Doctors not declaring drug firm fees

Only around half of doctors and other healthcare professionals are putting their names to payments and benefits they receive from drug companies in the register run by the industry’s trade association—far fewer than previously claimed.

A new analysis of data submitted to the Association of the British Pharmaceutical Industry’s Disclosure UK database (www.disclosureuk.org.uk) has found that just 55% of doctors and other healthcare professionals are allowing their names to appear alongside the fees and expenses they receive from drug companies, not the 70% that was claimed in June 2016 when the scheme launched.

The database lists details of the fees and benefits in kind paid by the industry to doctors, pharmacists, nurses, and healthcare organisations. Only those that give consent are identified.

Mike Thompson, chief executive officer at the ABPI, said that he wanted 100% of UK healthcare professionals to be open about payments from drug companies. He said that NHS England’s new guidance on declaring conflicts of interest, launched last month, would help “make this a reality.”

NHS England’s guidance “advocates disclosing on our database,” said Thompson. However, NHS England abandoned plans to force doctors to declare the income they earned from outside the NHS after doctors objected.

In the new analysis, RAND Europe found inconsistencies in how companies recorded data relating to healthcare professionals who did not give their consent to publish details of payments or benefits in kind they received, giving rise to the new figures.

The General Medical Council does not have the power to make mandatory such disclosure by doctors, and a recent proposal to make voluntary declarations was rejected by doctors. GMC chief executive, Charlie Massey, said, “We strongly urge doctors involved in the pharmaceutical sector to participate fully in this scheme to ensure patients’ confidence in the profession is maintained.”

Commenting on the issue, the GP and BMJ columnist Margaret McCartney said, “Without statutory declarations of financial conflicts of interest, it’s clear that voluntary registers contain significant gaps. I hope that the House of Commons Health Committee asks the GMC why it didn’t consider mandatory reporting.”

Mike Thompson, chief executive officer at the ABPI, would like to see all UK doctors declaring their fees and benefits from industry

Ingrid Torjesen, London
Cite this as: BMJ 2017;356:j1574
GP funding

BMA condemns lack of resilience cash

The BMA urged NHS England to urgently deliver £16m in resilience funding that it promised to deploy to struggling general practices by the end of this financial year. The funding was due by the end of March as part of a four-year, £40m resilience package. But a BMA survey of local medical committees found that only 60% of local commissioners had identified and notified the practices due to receive funding. And only 16 committees (40%) said that the promised funding had been made available. (doi:10.1136/bmj.j1562)

Teenage pregnancy

Rate is lowest since records began

The rate of conceptions in women under 18 in England and Wales fell to 21 in 1000 in 2015, the lowest since comparable figures were first produced in 1969. The rate was 22.9/1000 in 2014 and 47.1/1000 in 1969. The drop is thought to be due to investment in sex education, improved access to contraception, and more young women staying in education. Last month Justine Greening (below left), the education secretary, said that all secondary schools, including academies, private schools, and religious free schools, would have to offer sex education classes.

Women’s health

GPs challenge claim that they do not do enough

Helen Stokes-Lampard, chair of the Royal College of GPs, challenged the notion that GPs do not take fibrosis and endometriosis seriously after a survey found that 62% of women were not satisfied with information they received about treatments. Some 40% of respondents had had 10 or more GP appointments before being referred to a specialist. Stokes-Lampard emphasised that endometriosis symptoms were broad, adding, “All of our patients should be treated with dignity and respect . . . whatever their symptoms, and whatever their condition, their GP will always take their condition seriously.” (doi:10.1136/bmj.j1533)

International health

Heat resistant rotavirus vaccine is “game changer”

A new vaccine against rotavirus—known as BRV-PV—is safe and efficacious against severe gastroenteritis, showed a trial of 4000 children aged under 2 in the Maradi region of Niger, published in the New England Journal of Medicine. Micaela Serafini, medical director of Médecins Sans Frontières, described the vaccine as a “game changer” because it is heat stable and does not require refrigeration, meaning that it can reach children in the most remote parts of the world, and it costs less than $2.50 (£2).

Consultant must repay £525000 or face jail

A hospital consultant who became a loan shark to nursing staff and other colleagues has been ordered to repay £525 000 to his victims or face five years in jail.

Arjan Savani (inset), 50, who worked in the emergency department at Central Middlesex and Northwick Park Hospitals in Harrow, northwest London, was sentenced last October to 10 months’ imprisonment, suspended for two years, and ordered to do 120 hours of unpaid work.

Prosecutors said that Savani, who had pleaded guilty at Harrow Crown Court to two counts of illegal money lending, made 271 loans worth a total of over £1m to 90 people since 2011, charging interest rates of between 1.5% and 8% a month.

After his conviction, prosecutors made a “proceeds of crime” application to seize his illegal gains. At a new court hearing he was ordered to pay back £525 000, the total amount he received in payments from his debtors. He has three months to come up with the money, or he will face a sentence of five years in prison.

He has been suspended from practising and is under investigation by the General Medical Council. A fitness to practise hearing is expected but no date has been set. (Clare Dyer, The BMJ) Cite this as: BMJ 2017;356:j1532

Child obesity

Government’s plan needs work, say MPs

Sarah Wollaston, chair of the parliamentary health committee, said that “vague statements” about the progress of last year’s government plan for tackling child obesity in England “are inadequate for the seriousness and urgency of this major public health challenge.” The committee called on the government to stop discounts and price promotions of unhealthy food and drink. (doi:10.1136/bmj.j1556)

Hospital finances

Three more trusts enter special measures

St George’s University Hospitals NHS Foundation Trust, Northern Lincolnshire and Goole NHS Foundation Trust, and University Hospitals of North Midlands NHS Trust were put into financial special measures by NHS Improvement. The three trusts have failed to keep up with their agreed financial control totals and are forecasting a combined deficit of £145m.
**Hepatitis C**

**European patent of key drug is challenged**

Médecins Sans Frontières, Médecins du Monde, and civil society organisations from 17 countries filed simultaneous patent challenges with the European Patent Office on Gilead’s hepatitis C drug sofosbuvir, in a bid to increase access. Sofosbuvir is one of a range of oral “direct acting antivirals” to come to market in the past four years and forms the backbone of most hepatitis C combinations. In Europe, Gilead charges as much as $59 000 (£47 000) for a 12 week sofosbuvir treatment, but studies have shown that it costs less than $1 a pill to produce. Key patents on sofosbuvir have already been revoked in China and Ukraine.

