Brexit could worsen NHS staff crisis

UK healthcare leaders have hailed the contribution of staff from other European Union countries, amid fears that the NHS may struggle to retain and recruit staff from the EU after the UK voted to leave the union.

England’s health secretary, Jeremy Hunt, said that staff from other EU countries were “a crucial part of our NHS,” while NHS trusts and senior leaders paid tribute by taking part in a social media campaign with the hashtag #LoveOurEUStaff.

The display of solidarity came as concern was raised that uncertainty in the wake of the referendum result was causing some nurses and doctors recruited from other EU countries to reconsider their decision to work in the UK.

Nick Gerrard, director of finance at East Kent Hospitals University NHS Foundation Trust, tweeted on 28 June, “This is real now. We have had applicants from the EU pull out of consultant post recruitments.”

Alex Scott, a consultant in anaesthesia and intensive care medicine at Calderdale and Huddersfield NHS Foundation Trust, said that the referendum was already having a negative effect on recruitment. He told The BMJ, “Our regional major trauma and transplant centre has already [before Brexit] had to shut beds and cancel liver transplants because of staffing crises. I now hear rumours from hospital managers in West Yorkshire that our EU recruiting drive has been sabotaged by the referendum result and we will not get the staff we recruited because of very reasonable fears for the future. British patients will lose out.”

Chris Hopson, chief executive of NHS Providers, said that it was important to reassure workers from other EU countries about job security. “This is vital to ensuring that EU nationals considering coming to work as health and care professionals in the UK are not deterred from doing so. Anecdotal indications are that this is already happening,” he warned.

The Royal College of Radiologists said it had already been contacted by clinical radiologists and oncologists from other EU states working in the UK and concerned about their employment status after the referendum result. A consultant doctor from Poland working in the north of England, who wished to remain anonymous, said that he would advise Polish doctors to “think again” about coming to work in the UK because of the uncertainty Brexit had created.

Cite this as: BMJ 2016;353:i3604

Chris Hopson, chief executive of NHS Providers, said that there were indications that EU nationals were being deterred from working in the UK.
UK stands by nasal flu vaccine for children

The £100m a year childhood flu vaccination campaign in the UK will continue despite evidence from the US that the inhaled vaccine is ineffective.

Public Health England (PHE) said that its data contradict those of the US Advisory Committee on Immunization Practices, which recently advised the Centers for Disease Control and Prevention (CDC) to stop vaccinating children because, for the past three flu seasons, the vaccine seemed to have little effect.

PHE published provisional figures for the UK which showed that the inhaled vaccine taken by 2 to 17 year olds achieved similar protection against laboratory confirmed flu as did adult vaccines in older age groups. The vaccine prevented flu in more than half of the children given it, with an effectiveness of 57.6% (95% confidence interval 25.1% to 76%). Similar results had been reported by the Finnish National Institute for Health and Welfare, which found an effectiveness of 46%.

Richard Pebody, head of flu surveillance for PHE, said, “We remain confident that the vaccines used in the annual flu vaccine programme are the most effective that are currently available in protecting both those vaccinated and in reducing transmission of the flu virus in our communities.”

By contrast, data collected by the US Influenza Vaccine Effectiveness Network for the 2015-16 season showed only 3% effectiveness in 2 to 17 year olds (~49% to 37%) with the inhaled vaccine, compared with 63% (52% to 72%) with the injected vaccine.

Scientists have been puzzled at the apparent ineffectiveness of FluMist (Fluenz in the UK), which is contested by AstraZeneca. The company stated that it would continue to work with the CDC “to better understand its data to help ensure eligible patients continue to receive the vaccine in future seasons.”

Nigel Hawkes, London
Cite this as: BMJ 2016;353:i3546

BMA annual meeting

Extend self certification
Doctors called for self certification for illness to be extended from seven to 14 days. Delegates at the BMA’s annual representatives meeting in Belfast voted in favour of a motion that also called for the Department for Work and Pensions to establish its own means of determining benefits.

Krishan Aggarwal, a GP, said, “Why is it that we as GPs have to police the sickness of the nation, in order that an individual may be excused from work?”

Abolish locum cap
Delegates called for abolition of the cap on hospital doctors’ locum rates. Proposing the motion, Thomas Micklewright, a junior doctor, said, “‘Locuming’ is an active career choice for many, including working parents and foreign doctors. These caps are a death knell for working outside of a training contract.”

Decriminalisation of abortion
Doctors asked the BMA to work towards decriminalising abortion. After the vote was agreed John Chisholm, chair of the BMA medical ethics committee, said, “Despite the BMA’s longstanding role in the abortion debate, the BMA does not have a clear view on decriminalisation.” He said that the medical ethics committee would produce a briefing paper on the current law and would look at what decriminalisation actually means.

