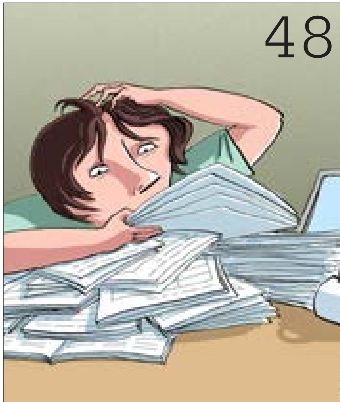

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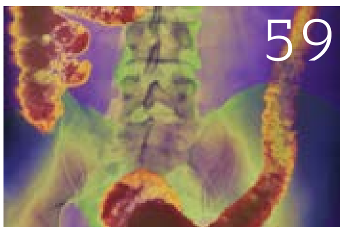

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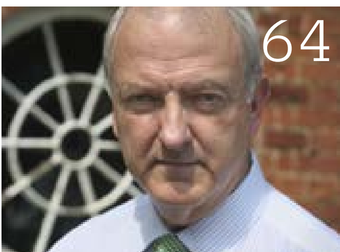

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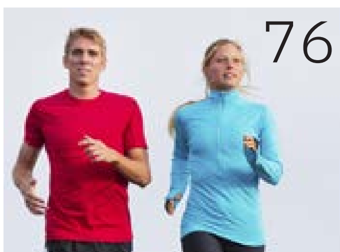

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EDITOR'S CHOICE

Casualties of war

The first strike by doctors in 40 years is both historic and deeply sad. Though reluctant to strike, junior doctors were nearly unanimous in deciding to do so and have wide support among senior colleagues, other health professionals, and the public (p 43).

England's two most senior doctors, chief medical officer Sally Davies and NHS medical director Bruce Keogh, have spoken out against the strike. This should come as no surprise. Both are public servants with legal and statutory accountabilities. Keogh's letter just after the decision to strike has created most upset, for his choice of words and then because of revelations that the letter was reviewed by the Department of Health (doi:10.1136/bmj.i130).

Margaret McCartney says we need to be assured that Keogh's views were arrived at entirely independently (p 63). Nigel Hawkes disagrees (p 64). When governments face acute difficulties, it's their job to make sure that all the spokespeople they can influence are speaking with the same voice, he says.

Paradoxically, the very thing the government wants to achieve, a seven day service, has become the first casualty. Work was well under way by 2013 to understand the problem at weekends, gather new evidence of its scale, define the main areas most in need, and build a professional consensus around clinical standards for assessing weekend care. Led by Keogh, the process was driven by clinicians. As I describe on p 56, it has taken the government only six months to derail this consensus. With no money to fund its unrealistic and often changing definition of seven day services, it now needs scapegoats and fall guys. Junior doctors are one vulnerable group. If nurses were next, this would lead to flight rather than fight, their new leader says (p 53). To avoid piecemeal attrition, the professions must stand together.

We should not allow the government to drive a wedge between Keogh and the profession. Over many years in different roles he has shown courage, integrity, and commitment to patients, doctors, and the NHS. His departure would be an individual injustice and a collective loss.

There are other potential casualties of this war. The biggest may be the NHS itself. By picking a fight with doctors, the government has created a damaging and unnecessary distraction from the real challenges that the NHS faces. Norman Lamb has called for a commission to openly debate and decide the future of the NHS (p 49). I support his call.

Fiona Godlee, editor in chief, *The BMJ*
fgodlee@bmj.com

Cite this as: *BMJ* 2016;352:i203

RICHARD H SMITH

Bruce Keogh's departure would be an individual injustice and a collective loss

thebmj

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this week

FRED KAVALIER

Strike sends strong message to Hunt

Doctors demonstrate outside the Whittington Hospital in London

Thousands of junior doctors turned out to express their unhappiness about proposed changes to their contract on the first day of industrial action by the medical profession for 40 years, on Tuesday 12 January.

The atmosphere among doctors on picket lines across England was described as one of solidarity and good natured, with strong public support. The walkout is backed by two thirds of the public (66%), showed the results of an Ipsos MORI poll for the *Health Service Journal*.

Johann Malawana, chair of the BMA's Junior Doctors Committee, said, "Today's action sends a clear message to Jeremy Hunt and David Cameron. Junior doctors in their thousands have made it quite clear what they think of the government's plans to impose contracts in which junior doctors have no confidence.

"We deeply regret the level of disruption caused, but this is a fight for the long term safety of patients and junior doctors' working lives.

"Before the government seeks to blame junior doctors for the wider, daily pressures on the NHS, Jeremy Hunt should reflect on the 16 397 operations cancelled in just one quarter last year. Or what he plans to do about the £1.6bn deficit facing NHS trusts. Or his fanciful promises of thousands of new GPs during a recruitment and retention crisis."

Acas (the Advisory, Conciliation and Arbitration Service) said that it hoped that talks between the BMA and NHS Employers would resume later this week, but if these break down junior doctors plan further industrial action from 8 am on Tuesday 26 January to 8 am on Thursday 28 January and then full withdrawal of labour, including emergency cover, from 8 am to 5 pm on Wednesday 10 February.

The main sticking points in the contract for the BMA are safeguards on safe working and proper recognition for working unsocial hours.

Speaking on BBC Radio 4's *World at One* news programme on 12 January, Jeremy Hunt, the health secretary for England, said, "This is a wholly unnecessary dispute. We want all NHS patients to have the confidence that they will get the same high quality care every day of the week. The right thing to do is to sit round the table and talk to the government about how we improve patient safety and care—not these very unnecessary strikes."

Zosia Kmietowicz, *The BMJ*

Cite this as: *BMJ* 2016;352:i188

NEWS ONLINE

- Stop smoking services are under threat owing to budget cuts
- Ex-health ministers call for commission to review NHS and social care funding
- Abortion numbers halve in Northern Ireland as doctors fear prison

SEVEN DAYS IN

GP who orchestrated cigarette scam is struck off

A GP who helped his girlfriend smuggle duty free cigarettes into the United Kingdom and falsely claimed to have won a medal for rescuing a child has been struck off the medical register.

Alan Pollock, 50, was given a two year suspended prison sentence at Lewes Crown Court in January 2015 after admitting running the cigarette scam between 2011 and 2013 with his then girlfriend, Jayne White, and her daughter Lucy.

The women would take domestic flights but use international boarding passes forged by Pollock to fool airport shop staff into believing that they were entitled to the duty free allowance. The cigarettes were sold on the black market, depriving the tax authorities of around £28 000 in duty and tax.

White and her daughter were stopped by Border Force officers in April 2014 with 3000 duty free cigarettes. Investigators found a large number of counterfeit boarding pass images on Pollock's computer, and a search of his house and computers showed counterfeit international rail tickets and an expired counterfeit UK passport.

A panel of the Medical Practitioners Tribunal Service found that Pollock, who worked at Abbey Court Medical Centre in Tunbridge Wells, Kent, was "in a state of denial."