**Research news**

**Cutting salt could reduce urge to urinate at night**

Cutting salt intake could reduce the need to get up in the night to urinate, showed a preliminary study presented at the European Association of Urology congress in London. The Japanese study included 321 men and women who experienced nocturia during sleep and had a high dietary salt intake (≥8 g/day in men and ≥7 g/day in women), 223 (69.5%) of whom reduced their salt intake from a mean of 10.7 g/day to 8.0 g/day, and whose average night time frequency of urination reduced from 2.3 times to 1.4 times (P<0.001). ( doi:10.1136/bmj.j1527)

**Viagra**

Drug agency considers prescription status

Pfizer applied to the Medicines and Healthcare Products Regulatory Agency to request that sildenafil (Viagra) for erectile dysfunction is made available through pharmacies. The risks from sildenafil and of intentional abuse are low, says the consultation, adding that making it available over the counter would benefit men who are embarrassed to seek a doctor’s advice. It could also help to identify men with heart disease and reduce the risks associated with buying counterfeit sildenafil online. The consultation runs until 18 April.

Cite this as: BMJ 2017;356:j1568

**New drugs against hepatitis C are too costly, say charities**

Hospital, regardless of distance, a study published in the European Heart Journal found. The researchers used data on 41 186 patients in Denmark who had experienced a cardiac arrest out of hospital, 3550 (9%) of whom were still alive 30 days later. Direct admission to an invasive heart centre rather than a local hospital was independently associated with lower mortality (adjusted hazard ratio 0.91 (95% confidence interval 0.89 to 0.93)). (doi:10.1136/bmj.j1572)

**Specialist centres are urged for cardiac arrest**

Patients have a better chance of survival after a cardiac arrest if they are taken immediately to a specialist heart centre rather than the nearest general hospital, regardless of distance, a study published in the European Heart Journal found. The researchers used data on 41 186 patients in Denmark who had experienced a cardiac arrest out of hospital, 3550 (9%) of whom were still alive 30 days later. Direct admission to an invasive heart centre rather than a local hospital was independently associated with lower mortality (adjusted hazard ratio 0.91 (95% confidence interval 0.89 to 0.93)). (doi:10.1136/bmj.j1572)

**SIXTY SECONDS ON...**

**HAPPINESS**

I’M VERY HAPPY, GAZING OUT AT A FJORD, ENJOYING MY PICKLED HERRING

Of course you are—you’re Norwegian. The World Happiness Report 2017 says that Norway is the happiest country in the world. The US ranks 14th of 155 countries, the UK is 19th, and France is 31st. The poor old Central African Republic is last.

IS IT TO DO WITH MY HERRING?

Well, the report doesn’t measure pickled herring consumption specifically (unless I’ve missed something). It studies income, healthy life expectancy, having someone to count on, generosity, freedom, and trust—the last measured by the absence of corruption in business and government.

WHY IS NORWAY SO HAPPY?

A Norwegian man writing in the Guardian puts his compatriots’ joie de vivre down to having a log cabin in the mountains or by the sea—or both (he doesn’t mention herring but does mention berry picking and cosiness, or _hygge_). The report takes a more prosaic view: the country is happy not because of its wealth but despite it. Norway invests in the future rather than on short term measures. “To do this successfully requires high levels of mutual trust, shared purpose, generosity and good governance,” said the report.

SO, WHAT MAKES US MISERABLE?

One revelation is that mental and physical ill health, unemployment, and poor relationships lead to misery. Surveys of wellbeing in Australia, the UK, and the US found that poor mental health was the most important factor. In poorer countries income difference was more important, but poor mental health was still high on the list.

**WHAT ABOUT THE UK?**

The Office for National Statistics measures wellbeing in the UK, although it surveys individuals rather than populations as in the World Happiness Report. But the survey and the happiness report both show that the UK is getting happier. Levels of wellbeing have risen every year since 2011, when the ONS surveys began. And 2017 is the first year the UK has been in the top 20 since the report began in 2012. Things can only get better . . .

Anne Gulland, London

Cite this as: BMJ 2017;356:j1539

**NURSES**

From September to December last year an average of 194 nurses a month from other EU countries signed up to work in the UK, down from 797 in 2015 [Nursing and Midwifery Council]
We see a greater variety of illness...and yet we have the shortest training time

Kamila Hawthorne

The vice chair of the RCGP discusses the college’s ambition for four years of GP specialty training

“Ian Finlay, chair of the Shape of Training steering group, wrote to the college to say that it had rejected four year GP training and instead proposed a ‘three plus one’ model. This proposal was put to the RCGP council, which overwhelmingly rejected it.

“Our understanding of three plus one is that it would be three years of training, as it is now, and that the ‘plus one’ would be a yearlong fellowship after the certificate of completion of training (CCT). This would allow newly qualified GPs to do a little bit more in an area that interested them, so they might, for example, become a GP with an extended role (the term now used for GPs with a ‘special interest’). We pointed out to Ian Finlay in a reply that the fellowship year is actually not pre-CCT training and really what we were interested in was enhanced GP training.

“General practice has changed a lot in the past 20 or 30 years, but the training, and the amount of time given to training, hasn’t. We have now got a lot more to do in general practice: a large number of services have moved out of hospital and into primary care, and patients are discharged from hospital much earlier. The population is getting older, with increasing complexity of presentations and multiple morbidities. GPs are being brought into positions of leadership and management with little or no formal training.

“We also see a greater variety of illness than any other specialty, and yet we have the shortest training time. I was pleased that our council voted in favour of enhanced GP training that would entail both the extension of training to at least four years and an improved quality of that training.

“The college is proposing to review and refresh its original offer of the four year extended training and bring it up to date, because it’s now two or three years since it was written, and these things can always be improved. So, that is the next step for us.”