Drug regulation
Astellas UK is suspended from ABPI after “deception”

The UK subsidiary of the Japanese drug company Astellas had its membership of the Association of the British Pharmaceutical Industry suspended for 12 months over “deception on a grand scale.”

Brexit
Hunt may run for PM
As The BMJ went to press, the health secretary for England, Jeremy Hunt, announced that he was “seriously considering” running for the Conservative Party leadership. He told ITV’s Good Morning Britain on Tuesday, “I want to start making an argument as to what we do next as a country” after the EU referendum. Hunt has already called for a second referendum on the terms of Britain’s EU exit.

Diane Abbott is new shadow health secretary

The Labour Party leader, Jeremy Corbyn, appointed the Hackney MP Diane Abbott as shadow health secretary. She replaced Heidi Alexander, one of 48 members of the Labour front bench who resigned in protest at Corbyn’s performance over the EU referendum. Abbott’s tenure may be short, as Corbyn faced a no confidence vote from MPs as The BMJ went to press.
Public health
Children call for obesity action
Children favour a ban on takeaways delivering food to school gates and want to see initiatives such as loyalty cards that reward healthy food choices, a report published by the Royal Society for Public Health showed. The Child's Obesity Strategy found that a quarter of young people aged 13 to 17 had ordered a takeaway to their school, that half blamed fast food manufacturers for rising child obesity, and that 82% thought food manufacturers misled consumers through food labelling.

Air pollution causes excess deaths in France
Air pollution in France is responsible for 48,000 deaths a year caused by fine particles, mainly from vehicle exhausts, France’s new public health agency said. Santé Publique France said that 30 year olds in a busy urban area have a life expectancy 15 months shorter than if they were living in an area with no manmade pollution. (doi:10.1136/bmj.i3523)

Zika vaccine trial is set to start in North America
Inovio Pharmaceuticals, of Pennsylvania, is preparing to begin a phase I clinical trial in the US and Canada of the first potential Zika virus vaccine to be approved for human testing. The GLS-5700 vaccine involves DNA injected directly under the skin. The injection site is then stimulated with a short electrical pulse to force the DNA into cells. These host cells then produce the pathogen’s proteins and display them on their surfaces, where the immune system recognises them as foreign and mounts a response. (doi:10.1136/bmj.i3588)

Gun violence
AMA calls to end ban on gun violence research
The American Medical Association, whose annual meeting earlier this month declared gun violence in the US a public health emergency, will lend its lobbying arm to help overturn a congressional ban on government sponsored epidemiological research into factors behind gun deaths. On 22 June, Democrats staged a sit-in on the floor of the House of Representatives, demanding a vote on gun control measures. (doi:10.1136/bmj.i3529)

Mass shootings in Australia vanish after gun ban
Since Australia banned rapid fire long guns 20 years ago, it has seen no mass shootings and an accelerated decline in total firearm deaths, a study in JAMA showed. In the 18 years before the ban, Australia had had 13 fatal mass shootings. A government buyback scheme purchased and destroyed nearly 660,000 semiautomatic and pump action rifles and shotguns by 2001 and a further 70,000 in 2003. (doi:10.1136/bmj.i3527) Cite this as: BMJ 2016;353:i3586

BULLYING AT WORK
Of 664 consultants who responded to a survey from the Royal College of Obstetricians and Gynaecologists 44% said they had been persistently bullied or undermined

SIXTY SECONDS ON...

ASPIREASSIST
SOUNDS LIKE A HEALTH INSURANCE PLAN
Nope. It’s a controversial new weight loss device from the inventor of the Segway that has just been approved by the US Food and Drug Administration.

EXCELLENT! WHAT IS IT?
Wearers and readers need a strong stomach—literally. What looks like an overflow pipe is inserted into a tube in the abdomen that has been previously inserted by a doctor. It comes with a little valve that, when turned on, drains food directly from the stomach into the toilet. The device when used as directed removes about 30% of food consumed before it can be digested.

SO I CAN LITERALLY HAVE MY CAKE AND EAT IT?
Sounds like it. The results from a trial of 111 patients who used the device for 12 months showed that they lost an average of 12.1% of their body weight, which compared with weight loss of just 3.6% among the 60 patients in the control group.

I’M DESPERATE TO SQUEEZE INTO MY BIKINI THIS SUMMER. SIGN ME UP NOW!
Unless you have a body mass index of more than 35 you won’t get one. The FDA said that it should not be used for short durations by people who are moderately overweight. It is available in the UK, but I doubt the NHS will be approving it any time soon.