Clare Dyer, *The BMJ* **Cite this as: *BMJ* 2016;352:i149**

Saturday 9th

Doctors call for Keogh to resign

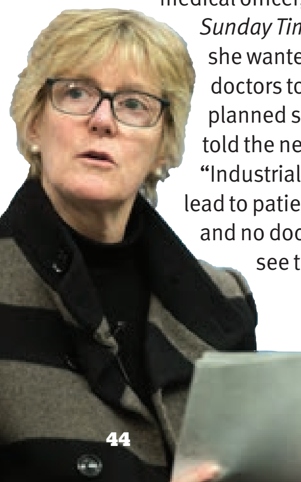
More than 1000 doctors called for the resignation of Bruce Keogh, medical director of the NHS in England, after revelations that he allowed Department of Health officials to beef up a letter to the BMA asking for assurances about the junior doctors' strike. In the letter Keogh had asked the BMA to guarantee that juniors would be available for work within an hour in the event of a terrorist attack such as the one that occurred in Paris in November.

COMMENT, pp 63, 64

Sunday 10th

Chief medical officer warns of dangers of strike

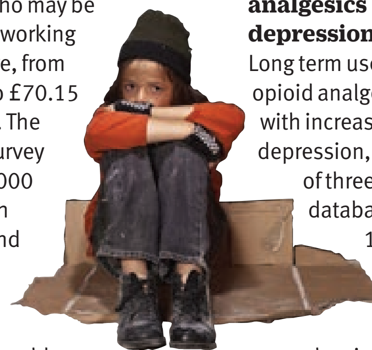
Sally Davies, England's chief medical officer, told the *Sunday Times* that she wanted junior doctors to call off their planned strike. She told the newspaper, "Industrial action will lead to patients suffering, and no doctor wants to see that happen."



Monday 11th

Benefit cuts will increase risk of homelessness

The charity Macmillan Cancer Support called for a halt to government plans to cut the weekly benefit paid to people who are assessed as too ill to work but who may be capable of working in the future, from £102.15 to £70.15 from 2017. The charity's survey of nearly 1000 people with cancer found that one in 10 would be unable or would struggle to pay their rent or mortgage if these cuts to Employment and Support Allowance went ahead.



Proton pump inhibitors are linked to risk of chronic kidney disease

Proton pump inhibitor use is associated with a 20-50% higher risk of incident chronic kidney disease, an observational study published in *JAMA Internal Medicine* found. The 10 year estimated absolute risk of chronic kidney disease among proton pump users was 11.8%, and the expected risk, had they not used them, was 8.5%. Similar findings were demonstrated for acute kidney injury. (See *The BMJ*'s full story at doi:10.1136/bmj.i128.)

Long term opioid analgesics are linked to depression

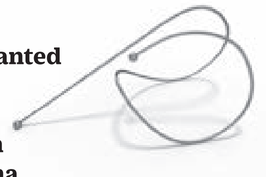
Long term use of prescription opioid analgesics is associated with increased risk of new onset depression, showed an analysis of three large US healthcare databases totalling over 100 000 patients. Newly diagnosed depression after opioid analgesic use occurred in 12% of patients in the Veterans Health Administration database, 9% of the Baylor Scott & White database, and 11% of the Henry Ford Health System. The mean lag time between the end of opioid use and new onset depression was 3.4 years. (Full *BMJ* story doi:10.1136/bmj.i134.)

Tuesday 12th

US guidelines advise mammogram every two years

New US guidelines confirmed that women at average risk for breast cancer should have mammography screening every other year from age 50 to 74. The task force said that mammography screening is effective in reducing deaths from breast cancer among women aged 40 to 74. The decision to start screening in women under 50 should be an individual one taking into account a woman's health history and preferences, it said. (Full *BMJ* story doi:10.1136/bmj.i118.)

Coils implanted into lungs show promise in emphysema



Implanting tiny coils in the lungs of patients with severe emphysema improved exercise capacity at six months, a study published in *JAMA* found. French researchers studied the effects of delivering coils of nitinol (a metal alloy) into the lungs with a bronchoscope. The coils aim to restore elasticity to lung tissue. Over three years the incremental cost effectiveness ratio would be about $270 000 (£185 000) per quality adjusted life year, similar to the cost of lung volume reduction surgery in the US. (Full *BMJ* story doi:10.1136/bmj.i133.)

MEDICINE

Wednesday 13th

Frozen faecal matter is as good as fresh for transplantation

Restoring protective colonic microbiota in patients with recurrent *Clostridium difficile* infection can be done just as well by transplanting frozen, and then defrosted, faecal matter as with fresh stools, a study published in *JAMA* showed. Frozen faecal microbiota transplantation would avoid many of the logistical burdens that clinicians face when preparing fresh material. (Full *BMJ* story doi:10.1136/bmj.i138.)

Shackleton had hole in heart

The explorer Ernest Shackleton may have had a hole in the heart, doctors wrote in the *Journal of the Royal Society of Medicine*. Shackleton, who led the Endurance Voyage across the Antarctic in 1914-16, had crossed the mountains and glaciers of South Georgia without any health problems, but in later expeditions his repeated attacks of breathlessness and weakness alarmed his companions. Doctors used material at the Scott Polar Research Institute in Cambridge, UK, to diagnose an atrial septal defect. Shackleton died of a myocardial infarction in 1922, a few hours after arriving in South Georgia to begin his fourth expedition. He was 47.

New guidance on TB

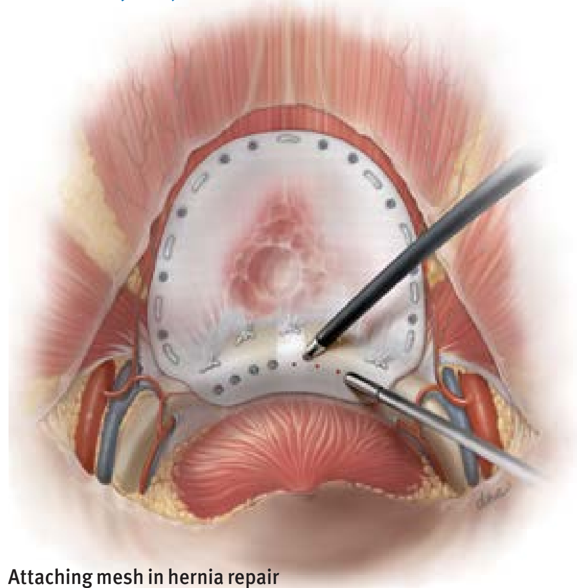
The National Institute for Health and Care Excellence published guidance on how to better treat and prevent tuberculosis (see p 72). England had the highest number of TB cases in Europe in 2014 at 6523, 39% in London. The new guideline highlights the need to search out active cases in communities most at risk and recommends that all under 65s with latent TB should be treated.