Abi Rimmer, BMJ Careers

Cite this as: BMJ 2017;356:j1553

Patient safety test will be part of NHS staff appraisals from 2018

All NHS staff will have to sit an annual multiple choice test on patient safety as part of a drive by England’s health secretary, Jeremy Hunt, to make the service “the world’s largest learning organisation.”

The radical plans, unveiled in a consultation document published on 1 April, will require all NHS staff to sit the test as part of their annual appraisal from 2018.

Ministers are understood to have sounded out the production team behind the television quiz show Who Wants To Be A Millionaire? for advice on constructing the test.

In its consultation document the Department of Health outlines a list of sample questions that it may include in the final test. One mock question asks:

“How much does poor care cost the NHS financially?”

The options are:
(a) more than good care;
(b) less than good care;
(c) the same as good care; or
(d) don’t know.

Another question asks:
“What is the name of the leading US hospital often cited by Jeremy Hunt as a pioneer in the field of patient safety?”

The options are:
(a) Virginia Mason;
(b) Virginia Plain;
(c) Virginia Woolf; or
(d) Virginia Bottomley.

The announcement marks the latest phase of the health secretary’s Patient Power 2.0 plan, which he hopes will be the catalyst to create a “no blame” learning culture in the NHS. Hunt insisted that the measures would be “light touch” but would form an important part of a “360 degree, 365 days a year, 24-7, ultimate knowledge gaining experience.”

He said, “I truly believe that introducing this test will help us achieve our ambitious target of making our NHS the safest healthcare system anywhere in the world. It may not be ‘evidence based’ in the traditional sense, but if you look at leading trusts like Salford Royal, and Frimley, which are already delivering wonderful care, they would probably be delivering even more wonderful care than they already are if they used this test.”

But doctors’ leaders condemned the proposals as bureaucratic, foolish, and lacking in evidence.

Mark Porter, BMA chair, said, “The NHS is underfunded and services are unable to keep up with rising demand, but, instead of addressing this, the government has chosen to implement what effectively amounts to a multiple choice trivia quiz.”

A spokesperson for the Centre for Quiz Based Medicine said, “Where is the evidence base for this? This is pure folly from a secretary of state who seems intent on imposing time wasting gimmicks and fads on the medical profession.”

Gareth Iacobucci, The BMJ

Cite this as: BMJ 2017;356:j1542
The NHS isn’t getting the most out of its consultant workforce, not because they aren’t working hard enough but because of poor workforce planning, especially in the lack of nurses. Gareth Iacobucci reports on new research that analyses productivity across NHS hospitals, while John Appleby considers the pitfalls of measuring such activity.

“**Ineffective use of staff**” blamed for fall in clinical activity of senior doctors

The productivity of consultants working in NHS acute care hospitals in England has fallen by an average of 2.3% over the past six years, new research has shown. The think tank the Health Foundation, which conducted the research, attributed the fall to poor workforce planning. It highlighted a 22% rise in the number of NHS consultants over the past six years, whereas the number of nurses rose by just 1%.

Anita Charlesworth, director of research and economics at the Health Foundation and coauthor of the paper, said, “Consultant productivity has been falling, but not because staff aren’t working incredibly hard. NHS consultants work in a system, and if that system isn’t well designed they can’t be productive.

“Much better workforce planning is critical. Increasing the number of consultants by a fifth without investing in nurses is a prime example of short term cost savings undermining the essential task of improving long term productivity.”

The analysis looked at consultant productivity across 150 NHS acute hospitals between 2009-10 and 2015-16. It compared cost weighted activity led by consultants, which rose by 1.8% a year through the six years, with the number of full time equivalent consultants, which rose by just over 4%.

The study concluded that the decline in productivity was due to “systemic problems,” meaning that the NHS was not getting the most out of its consultant workforce. It noted that the output per full time equivalent consultant was 29% higher at the most productive hospital than at the least. Hospitals with the lowest consultant productivity were found to have fewer nurses and support staff working with consultants, a higher number of delayed transfers of care, and pay rates that were less competitive for their area.

The researchers acknowledged that their measure of consultant productivity was crude, as it did not adjust for quality of output, but they added, “With the magnitude of our results this will not affect the overall conclusions.”

National policy decisions such as cutting numbers of nurse training places while consultant numbers were rising, and three years of raids on capital budgets to bail out deficits, had also contributed to poor productivity, the analysis added.

The authors warned that the failure to tackle ineffective use of staff was making it increasingly difficult to reach the £22bn of savings by 2020 set out in NHS England’s Five Year Forward View, which means increasing NHS productivity by 2%-3% a year.

Keith Brent, chairman of the BMA’s Consultants Committee, said that consultants were working harder than...
ever but were being let down by a system “at breaking point.” He also emphasised that “clinical activity is not the same as quality of care or patient outcome.”

Brent said, “Consultants will always treat patients as individuals, not as units to be processed in ever greater quantity. This research highlights the shortage of doctors and nurses in some areas and the need for an NHS with the right mix of skill to deliver high quality care.”

Jane Dacre, president of the Royal College of Physicians, said, “Money alone will not solve this issue: workforce planning is crucial.

“If we are to improve productivity consultants need to be supported by strong teams encompassing nurses, management, and support staff.”

Cite this as: BMJ 2017;356:j1552

DATA BRIEFING

How productive are NHS consultants?

On paper at least, the productivity of consultants is falling. But is one reason because the quality of their work is increasing, asks John Appleby?

On the face of it, measuring the productivity of the workers in an industry or business is straightforward. The ONS Productivity Handbook defines productivity as simply the volume of output per unit of input. Inputs (the number of workers) may increase over time, but if the outputs (widgets) increase at a faster rate then productivity will have increased. On this basis, have NHS hospital consultants been producing less, the same, or more widgets over the past few years?

It turns out that dividing one number (outputs) by another (inputs) to get a third (productivity) is somewhat harder in practice than the arithmetic implies.