WHAT’S BEEN THE REACTION?
The chat show host Stephen Colbert called it a “barf-bot” and a “pizza drain.” When it was launched in 2013 the Daily Mail described it as “repulsive.”

SOUNDS LIKE THE LAST DAYS OF THE ROMAN EMPIRE
According to stories beloved of schoolchildren, Romans would gorge themselves on food, make themselves sick, and then carry on eating. Historians have questioned the veracity of this, but AspireAssist surely marks the end of civilisation as we know it.

Anne Gulland, London
Cite this as: BMJ 2016;353:i3540
UK science and health outside the EU

Anne Gulland assesses the outlook for the NHS, pharmaceutical industry, and public health

What will happen to NHS finances?
NHS funding was one of the key battlegrounds of the referendum campaign. Prominent Brexit campaigners now seem to be rolling back on the pledges plastered on the side of their battle bus and on official posters that the £350m a week they claimed the UK sends to Brussels should be spent on the NHS.

Conservative MP Iain Duncan Smith, member of the Vote Leave campaign, told the BBC after the result, “I never said that the £350m was an extrapolation of the £19.1bn—that’s the total amount of money we gave across to the European Union [in 2014]. What we actually said was a significant amount of it would go to the NHS.”

Researchers at the London School of Economics put the real weekly figure as £164m after taking into account the rebate and payments for areas such as agriculture and research. However, they write, “We would still not be able to reinvest all of the repatriated monies into our underfunded NHS as is often suggested. This money would be needed to negotiate trade deals, particularly if we want access to the single market . . . and to fund other areas which are currently heavily supported by EU contributions.”

Sarah Wollaston, Conservative chair of the Commons’ Health Committee and a former general practitioner, has vowed to hold the Leave campaigners to account on their pledges.

“It was always a ridiculous claim to make, the idea there was £350m a week,” she told The BMJ. “Not only was it on the side of the bus but it was also alongside the NHS logo, which they deliberately used because it’s a very trusted brand. They should never have been allowed to make that claim.”

What the NHS needs is a strong economy and that requires “stability and confidence,” she added.

But all those who before the referendum predicted an economic downturn are continuing to issue dire warnings. The morning after the referendum result the Economist Intelligence Unit mapped out “high disruption” and “low disruption” scenarios for the UK economy and politics. (The low disruption scenario saw David Cameron and Boris Johnson working together to restore stability.) The high disruption scenario, which the report says is more likely, sees gross domestic product 6% lower in 2020 than if the UK had remained in the EU. Most economic forecasters predict lower economic growth reducing tax revenues and hence reducing the opportunity to spend more on the NHS.

How will Brexit affect the pharmaceutical sector?
The European Medicines Agency is based in London, which gives the UK regulatory clout. Most predict that the agency will have to move from its London headquarters.

Where does the vote for the UK to exit the EU leave the NHS, the health workforce, science, and research? The BMJ asked a range of people for their thoughts.

KIERAN WALSH. Manchester Business School
The NHS and universities both have highly internationalised and mobile workforces, and both benefit from the free movement of people within Europe. If Brexit threatens that free movement, or makes the UK a less attractive place to live and work, it will have a profound effect on health services and on higher education and research.

The best and the brightest, and those earlier in their careers with fewer institutional or family ties, are likely to vote with their feet and leave. NHS staff shortages and a downturn for research and higher education will follow.

NICKY CULLUM, head of the school of nursing, midwifery, and social work, University of Manchester
The NHS does not have enough nurses and midwives. Most trusts have been actively recruiting nurses from as far afield as India and the Philippines. Any change that makes the UK seem less welcoming for European health workers will be another shot in the foot. A positive effect of Brexit will be that we will no longer have to adhere to EU requirements for nurse training which say that pre-qualifying courses must comprise 4600 hours of study, at least 2300 of which has to be in clinical placements. Excellent clinical competency can be gained in far less time.

SIMON WESSELY, president of the Royal College of Psychiatrists
There will be less money for the NHS and science. I cannot hide my anger with how swiftly the
The Unified Patent Court, to which the UK is a signatory and which will grant patents with legal jurisdiction across the EU, is also due to open offices in London in 2017. Its future is now uncertain, as is the UK’s involvement in the court.

EU clinical trials regulations are also expected to take effect in 2017-18, harmonising procedures for the assessment of applications for clinical trials and increasing transparency in trial outcomes. Whether the UK will still enact the regulations and the effect of being outside the regulations are unclear.

Another area where there is a big question mark is around access to EU research funding, including Horizon 2020. Will researchers who currently have grants be able to keep them? And what access will they get after 2020? The UK gets around 15% of the fund currently, but non-EU countries such as Israel and Norway also have access. However, they have to pay into the scheme and cannot influence research policy.