Thursday 14th

Low cost mesh for hernia repair is as good as commercial mesh

Men undergoing hernia repair that uses a low cost mesh have a similar rate of hernia recurrence and postoperative complications as those treated with a commercial mesh, showed a randomised trial in Uganda. Costing $125 (£86) in Uganda, commercial meshes are too expensive for most patients in low and middle income countries, so researchers compared it with a low cost mesh of 100% polyethylene that is normally used for mosquito netting and costs less than $1. (Full *BMJ* story doi:10.1136/bmj.i168.)

Cite this as: *BMJ* 2016;352:i153

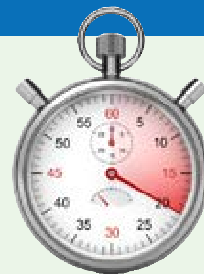


Attaching mesh in hernia repair

TB

At **6523** England had the most cases of TB in Europe in 2014

SIXTY SECONDS ON… ALCOHOL GUIDELINES



I SEE WE'RE BEING TOLD TO DRINK LESS

Not at all! We're being told how much we can drink before we increase our lifetime risk of premature death by 1%.

AND THAT'S LESS?

Yes. It's now 14 units of alcohol a week for men and women, lower than the old guideline of 2-3 units a day for women and 3-4 for men.

ISN'T WINE SUPPOSED TO STAVE OFF HEART DISEASE?

A much exaggerated benefit, in the view of the experts who drew up the new guidelines. They say that the cardiac benefit is significant only in women over 55 and then only at a consumption level of five units (two large glasses) a week. More than that and the effect is lost.

ANY OTHER BAD NEWS?

Yes. Since 1995, when the last guidance was drawn up, evidence of the effect of alcohol on risk of some cancers has improved. For these cancers—such as breast cancer in women and oesophagus cancer in men—there is no completely safe level of drinking below which the risk is not increased.

THEN WHY NOT RECOMMEND TOTAL ABSTINENCE?

Life's full of risks. The guideline aims to set a drinking level that, if followed, imposes risks similar to others we accept, such as those associated with cycling 25 km a day for 50 years, if you chose to do that.

THE OLD GUIDELINES WERE LARGELY GUESSWORK. ARE THESE ANY SOUNDER?

They're based on the evidence. But that neglects the social benefits of alcohol such as lubricating social interaction or encouraging conviviality.

ARE THESE GUIDELINES NOW POLICY?

They're open for consultation, but that only asks whether they're clear and understandable, not whether they're right.

NEWS, p 48

Nigel Hawkes, freelance journalist, London

Cite this as: *BMJ* 2016;352:i125

From the picket line

BMJ reporters **Gareth Iacobucci** and **Abi Rimmer** spoke to junior doctors at the Royal London Hospital during the 24 hour strike across England on Tuesday

Kirsty Lloyd, pathologist
"We've had incredible support from the public. I've just spoken to some 'bikers for strikers'—cycling around the pickets in London today to show support. They don't work in the NHS—they're all patients."

Shireen Hilmi, dentist working as a maxillofacial clinical fellow
"I've just come off a 13 hour night shift. It is frankly insulting: if Jeremy Hunt wants a more comprehensive seven day service than what is here, we need more doctors. We can't be stretched even thinner because patients will suffer."

Andrew Lock, junior doctor in east London
"The reason I'm striking is that the government wants to impose a contract for junior doctors which isn't safe for patients or for doctors. We obviously don't want to strike, but sometimes you have to. I really hope that the government will come back to the negotiating table, but with a fairer and more reasonable attitude."

Fiona Hansell, core trainee, currently in neurology
"I've just come off a night shift. We've been backed into a corner and forced to strike. The pickets are our last defence against this new contract. It's not just about the BMA—this is grassroots action."

Vishnu Prameshwaran, junior doctor, Barts Health NHS Trust
"Our primary concern is safety: for patients and for doctors. At the moment if doctors are rotated to work longer than they should, trusts get fined. Under the new contract there is nothing that will stop trusts from working us into the ground. Ultimately no one wants an overworked, exhausted doctor."

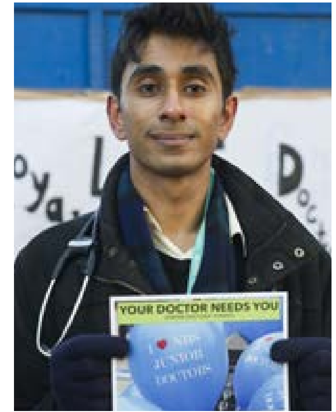
Hannah Marshall, third year specialty trainee in paediatrics
"The contract is being enforced, which is not a good way to introduce a contract into any workplace. I work in A&E, and all of my nursing colleagues, our portering staff, loads of the patients and parents, as well as our consultants have been very much in support."

Ariane Waran, second year specialty trainee in paediatrics
"Junior doctors are upset that it's come to this point. If Jeremy Hunt has done anything it's to unite us all in solidarity. We're not asking for a pay rise, but we're certainly not prepared to accept a pay cut. And I believe it's the first step in dismantling the NHS by this government."

Gareth Iacobucci, *The BMJ*, Abi Rimmer, BMJ Careers
Cite this as: *BMJ* 2016;352:i193

"It's not just about the BMA—this is grassroots action"

Fiona Hansell, core trainee



"Under the new contract there is nothing that will stop trusts from working us into the ground"

Vishnu Prameshwaran, junior doctor

"If Jeremy Hunt has done anything it's to unite us all in solidarity"

Ariane Waran, second year specialty trainee in paediatrics

"We've had incredible support from the public"

Kirsty Lloyd, pathologist

"I really hope the government will come back to the negotiating table with a fairer attitude"

Andrew Lock, junior doctor

"The contract is being enforced, which isn't a good way to introduce a contract into any workplace"

Hannah Marshall, third year specialty trainee in paediatrics

RICHARD H SMITH

Cut paperwork to retain GPs, researchers say

Reducing paperwork and slowing the pace of administrative change would help retain young GPs in the workforce, researchers have said.

The research, published in the *British Journal of General Practice*, found that many young GPs felt unsupported and vulnerable to burnout as a result of increases in their workload pressures and changes to the nature of their work.

The research was commissioned by Health Education England and NHS England to investigate why "so many GPs leave the NHS below the age of 50 years."

The researchers, from the University of Bath, University of Bristol, and Staffordshire University, surveyed 143 GPs under the age of 50 who had left the English medical performers' list between 2009 and 2014. They also conducted telephone interviews with 21 of them.

They recommended that, to improve retention, "the pace of administrative change needs to be minimised and the time spent by GPs on work that is not face to face patient care reduced."

The researchers found that GPs had multiple reasons for leaving general practice, and many described problems caused by "an unprecedented increase in organisational changes."

"According to participants, continual organisational changes fundamentally altered their professional role to a 'government clerk' or a 'data clerk for public health and for management,'" the researchers wrote.