Over the past seven years, the good news is that as consultant numbers have increased, so too has their elective activity (fig 1). The English NHS increased its elective output by around 19% from September 2009 to September 2016. But the bad news is that at the same time, the consultant workforce grew by around 22%.

This means that the average productivity per consultant has fallen by 3% since 2009 (fig 2).

But here’s the first problem with this calculation: consultants’ output is not just measured in elective activity but includes outpatient attendances and emergency work. Although consultants will also spend their time in meetings, management, and other administrative duties, these are assumed to be intermediate activities that contribute to their final output. But what about teaching and research? What to include in the overall output measure is not always clear. And though there are ways to aggregate the apples and pears of different types of activity into one overall measure of output (weighting them by the proportion of their total spend for example), this presumes their importance or value is related to their cost.

There is a second and rather fundamental problem, which is not just specific to a publicly funded NHS or, indeed, to healthcare but which exists for virtually all industries, public, or private.

The problem is how to ensure outputs are comparable over time. For producers of mobile phones we can count the number of phones produced every year and call that their output. But it’s clear that, although still a phone, Apple’s 2016 iPhone 7 is somewhat different to Nokia’s 1997 6110 mobile (though both cost around the same). Over two decades the power and capabilities of mobile phones have increased hugely. The 2016 mobile phone product is not the same as its 1997 counterpart.

And the same is true for healthcare. The attributes that patients’ value in the things consultants’ produce (operations, attendances, etc) have changed over time, mainly for the better—from time spent waiting to get treatment and experience of care, to the probabilities of experiencing complications and the change in health status as a result of treatment.

Adjusting the output of consultants to reflect changes in the quality of the “product” is not easy, but without it productivity can be seriously underestimated over time. For the NHS as a whole, Office for National Statistics adjustments for quality (improved waiting times, reductions in mortality, etc) have accounted for around 40% of the increase in the productivity of the NHS since 2000 and about 17% between 2009 and 2014 (fig 3).

If such an addition, assuming the quality increase in 2015 was the same as in 2014, was applied to the elective outputs of consultants, it would have been enough to have just about compensated for the 3% fall in unadjusted productivity between 2009 and 2015 (fig 2).

Cite this as: BMJ 2017;356:j1520

PRIVATE PROVIDERS TAKE LARGER SLICE OF NHS CASH

• Spending by NHS trusts on private sector and other non-NHS providers rose by 18% between 2014-15 and 2015-16, from £810m to £960m
• In the same year, NHS providers’ total budget grew by £800m, an increase of just 1.1% in real terms
• £1 in every £8 of local commissioners’ budgets is now spent on care provided by non-NHS providers
• Capacity constraints mean that NHS hospitals are increasingly limiting elective care to manage pressure in emergency care and that a growing share of preplanned care is being outsourced to private sector providers
• The NHS should re-examine the marginal rate payment tariff for emergency care, which halves payments for emergency admissions above the 2008-09 levels

Source: Health Foundation

Cite this as: BMJ 2017;356:j1552
BMJ OPINION Anita Charlesworth

National policy creates barriers that undermine productivity

New Health Foundation research shows that between 2009-10 and 2015-16 consultant productivity in 150 acute hospitals fell by an average of 2.3% per year. This decline isn’t because consultants aren’t working hard enough, but because of systemic issues with the way the NHS is organised. Our research analysed some of these factors, which are all too familiar.

Most important is workforce planning. Our research finds hospitals with a higher proportion of nurses have higher consultant productivity. Increasing the proportion of nurses by 4% in a hospital can increase activity per consultant by around 1%. A more balanced rise in numbers among different staff groups may ensure that the NHS uses consultants’ skills well, but recent years have seen disjointed workforce planning at best. The decision to cut nurse training places in the early part of this decade may have saved some short term costs but looks to have undermined the drive to improve productivity.

Another challenge is capacity: consultant productivity is lower in hospitals with higher rates of delayed transfer of care. Increased pressures on the social care system have exacerbated this issue. The extra £2bn for social care over the next three years announced in the budget is unlikely to be sufficient as pressures on the social care system are rising even faster than the NHS.

We also found that consultants who work in hospitals that invested more in infrastructure and building through private finance initiatives (PFIs) are more productive. The research did not seek to assess the value for money of PFI as a system of financing hospitals, but used PFI spending as a proxy measure for more modern facilities and equipment. It’s not hard to imagine how working in modern, fit for purpose facilities with the right IT and equipment allows consultants to work more productively.

Another challenge is capacity: consultant productivity is lower in hospitals with higher rates of delayed transfer of care. Increased pressures on the social care system have exacerbated this issue. The extra £2bn for social care over the next three years announced in the budget is unlikely to be sufficient as pressures on the social care system are rising even faster than the NHS.

We also found that consultants who work in hospitals that invested more in infrastructure and building through private finance initiatives (PFIs) are more productive. The research did not seek to assess the value for money of PFI as a system of financing hospitals, but used PFI spending as a proxy measure for more modern facilities and equipment. It’s not hard to imagine how working in modern, fit for purpose facilities with the right IT and equipment allows consultants to work more productively.

So it’s worrying that NHS investment funding is instead being used to bail out hospital deficits. In each of the past three years the Department of Health has raided the capital budget to prop up running costs, and further transfers are reportedly planned for the next three.

The research suggests that national policy can create substantial barriers that undermine consultant productivity. Three in particular must be addressed: workforce planning, social and community care capacity, and capital.

Anita Charlesworth is director of research and economics at the Health Foundation
Leading anaesthetist praises NHS response to Westminster attacks

Clinical director at Imperial says training “kicked in” when incident was declared.

Anne Gulland reports

A consultant anaesthetist at one of the trauma centres that received casualties after last week’s attacks in Westminster has praised his colleagues for their “fantastic response.”

Helgi Johannsson, clinical director of anaesthesia at Imperial College Healthcare NHS Trust, which received eight casualties, said that the trust had taken part in a pan-London simulation exercise in the past year, which simulated a major train accident. He said that the training kicked in once the Westminster incident was declared at 15.55 on 22 March.

“I couldn’t fault our teams, they did an absolutely fantastic job. The whole process worked very well,” he said.