Clifford Holt, a senior editor at Pan European Networks, a company that monitors the Horizon 2020 grants, says that organisations currently in receipt of funding will continue to have access because grants have already been assigned.

“But future funding is in question,” he says.

Another concern is drug sales. In its report on the effects of Brexit on the economy the Economist Intelligence Unit predicts that pharmaceutical sales will total £19bn by 2020, compared with £21bn if the UK were to remain in the EU.

What key public health legislation will be affected?

Nasrul Ismail, visiting research fellow and public health law expert at Bristol University, says that the public health legislation most likely to be repealed in a post-Brexit UK are the regulations governing air and water quality. The Industrial Emissions Directive and the Water Quality Framework both require a high degree of monitoring—something that those arguing to leave the EU wanted to lessen.

Ismail believes that the two year negotiation will not be enough time to go through all the legislation affecting health such as energy, tobacco products, food standards, and environmental protection.

“We would have to go through about 80 000 pages of regulation and decide whether we want to keep, repeal, or amend them,” he says.

Anne Gulland, freelance journalist, London, UK

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Over two years of negotiation, there would be 80 000 pages of regulation on health to keep, repeal, or amend

The leave campaign has admitted what we all knew—there never was £350 million a week for the NHS. I know that there is unlikely to be any threat to the 10% of doctors and 5% of nurses from the EU who work here. But will we be able to attract the best doctors and scientists in the future?

THOMAS NIXON, ophthalmology registrar at Lister Hospital

I’ve had bosses describe how they cannot employ someone from outside the EU if there are technically appointable candidates from inside the EU. [Voting to leave the EU] is about the UK being a level playing field for all people. The second reason [that I voted to leave] was the public procurement act which stopped a clinical commissioning group trying to reorganise services in a particular way—they were told that they would have to put it out to tender because of EU law. The NHS runs very differently in the UK from other places in Europe and we need solutions that are specific to the UK.

MICHAEL MARMOT, director of UCL Institute of Health Equity

Around 90% of economists predicted that, in the case of Brexit, we would be a poorer country in the short and medium term. A poorer country will have less money to spend on social services, healthcare, education, and research: this will damage health. We recruit foreign nurses and doctors because we don’t train enough of our own. If it becomes more difficult to recruit, we will have to find the money to train more or do without, with adverse consequences. Just as important as all this, for me, is the message that Brexit sends. What I do in my day job is promote learning from other countries and cultures, sharing of perspectives, realising that we have common purposes in improving people’s lives, and creating health equity. The Brexit campaign promoted an image of a Britain that stands apart, unwilling to cooperate with other nations in dealing with the challenges we all face: global inequality, climate change, tax avoidance, human rights.
What does Brexit mean for doctors working in the UK?

Extricating the UK from the EU will have an impact on the UK’s medical workforce. Tom Moberly reports

Sarah Wollaston said that the effect on the workforce was the most worrying aspect of Brexit

Doctors from other European Union countries make a huge contribution to the NHS. One in 10 doctors registered in the UK qualified in another EU country (see figure, right), and over a quarter of doctors entering the medical register each year are from other EU countries.

Sarah Wollaston, the Conservative MP and chair of the parliamentary health select committee, said that the effect on the workforce was the most worrying aspect of Brexit. “We have 130 000 people working in the NHS who qualified elsewhere in the EU,” she told The BMJ. “The number one priority is to make sure they still feel welcome and those who are in the process of being recruited are given a reassuring message. They have to feel that coming to Great Britain is a positive step. No one is suggesting that people who are already here are going to have to leave—we have to give out a reassuring message.”

Samantha Currie, senior lecturer at the University of Liverpool’s School of Law and Social Justice, believes that the process of deciding the status of EU immigrants in the UK, as well as UK nationals living in other EU countries, will “constitute a significant part” of the Brexit negotiation process. “It will take time for clarity to emerge and, in the meantime, EU migrant workers in the UK will undoubtedly experience a greater sense of uncertainty than they have been used to as a consequence of the referendum result.”

Working Time Directive
One EU initiative that has long been the focus of opposition from the government and parts of the medical profession is the European Working Time Directive. “It is clear that the Working Time Directive has been a particularly contentious measure in the UK,” Currie says. “From this point of view, any continuation of the working time rules is likely to face some opposition.”

Jason Heyes, professor of employment relations and director of the Work, Organisation and Employment Relations Research Centre, says that another piece of employment legislation that a future government might want to look at is the agency worker regulations. “These give agency workers who’ve been working in the same job for 12 weeks the right to the same basic employment and working conditions as comparable employees,” he says. “In the health service that applies to many locums, and some people are very unhappy about that.”