Of the GPs who responded to the survey, 50% said that rising non-clinical workload was a factor in their decision to leave general practice early, while 84% said that pressure of work contributed to their decision. "The higher administrative workload reduced the time available to spend with their patients, leading to a

CMO warns heavy drinkers of cancer risk

The weekly units shoud not be "saved up" but spread over three or more days, the guidance says

New guidelines from all four UK chief medical officers warn that drinking any level of alcohol raises the risk of a range of cancers.

An expert advisory group examined the evidence from 44 systematic reviews and meta-analyses published since its 1995 *Sensible Drinking* report and concluded that there was strong evidence that the risk of a range of cancers, particularly breast cancer, increased directly in line with consumption of any amount of alcohol (table).

The guidelines came out at the same time as a report from the Committee on Carcinogenicity, a UK non-statutory advisory body, which said that between 4% and 6% of all new cancers in the UK in 2013 were caused by alcohol consumption. This report said that research now showed a statistically significant increase in the risk of cancer at low, medium, and high levels of alcohol intake for cancers of the oral cavity and pharynx, oesophagus, and breast (in women). At medium and high levels of alcohol intake (over 1.5 units a day) there was an increased risk of cancers of the larynx and colorectum, and at high levels of intake (over 6 units a day) there was an increased risk of cancers of the liver and pancreas.

Although the chief medical officers' guidelines emphasised that there was no "safe" level of drinking, to keep risks to health low men and women should not drink more than 14 units of alcohol a week. This is roughly equivalent to six pints of average strength beer. The previous daily guidelines were 21 units for men and 14 for women.

The guidelines say that these units should not be "saved up" but spread over three or more days, as people who have one or two heavy drinking sessions increase the risk of death from injury and long term illness. They recommend that a good way to reduce alcohol intake is to have "several" alcohol free days a week but do not specify how many. The guidelines do not set a number of units that should not be exceeded on a single day, but the expert group may produce guidance on this at a future date.

The advice to pregnant women has also been updated to make it clear that no level of alcohol is safe during pregnancy. The evidence review also found that any benefits of alcohol in protecting against heart disease applied only to women aged 55 or over, when they limited their intake to around five units a week, equivalent to two standard glasses of wine.

The Committee on Carcinogenicity's report said that all types of alcoholic drink could cause cancer, with little difference between wine, beer, and spirits. David Phillips, the committee's chair,

fundamental change in the doctor-patient relationship," the researchers wrote.

The negative portrayal of GPs in the media, a lack of time for interaction with patients and colleagues, and a perceived blame culture also contributed to young GPs leaving the profession.

Responding to the findings, Tim Ballard, vice chair of the Royal College of General Practitioners, said in a statement that the amount of red tape and bureaucracy that GPs faced was overwhelming. This, he said, was "driving family doctors to leave our profession at a time when we should be doing everything possible to retain them."

To improve retention "the pace of administrative change needs to be minimised"

He added, "With more and more of our working hours being taken up with form filling, ticking boxes, and preparing for CQC [Care Quality Commission] practice inspections, we are drowning in red tape, and this only serves to keep us away from delivering frontline patient care, which is why we become doctors in the first place."

Abi Rimmer, BMJ Careers

Estimated lifetime prevalence of cancer (No of cases per 1000), by alcohol consumption

Weekly consumption (units)	Breast cancer (women)	Bowel cancer (men)	Oesophagus cancer (men)
0	109	64	6
‹14 (within new guideline)	126	64	13
14-35	153	85	25
›35	206	115	58

Source: Chief Medical Officers' Alcohol Guidelines Review

said, "The risk of getting cancer increases the more alcohol a person drinks. Even alcohol intake of below 1.5 units a day, or 10.5 units a week, gives an increased risk of cancer of the mouth, throat, and gullet. This level of drinking also increases the risk of breast cancer in women. When alcohol consumption is above around 1.5 units a day, or 10.5 units a week, there is an increased risk of cancer of the voice box and large bowel. If alcohol intake is above about six units a day, or 42 units a week, there is an increased risk of cancer of the liver and pancreas."

Sally Davies, England's chief medical officer, said, "Drinking any level of alcohol regularly carries a health risk for anyone, but if men and women limit their intake to no more than 14 units a week it keeps the risk of illness like cancer and liver disease low."

John Holmes, senior research fellow at the University of Sheffield's Alcohol Research Group, which was commissioned by Public Health England to provide an analysis of the evidence on health risks associated with different levels and patterns of drinking, commented, "While many scientific studies suggest moderate drinking can be good for your heart, researchers are increasingly concerned that problems with those studies mean any protective health effects which alcohol may provide have been substantially overestimated."

He added, "Our analyses did take evidence of protective health effects at face value but still found that, after accounting for the health risks of drinking, any remaining protective effect was small, associated with very low levels of alcohol consumption, and only likely to benefit specific groups in the population even if it was genuine."

Jacqui Wise, London

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FIVE MINUTES WITH . . .

Norman Lamb

The former Lib Dem health minister explains his plan for a cross party health and care commission

"There is a significant shortfall in the NHS and social care. I think everyone can see what the projections are like and what the potential consequences are in the aftermath of the government's spending review. I don't think what is planned is tenable in terms of maintaining a functioning health and care system.

"Is it not bizarre that as a modern economy we are choosing to spend a reducing proportion of our national wealth on health and care, given that we know for certain that demand will continue to rise at such a significant rate? I think that needs to be challenged. And to add to that, there has been no fundamental assessment since 1948 of whether the system—particularly the divide between health and social care—still makes sense. It's crying out for a big process and a big new settlement, in terms of the money but also ensuring that the design is fit for the 21st century.

"How much as a society we are prepared to pay for our health and care system, given the growing pressures, has to be central to this. And there is a fairly inevitable conclusion that we probably have to spend more. But let's have the discussion—and let's have it with the public and the staff of the NHS. I'm also very convinced that we can spend money more effectively as well. This is not just about more cash.

"I'm a strong supporter of the NHS and the principles behind it—free at the point of need—and I talked in parliament about the sense of solidarity and decency that I think the NHS provides to this country. But in making this call I wouldn't want to prevent other people from putting their ideas forward. I think we must be willing and able to have an open conversation.

"I'd like it set up straight away, and I purposefully have not talked about a royal commission. I don't want something that ponders on this subject for three years."

Norman Lamb is the Liberal Democrat MP for North Norfolk and was the minister for care services in the previous coalition government.

Gareth Iacobucci, news reporter, *The BMJ*

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EDITORIAL

WHO analgesic ladder: a good concept gone astray

Our mistake is to treat chronic pain as if it were acute or end of life pain

In 1986, the World Health Organization (WHO) developed a simple model for the slow introduction and upward titration of analgesics, which became known as the WHO analgesic stepladder.[1] Before this, people were dying in unnecessary pain because drug regulations introduced earlier in the century had increased the stigma and fear associated with both prescribing and taking opioids.