Four people died and 40 were injured, some critically, when a man ploughed his car into pedestrians on Westminster Bridge at 14.40 on 22 March. The responses to major incidents such as this are planned for under guidance in the NHS’s Emergency Preparedness, Resilience and Response plans.

Johannsson said that, once a major incident is declared, an automated switchboard calls all relevant individuals. He said that there was a “fantastic response … We had people not only offering to come in there and then but also coming in for the night shift. Two of our senior trainees formed an augmented night shift.” He added that one emergency coordinator had worked downstairs in the emergency department and one upstairs in theatres.

“The response to the Westminster attacks was more coordinated than the response to the attacks in July 2005”

“We kept most of the workforce in theatres, and we called down for people as we needed them,” said Johannsson. “We used every single bay in resus. When a patient in a bay went elsewhere we filled that bay with another team. We always had one in the queue and one team of people waiting to go in. We could have coped with a lot more casualties than we did.”

Johannsson was not working at Imperial during London’s last major incident in July 2005, but colleagues who were there at the time said that the response to the Westminster attacks was far more coordinated. He added that several debriefs took place after Wednesday’s incident.

“There’s always something to learn. This time it was mainly about...”

GOOD SAMARITAN ACTS

Sally Old and Oliver Lord, medicolegal advisers at MDU, explain what doctors need to know about being a good Samaritan

1 Ethical obligation

There is no legal obligation in the UK for a doctor to volunteer as a “good Samaritan” during an emergency, but they do have an ethical obligation to provide assistance, even if they are off duty and wherever they are in the world.

2 International expectations

In some countries, however, there is a legal obligation to provide assistance, and if a doctor fails to help then they could be prosecuted. France, for example, has a dedicated good Samaritan law which compels doctors to assist in an emergency.

3 Protected by law

The risk of doctors being sued after they have helped in an emergency is very low with only a handful of cases ever having been attempted. Likewise, the Social Action, Responsibility, and Heroism Act 2015 is intended to protect those acting in an emergency in England and Wales from legal action.

4 Produce clinical records

If doctors do find themselves in a situation where a good Samaritan is needed, they should make a clinical record of any help given, including the patient’s name, if known, the treatment provided, and the doctor’s contact details. Hand over relevant information to those who will provide ongoing patient care.

8

1 April 2017 | the bmj
Low morale, extortionate exam fees, and a poor work-life balance are inherent to being a junior doctor in the NHS. Junior doctors would say these issues have been ignored. A new report from Health Education England details plans to tackle the crisis, including cutting the costs of exam fees and making training more flexible (http://bit.ly/2o907dQ).

Training less than full time (LTFT) is a tempting offer of greater flexibility and improved work-life balance. Until now it was open only to doctors with a “well founded individual reason.” The HEE report proposes that everyone should be eligible. This could encourage junior doctors to stick with specialties such as emergency medicine, where up to 50% leave before completing training. However, this may not help reduce gaps in the rota. More doctors working part time will mean fewer on the scheduled rota—how will this work in an NHS already struggling to provide a service?

HEE is introducing an LTFT pilot scheme from spring 2017 for all higher trainees in emergency medicine across England. If successful, other specialties struggling with recruitment could adopt a similar programme. This is the first indication of a system willing to be flexible to suit the needs of junior doctors.

HEE is also to be applauded for finally tackling a huge source of frustration to junior doctors. Currently, training is expensive and disruptive, with repeated moves and long commutes. HEE has promised to analyse the effects of rotations across large geographical areas. This should provide evidence on which to base changes to the current unfair and rigid system. With postgraduate training costing on average around £17 000 and anaesthetics training reaching £25 000, juniors have long called for financial support from their respective royal colleges. Vague promises of “best practice principles” are all that is currently offered by HEE, so proposals for reducing costs will be welcomed. But ideas on paper and their real life implementation are worlds apart. The current state of the medical workforce demands rapid and effective improvements. Solutions such as the LTFT pilot schemes show that HEE will be pragmatic in moving forward. Prioritising progress in reducing the cost and disruption of training is, however, essential. As NHS junior doctors we are concerned that promises will not materialise given the constraints of staffing rotas. These proposals may be seen by some as unnecessary extras. Yet the crisis in morale in the workforce will only worsen if things don’t change. We desperately hope that HEE will ensure that the NHS understands that this report is long overdue and that its implementation is urgently needed.

Oliver Loi-Koe is an FY2 trainee at Kent and Canterbury Hospital and Anya Göpfert is an FY2 trainee at Bristol Royal Infirmary

5 **Recognise your limitations**

Doctors may be asked to act as a good Samaritan at a time when they are unwell or tired. In this instance, it is important to assess whether they are competent to help. If another doctor or healthcare professional is at the scene it may be more appropriate for that person to help instead.
Nearly 40,000 doctors in Delhi and Mumbai have gone on strike to demand better security in government hospitals, after a spate of attacks on medical professionals. Pictured are staff from Sion Hospital, in Mumbai. If the government continues to ignore their safety concerns, doctors have threatened to call a nationwide strike.

Last week a 35-year-old junior doctor, Rohan Mhamunkar, was brutally assaulted by relatives of a patient in the emergency department of a hospital in Dhule, a city 300 km from Mumbai in the state of Maharashtra. Within days four more doctors in the state were attacked in separate incidents.

“The young doctor has lost his eyesight in one eye. In the face of such violence, all we want is more secure working conditions for us from the government,” said Doctor Ashokan of the Indian Medical Association.

To demonstrate their feelings about violence against the medical profession, doctors at the All India Institute of Medical Sciences in New Delhi wore helmets last week while they tended to their patients.

In India’s understaffed, under-resourced healthcare system, violent incidents against doctors are common. A survey conducted by the Indian Medical Association in 2015 found that 75% of Indian doctors had faced some form of violence in their workplace. Data from the past five years of the survey showed that patients’ relatives and attendants committed 68% of the violence.

As well as demanding more guards at hospitals, doctors want the government to impose a limit on the number of relatives allowed to visit patients on wards.