But Heyes points out that these changes will take time. “Nothing is going to happen immediately as far as employment law is concerned,” he says.

Currie says that “it is impossible to present a clear long term picture” of how the rights of EU migrant healthcare professionals working in the UK may change. “For now, however, it is important to remember that from a legal point of view nothing has yet changed,” she said. “EU migrants’ residency, employment, and social security rights remain intact for nationals living in other EU countries, immigrants in the UK, as well as UK expats. But however, it is important to remember that from a legal point of view nothing has yet changed.”

Currie says that “it is impossible to present a clear long term picture” of how the rights of EU migrant healthcare professionals working in the UK may change. “For now, however, it is important to remember that from a legal point of view nothing has yet changed,” she said. “EU migrants’ residency, employment, and social security rights remain intact for nationals living in other EU countries, immigrants in the UK, as well as UK expats. But however, it is important to remember that from a legal point of view nothing has yet changed.”

Sarah Main, director of the Campaign for Science and Engineering

This outcome provides a real challenge for our sector. Science is an area where the relationship between the UK and the EU was particularly beneficial. Not least because scientists won billions of pounds of research funding for the UK (£7.3bn between 2007 and 2013)—above and beyond what we put in. In addition, free movement of people made it easy for scientists to travel, collaborate,
and share ideas with the best in Europe. Our sector is facing great change, with the Higher Education and Research bill currently going through parliament, and leaving the EU will no doubt have huge additional impact.

**KATHERINE RIPULLONE AND KATE WOMERSLEY**, medical students at Cambridge University

The contract dispute and the often overlooked financial challenges of a medical education already dissuade young people from choosing medicine. Leaving the EU will exacerbate their misgivings. Brexit is likely to deepen disempowerment felt by junior doctors and medical students, particularly those of us who are women. Without the safeguards of EU laws, we face uncertain work conditions, unclear employment rights, and a precarious career path.

**ADRIAN BULL**, chief executive, East Sussex Healthcare NHS Trust

My principal reasons [for voting to leave] were democracy. The EU is drifting into rule by a self appointing oligarchy. The direct link between lawmakers and voters is stretched too thin. Constitutional democracy is more valuable to us than higher gross domestic product. Economic forecasting is notoriously unreliable and we should not vote on the basis of it. We should vote on the core principles of self determination. The current panic is unnecessary. We remain leading members of NATO, UN, WTO, and the Commonwealth. We will continue to work and trade with international partners.

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**Brexit threatens stability of medical research workforce**

The UK’s exit from the EU will threaten the stability of the medical science workforce by undermining projects funded by the EU and could make the UK a less attractive place for EU scientists to work, researchers have warned.

Rustam Al-Shahi Salman, a professor of clinical neurology at the University of Edinburgh, told the online publication Vox, “Brexit will immediately destabilize our ongoing European Union-funded multi-center studies.” He said that the future of projects being established or seeking funding would now be less certain, because such projects were all planned under EU regulation.

**Funding**

The UK relies heavily on the EU to staff and fund its research efforts. About 23% of research scientists are from other EU countries, and about 5% of students in the UK are from other EU countries. In addition, about 10% of funding for research in UK universities comes from the EU. The UK receives 16% of research funding from the EU, equating to more than £8bn between 2006 and 2015.

**Collaboration**

Venki Ramakrishnan, president of the Royal Society, said that EU funding “has been an essential supplement to UK research funds.” He added, “One of the great strengths of UK research has always been its international nature, and we need to continue to welcome researchers and students from abroad. Any failure to maintain the free exchange of people and ideas between the UK and the international community, including Europe, could seriously harm UK science.”

Tom Moberly, BMJ Careers

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BRITISH (PAKISTANI) CONSULTANT UROLOGIST

GERMAN CONSULTANT ANAESHTHETIST

IRISH RADIOGRAPHER

SPANISH SCRUB NURSE
The positive contribution that health professionals from the EU make to the NHS has been highlighted in a photograph posted by locum consultant urologist Junaid Masood.

Following the results of the Brexit referendum, he posted a picture of the surgical team that he was working with at the Homerton University Hospital, east London. The photo, simply captioned “We are Europe!” shows three scrub nurses from Spain, an Irish radiographer, a German consultant anaesthetist, a Greek urology specialist registrar, and a British-Pakistani urologist. Masood wrote, “Today we have been hard at work improving people’s lives! That is what our friends from Europe do for the NHS.”

The picture went viral on social media and has been reproduced by several newspapers.

Ingrid Torjesen, London
Caring with evidence based medicine
Evidence alone should never dictate care for a patient

The task of evidence based medicine is to care for each patient. In the 25 years since Guyatt first used the term, many tools—such as practice guidelines—have sought to bring evidence based medicine to all.