The underlying principle was that analgesics should be used incrementally, starting with non-opioids, progressing through mild and finally strong opioids, dosed in accordance with the patient's reported pain intensity. The goal was to allow patients to be as comfortable and interactive as possible during the short march towards death. Risks of addiction and hastened death were accepted in the principle of double effect: comfort is paramount.[2]

Floodgates opened

The stepladder approach had tremendous value when it was introduced. The success of opioid treatment in terminally ill cancer patients set the stage for extending the same moral imperative and treatment principles to the treatment of chronic pain, where previously opioids were considered too risky or not effective.[3,4] Suddenly, because chronic pain is ubiquitous and open ended, the floodgates opened. Over the past 30 years, in much of the developed world, we have seen more patients treated with opioids at higher doses than ever before. The extent to which the more liberal use of opioids would cause harm was not predicted.

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Over the past 30 years we have seen more patients treated with opioids at higher doses than ever before

Fix it. it's broken

The increase in opioid prescribing and its adverse consequences are nowhere more obvious than in the United States, where sales increased fourfold between 1999 and 2010 with parallel increases in prescription opioid deaths and admissions for misuse.[5] These alarming statistics are an indication that unfettered use of opioids in the community can have disastrous social consequences. But patients treated with opioids can experience many other adverse consequences with no clear evidence that the treatment is actually relieving pain in the long term.[6,7] Rates of harm have been directly correlated with dose, which in turn is correlated with continuous use, the precise dosing principles promoted by the WHO stepladder.[8]

The somatosensory component of pain of whatever aetiology is always nuanced by cognitive and affective influences, but these may assume greater prominence in chronic pain than in acute or cancer related pain. Functional neuroimaging has shown that pain that is initially associated with brain regions linked with the corresponding anatomical area becomes increasingly associated with emotional and reward brain circuits.[11] Thus prolonged pain becomes linked less with nociception and more with emotional and psychosocial factors.

Our mistake, we believe, was to treat chronic pain as if it were acute or end of life pain. These short lived pain states tend to exhibit a predictable and linear trajectory, they tend to respond well to opioids, and titrating opioids against pain intensity usually works well.

Chronic pain is different

Chronic pain does not have a predictable or linear trajectory and often does not respond well to opioids other than early in the course of treatment. Not only the report of pain, but also the experience of pain, is altered by mood, circumstance, stress, duration, meaning, acceptance, expectation, and fear. With so many factors altering chronic pain as it is experienced and reported, it is not surprising that pain scores do not respond in any predictable fashion to opioids.[12] In fact, attempts to lower pain scores using opioids has led to overuse and adverse outcomes without any appreciable lowering of the chronic pain burden at the population level.

The idea that for patients with chronic pain, opioids titrated to pain intensity can reliably reduce pain and improve quality of life, not only exposes patients to harm but gives them unrealistic and potentially damaging expectations, as well as resulting in therapeutic disappointment for clinicians.

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EDITORIAL

Opioids in pregnancy

High prescribing rates have probably contributed to recent increases in neonatal abstinence syndrome

The steep increase in the number of opioid prescriptions dispensed in the United States has been associated with a parallel rise in their misuse, fatal overdoses, and heroin use. More recently, attention has been focused on the large increase in the number of infants born with neonatal abstinence syndrome (NAS). In the US, between 2000 and 2009, the incidence of NAS increased from 1.20 to 3.39 per 1000 live births,[1] and between 2004 and 2013 the total percentage of days spent in intensive care because of NAS increased from 0.6% to 4.0%.[2]

The rise in NAS is also likely to be a consequence of increased opioid prescriptions—estimates indicate that 14-22% of pregnant women in the US receive an opioid prescription during their pregnancy[3]—as well as an increase in the prevalence of opioid use disorders among pregnant women.[4]

NAS results from the abrupt discontinuation of opioids at birth after a fetus has become physically dependent through exposure in the womb. The risk of NAS is greater if opioids are taken closer to the delivery day or for longer periods and if the drugs have short breakdown times.[5]

Clearance rate affects severity

Opioid induced physical dependence wanes after discontinuation, which explains why NAS is observed predominantly when opioids are used in the last trimester of pregnancy. Similarly, the rate of opioid clearance influences severity, such that opioid drugs with slow clearance rates (such as buprenorphine) result in less severe withdrawal than drugs with intermediate (such as methadone) or fast (morphine) clearance rates.

One study of pregnant women with opioid dependence reported that neonates exposed in utero to buprenorphine required significantly less morphine and shorter hospital stays for the management of NAS than neonates exposed to methadone.[6]

Other factors associated with increased risk of NAS include a maternal history of opioid or other drug misuse, exposure to other psychotropic medications, and smoking.[7] These associations suggest that women with babies affected by NAS could have been taking additional opioid medications or other drugs that produce physical dependence and withdrawal, such as alcohol, benzodiazepines, or barbiturates. Nicotine enhances the release of endogenous opioids, which might explain how smoking could increase risk of NAS.[8]

Estimates indicate that 14-22% of pregnant women in the US receive an opioid prescription during their pregnancy

The potential effects of opioid exposure on the developing infant brain are unknown. Preclinical studies in rodents have linked opioid exposure in utero to congenital defects in the central nervous system,[9] while human epidemiological studies have reported an association between opioid use during pregnancy and an increased risk of neural tube defects and other birth defects.[10, 11]

The opioid system is implicated in bonding between mother and infant [12]—for example, mice that lack the gene coding for the mu opioid receptor, the main target of opioid analgesics and heroin, show deficits in attachment towards their mothers.[13] Opioid use during pregnancy could theoretically disrupt attachment between women and their babies.

Cognitive impairments have also been reported in children and young people born to women who misused opioids during pregnancy, although the relative contributions of other drugs or lifestyle factors to such deficits are unclear.[14]

Short term use, if at all

The lack of scientific information on the effects of opioids on fetal brain development, combined with their known association with NAS, indicates that opioids should be reserved for pregnant women with severe pain that cannot be controlled through more benign means, and ideally limited to a short term use. If long term use is unavoidable, such as for women in need of buprenorphine or methadone maintenance therapy for heroin addiction, then careful assessment and monitoring should be undertaken to minimise the risk of overdoses, NAS, and misuse.

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JOHN GREIM/ALAMY

Infant born prematurely with neonatal abstinence syndrome

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ANTONIO MASIELLO/NURPHOTO

THE BMJ'S WINTER APPEAL

Vandals shut clinic in Calais refugee camp

Bringing care to thousands of refugees in northern France comes with many challenges, as **Richard Hurley** reports. The charity Doctors of the World is well versed in helping the most vulnerable people worldwide, which is why we've chosen it for *The BMJ*'s winter appeal this year. Please give generously

Soon after last November's terrorist attacks in Paris, vandals broke into the clinic run by humanitarian charity Doctors of the World in the heart of Calais's huge and longstanding refugee camp.

Mohammed Bakir, a senior house officer in the United Kingdom who has volunteered for Doctors of the World three times in Calais, saw the clinic before and afterwards. "No one knows who vandalised it," he told *The BMJ*. "It was the hub of the camp."