Writing for BMJ Opinion this week (blogs.bmj.com/bmj), Avinash Supe, professor of surgical gastroenterology at KEM Hospital in Mumbai, pointed to other triggers.

“There is a growing misunderstanding that doctors are unnecessarily admitting and treating patients for economic reasons, creating a divide of mistrust. Mounting health bills for services, along with misperceptions like these, become triggers for violence against doctors.”
Pollution of health news

Time to drain the swamp

US President Donald Trump placed the term fake news in the global lexicon with his repeated criticism of journalism that doesn’t suit him. But with the viral spread of that term, many now apply it to what is actually sloppy journalism. Fake denotes deliberate deceit. Sloppy refers to a much broader range of hurried, incomplete, poorly researched news, not necessarily with deceitful intent. They are different problems with different sources and require different solutions.

Journalists and public health officials have shown that Trump has promoted fake news about health and health policy with, for example, his statements about vaccines and autism.1 His recent State of the Union address included false assertions about the Affordable Care Act2 and the US Food and Drug Administration.3

The democratisation of the internet delivers the unfortunate side effect of allowing fake health news to be spread by websites that deliberately publish hoaxes, propaganda, and disinformation as real news—often using social media to drive web traffic and amplify their effect.4 Google and Facebook have taken steps to try to stop fake health news messengers, at least temporarily.5

Polluted stream

Social media sites are often mere conduits for news coming from further upstream, including vested interests that stand to gain by promoting their ideas in the most positive light. The sources of the pollution are often public relations news releases emanating from these vested interests, most notoriously from questionable commercial interests such as companies selling herbal cures for cancer, but also from mainstream government health agencies, researchers, universities, clinicians, hospitals and medical centres, drug and device manufacturers, and industry funded advocacy groups.

When researchers, their journal manuscripts, news releases, and journalists spin findings to emphasise the beneficial effect of an intervention,9 is that fake news? The definition seems to matter less than the imperative to find a solution.

The media watchdog HealthNewsReview.org has systematically reviewed more than 3 300 healthcare news releases in the past two years. Our aim is not only to check facts but to help citizens learn how to improve their critical thinking. If we had not begun looking, the following troublesome episode would probably have evaded scrutiny.

Last year, a University of Maryland news release claimed, “Concussion-related measures improved in high school football players who drank new chocolate milk.”10 We raised so many questions that the university announced an internal investigation. Its final report uncovered a debacle, describing a study with “too many uncontrolled variables to produce meaningful scientific results, particularly troubling because students were used as subjects.”11 The report stated that the lead researcher did not declare $200 000 received from the Allied Milk Foundation as a conflict of interest, and this was part of “a concerning lack of understanding of the basic principles of conflict of interest in research at all levels.”

We have no evidence that the authors set out to deceive deliberately, but their preliminary, un-peer reviewed, and unpublished data were seriously conflicting and had the potential to mislead. The report called for sweeping changes in university policy.

One aspect of this episode deserves more attention, since it has potential ethical ramifications for universities everywhere. This excerpt of the Maryland report captures the issue:

“The PI [principal investigator], as well as several others, expressed less concern for, and were perhaps less attentive to, the potential of a research conflict of interest in part because they felt that this project was in support of small business which is highly encouraged by the state and actively promoted by the university.”

The research was funded through the Maryland Industrial Partnerships programme, which “promotes the development and commercialization of products and processes through industry/university research partnerships.” Most universities now have such technology transfer programmes. How much more news that is conflicted or worse will we find emanating from such efforts, especially if researchers perceive that this is what they are being encouraged to promote?

There is a saying: “Journalism is printing what someone else does not want printed; everything else is public relations.” Media watchdogs often find substantially more of the latter than the former.

Many news organisations have increased their fact checking of political news in recent months. We wish we had seen a commensurate boost in checking of news about public health, healthcare, and biomedical research.

Journalism has the ability to expose and dismantle news that is fake and to refute unsubstantiated criticism of news that is not fake.

It is time to drain the swamp created by the polluted stream.

Find the full version with references at http://dx.doi.org/10.1136/bmj.j1262

Cite this as: BMJ 2017;356:j1262

EDITORIAL
Whatever happened to the polypill?

The idea is slowly but surely gaining ground

It has been nearly 15 years since Wald and Law proposed that a polypill could reduce cardiovascular events if taken by everyone from the age of 55 years (one form of primary prevention) and all people with pre-existing cardiovascular disease (secondary prevention). Initial responses to the idea were mixed, with most who voiced opinions expressing opposition. Others were enthusiastic about the idea’s potential, and since the 2003 publication several polypill trials have shown tolerability and benefit on intermediate and some clinical outcomes.

In a recent HOPE-3 trial a polypill reduced cardiovascular events by 29% over about 5.6 years, relative to placebo, in a sample of over 12 000 adults all at moderate risk of cardiovascular disease (3.6% v 5.0%; P=0.005). No participants had a history of cardiovascular disease, making this a trial of primary prevention. Rates of discontinuation (26.3% v 28.8%) and serious side effects did not differ between the groups.

The use of a polypill for secondary prevention, typically as a substitute for individual drugs, has become more acceptable, especially if it improves adherence and reduces costs. In one survey of US physicians published in 2011, about two thirds reported they would prescribe a polypill for patients with established cardiovascular disease. Even though more than half indicated they would prescribe a polypill to moderate risk patients for primary prevention (people without known cardiovascular disease), its use for primary prevention is still controversial. Data on hard clinical outcomes are sparse and many clinicians, patients, and the public remain concerned about “medicalising” an essentially healthy population.

The polypill concept is grounded in several important epidemiological principles. Key among them is that a large proportion of cardiovascular events occur in people with “normal” blood pressure and cholesterol levels. This prevention paradox occurs because most people are in the middle of the distribution of these risk factors and because there is a consistent proportional relation between these risk factor levels and cardiovascular events. Using “diagnosis” of hypertension or hyperlipidaemia as the basis for offering risk reducing therapies ignores these principles. It also does not consider the combined effect of risk factors or the fact that the strongest risk factor is age.