Three recent articles in The BMJ suggest that something got lost along the way and offer solutions. Yudkin and colleagues note that guidelines and clinicians overestimate the value of healthcare, and they suggest risk estimators to calibrate expectations. Elwyn and colleagues think that guidelines are not built to support how clinicians use knowledge in practice in social, intuitive, and contextual ways and suggest new evidence conduits for the clinical encounter. McCartney and colleagues join them in arguing that guidelines do not support evidence informed, individualised decision making. All three articles advocate for shared decision making.

It is thanks to evidence based medicine, however, that we have learnt about the corruption of the evidence and about the flawed production and dissemination of guidelines. From the beginning, a core clinical principle of evidence based medicine stated that the evidence alone should never dictate care for a patient. The authors are right to critique guidelines when they fail to account for the shortcomings of evidence or forget the core clinical principle and fail to contribute to the work of caring for people. And when guidelines do fail, new or adapted evidence based medicine tools should emerge to ensure individualised care for each patient. In advancing these new tools, however, we must be careful not to fetishise them.

No simple answer
Analysing video recordings from our experience in developing and testing aids for use in clinical encounters has been sobering. We have seen sophisticated forms of persuasion in which the decision aid is used as a prop. We have seen encounters in which the technical steps for shared decision making are as evident as the lack of real connection with the patient. Like guidelines, shared decision making and the aids that support it don’t necessarily result in care.

Both guidelines and shared decision making fail when they seek to inject certainty rather than do justice to the uncertainty of illness. When we seek certainty in the tools we risk making evidence, clinical practice, and the articulation of patient preferences definitive rather than contributory in caring for the person. By unduly advancing certainty—for instance, when guidelines make strong recommendations—we breed hubris, a sense that medicine is simply a matter of knowing what to do and that all the best clinicians and their patients should have this ability at their fingertips. Anyone who lives with or cares for people with depression, cancer, or heart disease knows that this is rarely the case. The real challenge is to deal with illness and how it fragments, disarticulates, and renders uncertain the conduct and dignity of human lives.

Maintaining a critical eye on the contribution of evidenced based tools to the care of individual patients is the way forward. Guidelines serve well to communicate our understanding of what’s best for most patients when this is clear. In less clear situations, appropriately constructed guidelines are also helpful, as some guidance is often better than none.

Shared decision making should not be seen as the communication of expert knowledge or preference, or as the joint review of knowledge summaries designed for the consultation. In our work, we emphasise shared decision making in conversations. The conversation is an appropriate environment to use evidence from clinical research to help distinguish among available options—a set of options perhaps curated in guidelines. Options are hypotheses for what is best for this patient now. These hypotheses are tested in conversation until a purposeful path forward becomes clear. It is in conversation that clinicians and patients draw out the importance of evidence, options, biography, purpose, goals, and needs as these contribute to an individualised treatment plan. In so doing, evidence based medicine, as originally intended, becomes careful and kind care.

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Ian Hargraves, designer, Marleen Kunneman, postdoctoral research fellow, Juan P Brito, assistant professor of medicine, Victor M Montori, professor of medicine, Knowledge and Evaluation Research Unit, Mayo Clinic, Rochester, USA
montori.victor@mayo.edu
Statins, news, and nuance

Journalism that exposes the public to ongoing controversies in science should be nurtured

Did news coverage of questions about the risk-benefit balance of statins influence their use in the UK? In a linked paper, Matthews and colleagues (doi:10.1136/bmj.i3283, p 18) assert that it did, describing “impact,” “the effect of negative media coverage,” and “a transient rise in the proportion of people who stopped taking statins.”¹ They assumed causality but did not prove it, despite the causal language used.

The news in question was not all negative. Stories swung between extremes. One newspaper headline claimed that “statins do not have major side effects” just days after another newspaper headlined “millions face terrible side effects as [statin] prescription escalates.” Those two stories might have had very different effects on current or potential statin users.

Weak link

Two stories are a slim sample on which to base conclusions, but that is all the authors cited, after describing “widespread media coverage” over a six month period that was both “intense” and “negative.” In one story, less than 20% of the text discusses potential harms.² The headline of the other story was “Doctors’ fears over statins may cost lives, says top medical researcher.”³ We should not rush to judge the media’s role in this episode. The authors provide no patient survey data to support the belief that people stopped because of news reports.

It is noteworthy that another linked paper about discontinued use of statins (doi:10.1136/bmj.i305) included this limitation:

“I suggest that this episode is far less about journalism than about how science and medicine deal with uncertainty.”