Fearing for its volunteers' safety, Doctors of the World has not reopened the clinic.

Mobile van torched

Days later, in the city, a £20 000 van that the charity's volunteers used for psychological consultations was torched.

Bakir explained, "People were angry after the Paris attacks. We were briefed not to wear our Doctors of the World jackets on the streets of Calais and not to talk about our work."

> "We were briefed not to wear our Doctors of the World jackets on the streets of Calais and not to talk about our work"

"There are people who do not support us," concurred Jean-François Corty, the charity's director for some 70 programmes in France.

"On Facebook and Twitter my team has been targeted by extremists, threatening potential attacks to vehicles and property."

Today some 5000 men, women, and children "live" in Calais's camp.

In the past three months, the number of refugees stuck in another camp at Grande-Synthe, a suburb of Dunkirk, has mushroomed from fewer than 100 to some 2500 people, including as many as 500 children.

"There is no respect regarding minimum humanitarian standards," Corty said. Despite the largely young population, 15 migrants died in the Calais camp between June and September 2015.

Because people in the camps have no access to drinking water, food, and healthcare, Doctors of the World launched an emergency programme, as it would in a war context. Last summer, it established a fixed clinic in the middle of the camp, and between June and November its volunteers provided 4000 consultations to migrants.

Sixth richest country doing nothing

The charity also works to try to compel the French authorities to act. The refugee camps are a political hot potato in France, with some commentators fearing that establishing even basic services might attract more refugees.

"For the sixth richest country in the world to do nothing and let thousands of women and children sleep outside is not acceptable, said Corty"

In September, a French court ruled that the authorities must provide access to clean water and identify and isolate minors, in a case brought by Doctors of the World and others.

"Today in Grande-Synthe [Dunkirk], the authorities are doing nothing," said Corty.

The charity's programmes in Calais and Dunkirk cost some €60 000 a month to run. "As an independent organisation we rely on private donations," explained Corty. "For advocacy it's essential to be independent. We are so grateful for donations."

Richard Hurley is features and debates editor, *The BMJ*
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Post this to: *Doctors of the World UK, 34th Floor, One Canada Square, London E14 5AA*

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INTERVIEW

Nurses' leader warns government not to pick fight with profession over seven day working

The new head of the nurses' union, Janet Davies, talks to **Chris Mahony** about a seven day NHS, the axing of the student nurse bursary, and, whisper it, the green shoots of recovery in nursing numbers

If ministers target nurses' payments for unsocial hours they are more likely to face a flight from the NHS than strike action, according to the new leader of the Royal College of Nursing.

Four months into her role, and after a long stint as number two in the organisation, RCN general secretary, Janet Davies, says that nurses tend to get "despondent" when it comes to their pay and working conditions.

Asked if she imagined nurses following the junior doctors into voting for strike action, she hesitates, choosing her words carefully.

"I've got no idea. Nurses are very mixed in their opinion—and it would be up to members. Nurses have got a lot of sympathy with the junior doctors.

"We should be more worried about losing nurses permanently than the odd day of a strike. It's much more serious if they vote with their feet."

She points out, however, that so far, apart from the pension scheme changes during the early days of the previous coalition government, "nothing has been taken away"—unlike the junior doctors' unsocial hours payments.

With weekend and evening working a key component of nurse incomes, any changes to help fund the government's "seven day" NHS would hit nurses hard, she says.

"It would be devastating—for some it would be up to 25% of their income, and there is something unfair about penalising those who have worked seven days a week for their whole career.

"The reality would be that nurses couldn't afford to work those [weekend and evening] shifts. Unsocial hours payments didn't come in because someone thought 'let's be kind'—they reflected the extra childcare costs and the extra costs of getting to work at the weekend.

"Why do we have these massive agency costs? They are paid largely on evening and weekend shifts because those shifts are unpopular."

Speaking days after Chancellor George Osborne announced the axing of student nurse bursaries, Davies, a former acute trust nursing director and ambulance trust chief executive, lamented "yo-yo workforce planning."

Janet Davies: "Nurses have a lot of sympathy with junior doctors"

She labels the bursary decision short sighted and asks what evidence it was based on.

Exactly two years ago her predecessor, Peter Carter, spoke to *The BMJ* about burnout, pay freezes, unsafe nurse to patient ratios, and low morale exacerbated by the Mid-Staffs scandal prompting accusations about a lack of compassion in modern nursing.

More nurses

Asked what has changed, Davies points to the start of a reversal in the decline in nursing numbers on the wards.

"I know it sounds ridiculous, but when they were looking for savings as part of getting foundation status and during the so called Nicholson challenge many trusts cut nursing staff . . . The Care Quality Commission is coming in now and criticising organisations for not having enough staff—that is a positive."

"We should be more worried about losing nurses permanently than the odd day of a strike. It's much more serious if they vote with their feet"

She also warns the government that whatever form its enhanced seven day NHS eventually takes, it will require more senior nurses on duty—"the decision makers."

Davies suddenly pleads to move the conversation on "to the positive things and the work we are doing with the other royal colleges."

Career development

As an example she cites the development of competences for nurses working in primary care that have been jointly accredited with the Royal College of General Practitioners.

This development of community and primary care nurses could be crucial to NHS England's five year forward view, with its emphasis on new models of working aimed at keeping people out of hospital.

"They can be key to managing long term conditions, coordinating care, and providing firstline support—taking the pressure off GPs by working in partnership with them."

Davies notes that it is community services, such as those provided by district nurses, where regular reorganisations and increased use of tendering have produced "a churn and short-termism" that distracts from long term service improvement.

As the RCN begins its centenary year, it's hard to escape the conclusion that Davies is most at home with this professional side of the college.

Is this a step away from the horny handed image of the trade union, perhaps mindful of ministerial eagerness to refer to the BMA as a trade union during the current dispute?

"That is a false distinction that is convenient for other people . . . We need to rehabilitate the idea of what a trade union is. It is an organisation that makes people safe and productive. Productivity in organisations that recognise trade unions is far higher.

"Nurses do not get paid enough to belong to both a trade union and a professional organisation—we're great value."

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yes

"Now I can drink as much as I did before, ignoring the need for regular breaks from alcohol"

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Two questions should be asked of any public health message about alcohol: is it evidence based and who is the target audience? Now in its fourth year, the Dry January campaign, which uses peer pressure to encourage abstinence from alcohol for the month, is promoted by the charity Alcohol Concern in England and Wales.[1] It is supported by Public Health England so in effect has government approval. The campaign estimates that "Last year over 2 million people cut down their drinking for January."[1]

But popular doesn't necessarily mean effective. Alcohol Concern's ambition is to alter people's relationship with alcohol by encouraging us to reduce the amount we drink, not just for a month but for life. Unfortunately, this type of campaign has had no rigorous evaluation.