Fortunately, the clinical approach to primary prevention has evolved. In contrast to the diagnostic approach, calculation of overall cardiovascular risk allows the clinician and patient to consider the combined contributions of all risk factors, regardless of their levels. This approach allows clinicians to shift focus from assessing and treating risk factors to assessing risk and offering interventions (statins and aspirin) to reduce risk. The polypill approach builds on this idea, adding drugs to lower blood pressure and taking us a few steps closer to a population strategy.

Questionable safety

One of the remaining concerns that makes a population level approach unacceptable to many clinicians, patients, and the public is the questionable safety of large numbers of people taking such drugs without supervision and monitoring. The ideal formulation for a polypill has been a matter of debate, but most proposed formulations contain a statin, blood pressure lowering drug(s), and possibly aspirin. For primary prevention, a pill without a β blocker and with an angiotensin receptor blocker instead of an angiotensin converting enzyme inhibitor would probably be better tolerated on a population level. The statin used should have minimal potential to interact with other drugs that might potentiate the risk of myopathy. Of the current proposed components, aspirin is the most potentially toxic, and the decision to include it needs to be carefully weighed against the risk of gastrointestinal bleeding, which also increases with age.

How can the polypill idea move forward? Only high income countries are likely to have the resources and infrastructure required to dispense and monitor large numbers of adults taking polypills, even if this is done through community pharmacies rather than clinicians’ offices. In low and middle income countries, where access to clinical services is limited, an over-the-counter or public health dispensing approach could be evaluated for effectiveness and safety.

We should continue to develop more and better evidence in different populations to firmly establish long term safety and effectiveness. If it is shown to cause minimal harm and reduce the risk of cardiovascular events, we may reach a time when everyone can choose to take a polypill when they reach a certain age or risk level. It certainly doesn’t reduce the need to encourage and facilitate a healthy diet and taking more exercise.

Cite this as: BMJ 2017;356:j1474

Find the full version with references at http://dx.doi.org/10.1136/bmj.j1474

Anthony J Viera, professor, Department of Family Medicine, University of North Carolina, Chapel Hill, NC, USA anthony_viera@med.unc.edu
The changing role of the CMO for England

Chief medical officers today must undertake a careful balancing act

Every six months the chief medical officers (CMO) from each EU member state meet to discuss emerging public health issues. For more than 40 years, the occupant of the British seat, the CMO for England, has been a valued contributor. If Theresa May has her way, and the UK actually manages to leave the EU by 2019 that seat will be vacated. This will be a great loss to Europe, given the expertise that successive CMOs have brought, but even more so for the UK, which will be excluded from important discussions on policies that will, despite Brexit, inevitably have consequences for this country. Yet, this is only the latest change in a role that has continually been evolving since it was created in 1855. The world has changed enormously. Has the role of CMO managed to keep pace?

The role of a CMO in the UK, as the senior medical adviser to the government as a whole—not just to a health ministry—is unusual. CMOs in the UK also have more independence, at least formally, than in many other countries. Second, although the English CMO represents the entire UK, and the dependent territories, in the international arena, there are also CMOs in Scotland, Wales, and Northern Ireland, with responsibilities divided in keeping with the UK’s constitutional complexity.

New developments

Four developments in particular have influenced the changing role of the English CMO. The first is the increasingly global nature of health threats and the corresponding need for an international response. The health consequences of globalisation are now well established. One is the role of international trade as a determinant of health and, with it, the power of international corporations, such as the manufacturers of junk food, alcohol, and tobacco. As exemplified by the World Health Organization’s Framework Convention on Tobacco Control, concerted international action is essential. Another is the threat posed by infectious disease and, especially, antimicrobial resistance. This too can be tackled only by a coordinated global response.

A second development has been the weakening of the British civil service, which has been subjected to relentless cuts for many years. The Institute for Government has warned that it simply may not have the capacity to implement the enormous changes that will result from Brexit. These cuts have had a disproportionate impact on professional advice to ministers. Earlier CMOs led teams of highly qualified doctors, each able to offer specialist expertise in different areas. That has now gone and, when the present English CMO assumed office, she had no professional staff and only minimal administrative support.

A third, and related, development has been the fragmentation of the health landscape in England, especially after the 2012 Health and Social Care Act. This created two new organisations—NHS England and Public Health England—that at least on paper operate at arm’s length from government and, by extension, from the CMO.

The fourth is the growing importance of evidence, at least in advice to ministers even if not always in the resulting policies. While earlier CMOs would often give advice based on their professional judgment, the expectation now is that advice is grounded in findings from research. The expectation now is that advice is grounded in findings from research.

Donaldson. In 2007 Donaldson led the development of the government’s first global health strategy, contributing substantially to the then emerging international global health agenda. Davies has continued this process, focusing on the global threat from antimicrobial resistance. She is widely credited with having led the process that culminated in the 2016 UN Declaration on Antimicrobial Resistance. This process showed the importance of being able to assemble a solid body of research and working across many sectors. This was exemplified in the report she persuaded David Cameron to commission from former Goldman Sachs chair Jim O’Neill, which predicted 10 million deaths per year by 2050 and a cost of $100trn (£80trn, €92trn) if nothing was done.

Choose your battles

Yet while Davies is widely admired internationally, criticisms have sometimes been voiced domestically. Some of the more vocal public health advocates had hoped that she would have been more vocal in opposing certain policies of the current government. Notwithstanding their statutory independence, CMOs must undertake a careful balancing act, choosing very carefully which battles they will fight in public. As successful generals have realised, it is best to choose battles you will win, which is not easy when powerful vested interests are supported by much of the British media, shout “nanny state” at every opportunity, and when ministers declare that we have had enough of experts. Despite these difficult circumstances, recent CMOs have had some striking successes. Where they have failed, it is difficult to see how others could have done better.

Martin McKee, professor of European Public Health, LSHTM, London WC1H 9SH, UK

Cite this as: BMJ 2017;356:j1545

Find the full version with references at http://dx.doi.org/10.1136/bmj.j1545
n the year that sees the 50th anniversary of the Abortion Act 1967, which created a framework for legal termination, campaigners argue that abortion should be decriminalised in England and Wales. A coalition of 20 organisations, We Trust Women, says that women who choose abortion should no longer risk life imprisonment under a law dating back to the Victorian era, when only men could vote. The organisations include the Royal College of Midwives and Doctors for a Woman’s Choice on Abortion. The BMA has no policy on the matter but has issued a discussion paper.