Reasons unknown

What do we know about patients’ preferences in this case? Perhaps news stories inspired patients to question trade-offs in ways they never did when they started taking statins because they had not been fully informed. We know nothing about the quality of the clinical decision making encounters before the start of treatment. We know nothing about why these patients stopped. A survey in the United States found that patients perceive that physicians tend to emphasise the advantages more than the disadvantages in 10 common decisions about care.⁴ Furthermore, patients in that survey reported that treatment of raised cholesterol concentration was one of the decisions for which they were least likely to be asked for input.

So we do not know whether the news coverage on statins had any causal effects on people taking statins, what other factors could have influenced patients’ decisions to stop, and why initiation of new use did not decline after this same “negative” news coverage. Hanging over all of this are questions about what manufacturers’ data that have not been made public or what better studies of statins in routine use might further reveal about harms. Statin intolerance is not a myth.⁵

For 10 years I have published HealthNewsReview.org, a US based project that systematically reviews media messages that make claims about healthcare interventions.⁶ Our data on several thousand stories show that most emphasize or exaggerate potential benefits while minimising or ignoring potential harms.⁷

We rarely see journalism about overdiagnosis, overtreatment, or shared decision making. Few stories clearly communicate the trade-offs involved in medical decisions. Far more stories fawningly promote more use of more interventions, evidence be damned. Journalism that exposes the public to ongoing controversies in science should be nurtured, not branded as negative.

Matthews and colleagues projected excess cardiovascular events as a result of discontinued statin use.¹ They did not explore the possibility of reduced reports of muscle pain, rhabdomyolysis, liver damage, diabetes, or cognitive side effects.

If news stories generate new questions from patients, or more complete conversations between patients and clinicians including better discussions on trade-offs, personal preferences, and values, that is an outcome to embrace. In the end, I suggest that this episode is far less about journalism than about how science and medicine deal with uncertainty.

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research, pp 18, 19
EU referendum result: our readers respond

The results of the EU referendum are in, and 52% have voted for the UK to leave the European Union. So what do the readers of The BMJ think about the results, and the impact that this may have on health in the UK?

John R King asks, “How valid is a difference of 48% to 52% in the referendum result? Given the fluctuation of sentiment from day to day, the vagaries of the weather, not to mention that some early postal voters have now woken up to the reality of what Brexit means and changed their minds, to base an epic decision on such a slender majority on a particular day seems ridiculous. For assisted suicide, a clear and settled intention is an essential requirement. Brexit should have specified a similar condition.”

Michael H Stone says, “I found it stomach-churning that many politicians who I feel sure would never have voted to establish an essentially free at the point of use, and paid for out of general taxation, NHS, and who I think given the chance would either destroy or ‘privatise’ the NHS, ‘stood behind’ this ‘we would have another £350m a week to spend on the NHS if we left the EU’.”

Goh Shyan writes, “Some readers who claim that healthcare professionals should treat non-residents essentially the same as UK residents, are simply careless about the basic principles of financial budgeting in the NHS; when there is a limit in the spending budget, there is also a limit to how many people you can provide a service to within a timeframe. The inclusion of illegal migrants or non-residents on the NHS waiting list no doubt means a delay of services to some UK residents (for which the NHS is funded) regardless of whatever ethical arguments people use. This fact polarises opinion of UK migration within those groups of people with lower socioeconomic status or reduced access to higher education, income, or employment.”

Did you vote leave, and do you think that this will have a positive effect on healthcare in the UK? Let us know your opinion by submitting a rapid response on thebmj.com.
Ask hospital finance directors what concerns them most at the moment and two issues are increasingly top of their list: problems with getting patients into hospital and problems getting them out. The two are not, of course, unconnected. In fact, the measure of problems of getting out of hospital—delayed transfers of care—connects with the whole process of hospital and out-of-hospital care, from the use of beds and clinical decisions to treat, to the flows (and blockages) in emergency departments. Apart from the costs of delays to patients in emotional and health terms, the cost to the NHS has been estimated at £900m a year. Other estimates put it at around £540m a year.

The numbers of patients in a hospital bed but ready to be discharged fell between 2007 and 2010, and then stayed relatively steady from 2010 to about 2013. However, in the past two to three years the number of patients delayed has risen by about 50% (fig 1)—far outstripping the increase in patients being admitted to hospital. The latest figures for England show that in April this year nearly 6000 patients who were ready to leave could not be discharged—accounting for around 168 000 patient days—compared with about 4000 in 2013-14.

Although the problem is perhaps popularly supposed to be securing out-of-hospital support from social care for patients ready to go home or into residential or nursing homes, around 60% of patients are currently delayed in hospital because of problems attributable to the NHS (fig 2).