Self selecting participants

It is not clear who Dry January is targeting. Because participants select themselves it could attract the people at lowest risk from health problems related to alcohol. Because they consume less alcohol they are also likely to find a month of abstinence relatively easy, as a recent study indicates.[2] The campaign should offer a range of advice and more carefully tailor these messages to match the individual's use of alcohol.[3] For example, one high risk group is people aged over 65. Trying to communicate a message about alcohol to the over 65s at the same time as the under 25s risks the message not being heard, as the way these groups use alcohol is likely to be different.

Many of us can be economical with the truth when it comes to how much we drink. Research comparing self reported alcohol consumption with total alcohol sold found a large disparity.[4] It is not clear whether this mass denial affects Dry January. At the very least an appraisal of how much and how often an individual really drinks will influence whether they see a need to test their ability to go without alcohol for a month or simply view the campaign as more nagging and switch off. If people aren't honest with themselves about their drinking, how can Dry January help?

All or nothing

Dry January also risks sending out a binary, all or nothing, message about alcohol—that is, either participate by abstaining or carry on as you are. Dry January could be adding to the confusion we know exists in communicating messages about alcohol—for example, in public health advice about safe levels of alcohol consumption using recommended maximum daily or weekly units of alcohol. Health professionals lack understanding about units.[5] Beyond the problems of misinterpreting the guidance, the advice depends on people keeping a tally of the number of units they consume; only 13% do this.[6]

Dry January has the potential to compound this muddle. Although not the intention, people may view their 31 days of abstinence as permission to return to hazardous levels of consumption till next New Year's day. "I've had a month off, so now I can drink as much as I did before, ignoring the need for regular breaks from alcohol."

Most people can stop using alcohol without any immediate harm. However, for some heavy drinkers or people who have experienced withdrawal previously, abrupt abstention from alcohol can induce serious symptoms such as seizures.[7] This is not a group of people who should be participating in a do-it-yourself detox such as Dry January. They will need expert help and a supervised detoxification programme to ensure their withdrawal from alcohol is managed safely. If Dry January's campaign material made this clearer it would go some way to minimise potential harm. Otherwise, the campaign risks setting up dependent drinkers to fail, compounding their inability to gain control of their drinking. We don't know what effect the additional attention given to alcohol through the promotional activity of Dry January has on this group.

In sum, parched of evidence Dry January could have unintended consequences which would do more harm than good.

Does Dry January do more harm than good?

Lack of evidence that such campaigns work and don't have unintended consequences, concerns **Ian Hamilton**. But **Ian Gilmore** thinks they are likely to help people at least reflect on their drinking

ADAM GRAY/SWNS

no

"The overwhelming experience of those participating is greater wellbeing, better sleep, and a sense of achievement"

Ian Gilmore, honorary professor of hepatology, Liverpool University, Liverpool, UK
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Although successive Westminster governments may have difficulty in acknowledging the scale and scope of alcohol related harm in the United Kingdom, few readers of *The BMJ* will fail to make the connection in their daily work (and play) between our increasingly uneasy relationship with our favourite drug and the burden on the NHS and emergency services and harm to others.

Our per capita consumption has doubled over 40 years, we have 1.5 million heavily dependent drinkers in this country, and alcohol has become a central part of most social occasions.[6] So what could possibly be wrong with encouraging and supporting the estimated two million or so adults who decide on Dry January[8] to take a month off the booze and have time to reflect on their drinking?

Sustained drop in drinking

Maybe it is the "nanny state" and interference with personal choice? Well, it is just a personal choice to take part in this voluntary event instigated by the charity Alcohol Concern, which receives no direct government funding. There has been some support in kind from Public Health England, and its independent evaluation of 2015's Dry January showed that 67% of participants said they had had a sustained drop in their drinking six months on.[8] In an earlier evaluation by the University of Sussex, 79% of participants said they saved money, 62% of participants said they slept better and had more energy, and 49% said they lost weight.[9]

Indeed, researchers at London's Royal Free Hospital showed that one month's abstinence produced quite remarkable changes in such diverse aspects as blood pressure, liver stiffness, γ glutamyltransferase concentrations, insulin resistance, and body mass index.[10]

More studies are needed to see how sustainable some of these benefits are, but the overwhelming experience of those participating is greater wellbeing, better sleep, and a sense of achievement. That and the relief that they are not as dependent on that regular "anxiolytic agent" as they thought; there is a life out there that does not have to revolve around drinking.

There are no "prohibition" or "temperance movement" agendas here, and the majority of people choose to return to drinking, although 8% of those followed up by Public Health England six months later had decided to capitalise on the benefits and stay dry.[8]

The campaign is aimed at social not dependent drinkers, and heavy drinkers are recommended to see their general practitioner before stopping suddenly and completely. But each year Dry January brings to light some dependent drinkers who need professional help, and services for them are still patchy and inadequate.[11] But it can't be bad that some of the 1.5 million dependent drinkers in the UK make the first steps towards help.

Some myths around Dry January need to be addressed. It should not be treated as a money raising sponsoring opportunity, culminating in drunken celebration at the month's end, nor as an excuse for thinking "job done; body detoxed; I can go straight back to the old ways for the rest of the year." But evaluations indicate that campaigns like Dry January are being used more as a way of people examining their relationship with alcohol and making longer term changes. Further study is needed, not just of the 50 000 people who sign up with Alcohol Concern[1] and get support but also the estimated two million people who simply decide to quit the booze after the Christmas break for a month.

Take a month off

Release of the UK chief medical officers' guidelines on drinking is timely, with their emphasis on having several alcohol-free days each week—some "dry weekdays."[12] Although it is unlikely that this will have much impact on health measures such as blood pressure and insulin resistance, it should be a focus for further research. Until we know of something better, let's support growing grassroots movements like Dry January and Dry July in Australia and take a month off.

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thebmj.com/podcasts
▶ Listen to *The BMJ*'s Richard Hurley interview the authors

How Jeremy Hunt derailed clinician led progress towards a seven day NHS

For six years NHS doctors have been making progress behind the scenes on seven day working. So why, asks **Fiona Godlee**, has Hunt portrayed clinicians as the main barrier to change and propelled junior doctors to strike for the first time in 40 years?

It may be hard to believe from the vantage point of this week's strike, but from 2011 to 2015 plans for a seven day NHS were progressing well (see timeline).

Unusually, for a policy change of this sort, there was an evidence base. Several studies in the UK and elsewhere, though observational and so unable to do more than show associations, gave a consistent message: an association between admission to hospital at weekends and a higher risk of death.

In 2011 the medical director of the NHS in England, Bruce Keogh, said that the NHS must "aim to be offering a seven day a week service across the board." He was clear that a move to seven day services should be driven by clinicians, not politicians. "This is not an imposition," he said, but a desire to "open a sensible debate among clinicians about the pros and cons, the merits, of running a seven day service."

Keogh continued to work on gathering data and developing plans for seven day services. In 2012 an analysis he worked on concluded that admission at the weekend was associated with an increased risk of death within 30 days.

In 2013 a forum that Keogh set up concluded that the higher mortality was likely to be a result of several factors, including lower staffing levels at weekends, a lack of senior decision makers, and unavailability of diagnostic and community services.

