fitness to practice tribunal each year, of which 70-75 each year will be erased.¹

Following each hearing, the tribunal produces a determination – a lengthy document that sets out the reasoning for our decisions at each stage of the hearing; facts, impairment and sanction. These are made publically available on the MPTS website www.mpts-uk.org.

Fellowship schemes

Whilst it has been commonplace for Neurology trainees to take time out for research, there are also an increasing number of leadership and management schemes, including the RCP's

Chief Registrar Scheme, Darzi fellowships, and The National Medical Director's Clinical Fellow Scheme.

I had been aware of the latter scheme for a number of years; it provides doctors (post FY2 and above), the opportunity to spend a year working for an ALB, alongside a programme of leadership and management training provided by the Faculty for Medical Leadership and Management (FMLM). The programme appealed to me as an opportunity to do something different for a year (having progressed straight from FY1 to ST7 without a break in training), to develop my leadership skills and gain a broader understanding of how the complex network of NHS hospitals, CCGs, GP practices, STPs and ALBs all work together.

There are 35 fellows on the scheme this year – placed with a number of organisations including NHS Improvement, NHS England, the GMC, NICE, CQC and the Health Foundation. The post with the hospitals directorate at CQC was my first choice placement; I could see the relevance of the CQC work to my day-to-day job, and I felt that this environment, with its emphasis on patient safety and quality improvement would be an ideal one in which to develop 'soft' skills that would be relevant to my future clinical practice.

At present, I divide my time between going on hospital inspections, and attending meetings at the CQC, and other civil service departments. I am involved in a variety of workstreams covering everything from improving the inspection process, and the intelligence framework (such as outliers on national audits) which inform CQC inspections and helping to improve the engagement of CQC with junior doctors. The work is intellectually stimulating, although I've been surprised at how much I've missed my patients and colleagues in the NHS. However, the ongoing existence of rota gaps has provided the opportunity to do ad hoc locums, and the flexible working environment offered by CQC has enabled me to continue with ongoing audit and QI projects.

Despite some accusations of turning to the 'dark side', my colleagues here at CQC – and in allied government departments – are intelligent, driven, and equally passionate about improving care for patients, even if they're not delivering it on the frontline of the NHS. Furthermore, the network of clinical fellows, across a variety of government departments has been a useful 'hive mind' through which to glean useful nuggets of information and make valuable contacts.

Travelling to different hospitals on inspections has also provided a valuable insight into what works well (and what doesn't), and has reinforced just how much of quality in healthcare flows from good leadership.² I'm gradually collecting a trove of ideas I'm hoping to implement, and I hope that my skills in leadership will enable me to help shape future workplaces into ones where

staff – of all grades and disciplines – work collaboratively, feel valued, and are empowered to improve the quality and safety of care we provide for patients.

The following organisations provide opportunities for trainees to sit on committees, organise conferences and develop policy. Details about appointments can usually be found through their websites.

- **British Medical Association:** engagement through the regional junior doctors committee, or attendance at the annual representative's meeting (ARM) provides opportunities to be appointed to other committees.
- **Royal Colleges:** The RCP and RCPE both have trainees committees, and may also advertise opportunities to be a question-writer for postgraduate examinations.
- **Association of British Neurologists:** has a trainee committee, with representatives from different regions. They represent the views of Neurology trainees to the ABN, and other organisations. Most other specialty organisations have similar committees.
- **Deanery training reps:** Each training Programme Director will typically seek regional reps for feedback on issues affecting trainees. Vacancies are typically advertised by the deanery.

Some organisations advertise paid roles, which junior doctors may be appointed to:

- **Care Quality Commission:** The CQC has a cohort of junior doctor specialist advisors who may be asked to assist on inspections on an ad-hoc basis. Vacancies are advertised at <https://www.cqc.org.uk/jobs-cqc>
- **Medical Practitioners Tribunal Service:** fitness to practice panellists: Open competition rounds are typically held every two years. See www.mpts-uk.org for details of vacancies.
- **General Medical Council:** quality assurance groups are tasked with inspecting medical schools. These teams typically have a junior doctor on board. Vacancies are also advertised for PLAB examiners and performance assessors. See <https://jobs.gmc-uk.org>

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