**DATA BRIEFING**

I’m a healthy patient. . . get me out of here!

Delays in discharging patients can’t be blamed solely on social care, finds John Appleby

Around 60% of patients are currently delayed in hospital because of problems attributable to the NHS

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**Fig 1** | Delayed transfers of care (monthly) in England, 2007 to 2015-16

**Fig 2** | Delayed transfers of care by responsible organisation and reason for delay, England April 2016

**Fig 3** | Average occupancy of general and acute beds in England, 2000-01 to 2015-16
Fig 4| Number of delayed transfers of care versus number of emergency department patients waiting over 4 hours to admission, transfer, or discharge, England (monthly time series, August 2010 to April 2016)**

Nevertheless, while delays attributable to social care are in the minority—around 33% of all delayed patients—over the past three years they have grown by 92% compared with a 19% increase in delays attributable to the NHS. The effects of funding cuts for local authorities plus increasing difficulties in the care home market are likely to have contributed to this trend.

**Delayed discharge**

Delays in discharging patients have knock-on effects and will have contributed to increasing bed occupancy rates. These, on average across all hospitals in England, have risen from around 85% to 89% over the past eight years (fig 3). This apparently small increase in the national average obscures the fact that the number of hospitals with over 90% average occupancy across the year increased from 49% to 74% between 2007-08 and 2015-16.

Increasing numbers of delayed discharges also backs up into other parts of hospitals. For example, the problem with increasing numbers of emergency department patients having to wait more than the government’s target of four hours to admission, transfer, or discharge is strongly linked not to the front door (increasing attendances) but to the back door, with problems in admitting patients to other parts of the hospital. And, in turn, there is an observed positive association between the numbers of emergency department patients waiting more than four hours to be either admitted into hospital, transferred out of the department, or discharged home and the number of patients waiting to vacate a bed elsewhere in the hospital (fig 4).

As a recent report on delayed transfers of care has noted, there’s no silver bullet that will improve the situation. Local authorities have been subject to fines since 2004 for delays that can be attributable to services for which they are responsible. While this may have had some effect in its early years, recent increases in delays arising from social care perhaps suggest such financial disincentives have lost their bite. As the varied reasons for delays suggests (fig 2), solutions too are varied—from better funding of demand for health and social care at a national level, through to better discharge planning and perhaps a review of the financial (dis)incentives faced by the NHS and local authorities.

**The cost of delays to the NHS has been estimated at £900m a year. Other estimates put it at around £540m**
Anthony Costello
Irreverent and dogged

What was your earliest ambition?
To be a doctor—and to play football for Millwall and cricket for England.

Who has been your biggest inspiration?
My grandfather, for his wit, charm, and principles.

What was the worst mistake in your career?
I don’t look back on career choices as mistakes, because my experiences were all opportunities to learn. Maybe I could have come to work at WHO a bit earlier.

What was your best career move?
Accepting a job with the Save the Children Fund to work in Baglung in the middle hills of Nepal, two days’ walk from a road.

Bevan or Lansley? Who has been the best and the worst health secretary?
David Ennals was principled and commissioned the Black report [into health inequalities]. I have concerns about Andrew Lansley’s reforms without evidence.

To whom would you most like to apologise?
My colleagues in Malawi, Nepal, Bangladesh, India, and UCL for failing (so far) to land a grant to study the impact of women’s and farming groups working together on sustainable agriculture and on household ecosystems for better child nutrition. We’d worked on the proposal for two years.

If you were given £1m what would you spend it on?
If not on that research project, I’d buy farmland and woods to create apothecary and potager gardens and a cooperative permaculture community.

What single unheralded change has made the most difference in your field?
Tablets for data collection that enable faster analysis and reporting of cluster randomised trials in large, poor, and remote populations. Also, recognition of the importance of empowering local people to transform their own health.

Do you support doctor assisted suicide?
Yes, but exceptionally: only if sanctioned by the judiciary and with widespread availability of excellent hospice and palliative care.

What book should every doctor read?
Poverty and Famines by Amartya Sen, a treatise on entitlements and the social and economic determinants of health.

What, if anything, are you doing to reduce your carbon footprint?
Video lectures, cycling, less red meat, and train travel. But my carbon footprint is still utterly shameful: in my current job it’s difficult to practise what I preach.

Summarise your personality in three words
Irreverent, melancholic, dogged.

Where does alcohol fit into your life?
I haven’t drunk a drop since 2005, when I started daily verapamil for right ventricular outflow tract tachycardia.

What is your pet hate?
Queues at airports.

What would be on the menu for your last supper?
Buffalo momos [dumplings], fish and chips, summer pudding, a Sprüngli chocolate rabbit, and an île flottante.

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