This forum also drew up 10 clinical standards to monitor whether weekend services were up to scratch. These included time to consultant review and access to diagnostics, consultant directed interventions, and ongoing review. A self assessment exercise was planned so that hospitals could judge how they performed on these measures.

By the end of 2013 senior doctors were on board with Keogh's plans, royal colleges were in support, patients' representatives had been closely involved, and work was under way to look at the costs and possible funding mechanisms. Keogh continued to examine the evidence base, updating his 2012 analysis with data from 2013-14, and he looked at which of the 10 standards were most likely to affect patient outcomes. Four were identified, and a self assessment exercise was planned so that hospitals could judge how they performed on these measures. So far, so good.

But in March last year seven day services became a Tory re-election pledge. At the Conservative Party's spring conference David Cameron announced that, by 2020, there would be "a truly seven day NHS."

With no firm definition of what "a truly seven day NHS" actually meant, and no additional money for delivering it, England's health secretary, Jeremy Hunt, has nonetheless chosen seven day services as the stick to beat doctors with.

Hunt has portrayed doctors as the sole barrier to change and propelled junior doctors to strike for the first time in 40 years. In the process he has derailed four years of a painstaking and productive, clinically led initiative that was set to deliver improvements to patient care.

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Ministers hijack Keogh's clinically led plan

2009

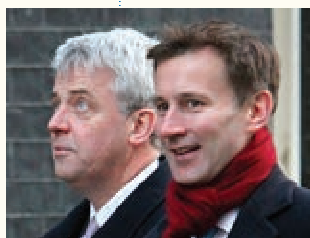
- Multiprofessional group the London Clinical Senate begins to develop 10 clinical standards for seven day NHS services, based on availability of diagnostics, senior decision makers, and support facilities

2011

- NHS medical director Bruce Keogh says the NHS must "aim to be offering a seven day a week service across the board." But he adds that this must be driven by clinicians rather than be imposed

2012

- Keogh and colleagues publish data showing that weekend hospital admission is associated with increased mortality risk within 30 days
- Jeremy Hunt takes over as England's health secretary



2013

- Keogh sets up the NHS Services Seven Days a Week Forum. Its initial findings, focusing on emergency services and supporting diagnostics, include 10 clinical standards for seven day services
- Talks begin on contracts for junior doctors and consultants. For juniors, talks aim to make pay more predictable and to limit working hours. But, for consultants, talks focus on changes needed to enable seven day working

2014

- David Cameron says, "People need to be able to see their GP at a time that suits them and their family. That's why we will ensure everyone can see a GP seven days a week by 2020"
- Contract negotiations for junior doctors and consultants come to standstill. Government refers the issue to the DDRB and asks for recommendations

Hunt has derailed four years of a painstaking and productive, clinically led initiative that was set to deliver improvements to patient care

2015

MARCH

- Cameron tells party members, "With a future Conservative government, we would have a truly seven day NHS . . . everyone will have access to the NHS services they need seven days a week by 2020"

APRIL

- Conservative Party election manifesto states: "We want England to be the first nation in the world to provide a truly seven day NHS . . . with hospitals properly staffed, so that the quality of care is the same every day of the week"

MAY

- Keogh and others submit to *The BMJ* an updated analysis of the 2012 examination of data on weekend admissions

- Conservatives win general election

JULY

- Hunt says, "Around 6000 people lose their lives every year because we do not have a proper seven day service in hospitals"

- Doctors tweet pictures of themselves at work at the weekend

AUGUST

- BMA's Junior Doctors Committee votes not to re-enter contract talks with government

SEPTEMBER

- Keogh and colleagues publish updated analysis of mortality associated with weekend admissions

- BMA agrees to re-enter talks on consultant contract. Government says it will impose a new junior doctor contract

OCTOBER

- Fiona Godlee tells Hunt he is inappropriately using data from Keogh's *BMJ* paper to suggest that excess deaths among patients admitted to hospital at weekends are due to poor staffing at weekends and are avoidable

NOVEMBER

- Junior doctors vote for strike action. After conciliatory talks, BMA suspends industrial action and agrees to enter talks with the government

2016

4 JANUARY

After talks break down, the BMA says that three days of industrial action will take place, starting on Tuesday 12 January

PETER LOCKE

Jonty Heaversedge, 44, is a GP in southeast London who sees patients, is a writer and broadcaster, and chairs the Southwark clinical commissioning group—a combination that should keep him busy. His television work includes programmes on smoking, organ donation, and healthy lifestyles, and he has a strong interest in mental health, backed by a degree in psychology and a masters in mental health. His book, *The Mindful Manifesto*, co-written with Ed Halliwell, brought the concept of mindfulness to a wider public and gained many endorsements from grateful readers. The *Guardian* found it "mercifully gibberish-free."

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Jonty Heaversedge
Happiest on a French retreat

What was your earliest ambition?
I've never really had any long term goals. We moved around a fair amount when I was young, and most of my focus was just on fitting in.

What was the worst mistake in your career?
It's been suggested that appearing on the *Jeremy Kyle Show* was a mistake, but I remain secretly quite proud! I do believe that, as medical professionals, we have to extend ourselves much further than we currently do to engage with the reality of people's lives, even if it takes us out of our comfort zone.

What was your best career move?
Joining the vocational training scheme at Guy's and St Thomas' at a time when general practice really felt like a vocation rather than an occupation.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
I'd like to say Bevan, even though he died before I was born. I still try to fulfil his aspirations for the NHS. Importantly, this doesn't mean simply ensuring equal access to medical treatment—it has to mean an equality of outcomes.

To whom would you most like to apologise?
My partner, Tye. Like many in our profession, I'm not as present as I should be at home. He's astonishingly supportive and generous.

Where are or were you happiest?
On a meditation retreat in Limoges, France; I was also at my saddest, angriest, and most in love. Learning how to practise being more open to my current experience, and not to try to manipulate it, continues to be difficult for me.

What single unheralded change has made the most difference in your field in your lifetime?
I've been a GP for just over 15 years and watched as health services have become increasingly focused on doing things to people that are driven by payment mechanisms and performance metrics rewarding activity over outcomes. The current shift towards shared responsibility for delivering outcomes that matter to people will help to reconnect services and enhance quality.

What book should every doctor read?
A Fortunate Man: the Story of a Country Doctor, by John Berger and Jean Mohr.

What is your guiltiest pleasure?
A thick cut slice of fresh baked bread with butter so thickly spread you can see the imprint of your teeth in it.

If you could be invisible for a day what would you do?
Worry that no one was noticing me.

What is your most treasured possession?
A T shirt that we got printed when I rowed from Oxford to London as a medical student at the Royal Free. It's over 20 years old and is worn thin.

Summarise your personality in three words
Conscientious, a tad controlling, and a little narcissistic.

What is your pet hate?
Cyclists wearing headphones: it leaves them literally senseless.

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