What is the law in England and Wales? Abortion is a crime under the 1861 Offences Against the Person Act. The Abortion Act creates an exception, making abortion on licensed premises lawful under specific conditions. Abortions under any other circumstances are unlawful. If a woman obtains abortifacient drugs online and uses them at home to terminate a pregnancy, even before 12 weeks’ gestation, she commits an offence under the 1861 act that is punishable by a maximum sentence of life imprisonment, the harshest penalty imposed by any European country.

Two recent prosecutions in England involved vulnerable women who obtained pills to carry out late term abortions.

What do campaigners want? Campaigners say that abortion is the only medical procedure that is regulated by the criminal law, denying women control of their bodies. Many countries in Europe recognise that a woman has a right to end a pregnancy before the fetus is viable. Campaigners want legislation repealing sections 58 and 59 of the 1861 act. Decriminalisation would not mean deregulation: abortion would still be regulated, says Sally Sheldon, professor of law at Kent University, who coordinated a letter to the Guardian newspaper signed by more than 200 legal experts in support of decriminalisation.

How far has the campaign got? A 10 minute rule bill, the Reproductive Health (Access to Terminations) Bill, was introduced in the House of Commons by the Labour MP Diana Johnson on 13 March. The second reading will be on 12 May, after MPs voted in favour by 172 votes to 142. It is unlikely to become law.

Have other countries decriminalised? In 1988 the Supreme Court of Canada struck down the criminal code governing abortion as unconstitutional, so abortion is no longer a crime there. The abortion rate has remained fairly low and there are few late abortions. Statistics for 2014 show an abortion rate of 14.7 per 1000, which compares with 15.9 per 1000 in England and Wales. In Canada 0.86% of abortions were performed after 21 weeks. England and Wales have no directly comparable statistic but less than 0.1% of abortions were done after 24 weeks. In some parts of Australia abortion has been decriminalised as part of overall reform of abortion law.

What do opponents say? Much of the opposition comes from Christian and antiabortion groups. Some midwives opposed to their royal college’s stance have labelled the measure “extreme.” Maria Caulfield, the Conservative MP who opposed the bill, said, “It would remove some of the few protections and regulations in abortion law, fuelling unethical and unsafe practices in many UK abortion clinics and leaving women less safe and less informed.”

Clare Dyer, legal correspondent, The BMJ
clearedyer4@gmail.com

Cite this as: BMJ 2017;356:j1485

Regulating abortion as healthcare

Consider the Canadian experience of nearly 30 years without a criminal law to police abortion. Abortion decisions are made in the same way as those about vasectomy or treating a ruptured appendix. They happen in the context of the doctor-patient relationship. Abortion is seen, funded, and regulated as a health service.

Since our criminal law was struck down, Canadian women have had improved access to abortion in hospitals and through the emergence of freestanding clinics, which now provide more abortions than hospitals. Overall abortion rates have been in decline since the mid-1990s despite relative stability in birth rate. This is not surprising. Although globally we see a direct correspondence between more legal restrictions on abortion and increased maternal mortality and morbidity, criminalisation of abortion is not associated with fewer abortions. Abortion in Canada has also become safer. Ensuring access with the fewest restrictions or delays is important because abortions are safer with each week earlier they can be performed. Furthermore, criminal law barriers to access are associated with the unsafe practice of illegal abortions, and can prompt women to access abortion methods without supervision and advice from regulated healthcare professionals.

W V Norman, associate professor, Department of Family Practice, University of British Columbia, Canada
wendy.norman@ubc.ca

J Downie, professor, Faculties of Law and Medicine, Dalhousie University, Canada
Cite this as: BMJ 2017;356:j1506
Devi Sridhar
Governing global health

What was your earliest ambition?
To be a professional tennis player and win the Miami Open.

Who has been your biggest inspiration?
My grandmother. In her 60s she finished a PhD, wrote several books, and even joined me for part of my fieldwork in the slums of New Delhi.

What was the worst mistake in your career?
Early in my career I used to say yes too often and found it hard to say no. The best advice I got then was that it’s better to be respected than liked.

What was your best career move?
Turning down a funded place at Harvard Law to do my PhD in Oxford.

To whom would you most like to apologise?
My dad, for not becoming a real doctor. At least I ended up in a medical school.

If you were given £1m what would you spend it on?
Building a massive centre to look at the political economy of global health: yes, we need investment in vaccines and drugs and new technologies, but we also need robust academic analysis of what needs to change to improve human health. We’re starting to build this through the Global Health Governance Programme.

What single unheralded change has made the most difference in your field in your lifetime?
Millions of children’s lives have been saved because of big partnerships in global health, such as the GAVI Alliance for vaccines and the Global Fund for HIV/AIDS, tuberculosis, and malaria.

What book should every doctor read?
Paul Farmer’s Pathologies of Power. He writes beautifully and conveys a powerful narrative about medicine’s close links to anthropology and politics.

What, if anything, are you doing to reduce your carbon footprint?
If I can video-Skype into a meeting I do that instead of travelling there.

What personal ambition do you still have?
To complete a triathlon.

Summarise your personality in three words
Curious, energetic, and loyal. I’m also usually sleep deprived.

Where does alcohol fit into your life?
Nowhere—I’m a non-drinker.

What is your pet hate?
Negativity and jealousy.

What would be on the menu for your last supper?
Papayas, mangoes, watermelon, dragon fruit, lychees, jackfruit, and starfruit.

Do you have any regrets about becoming an academic?
None at all. I get to teach enthusiastic and bright students, do interesting research that takes me all over the world, work closely with a focused team, and engage with government and UN officials and the media.

If you weren’t in your present position what would you be doing instead?
I’d be in the US, finding ways to be politically active.

Cite this as: BMJ 2017;356:j1490