Beta blockers’ role post MI in doubt

Patients who have had a myocardial infarction (MI) but do not have heart failure or left ventricular systolic dysfunction do not seem to benefit from beta blockers, a large UK study in the *Journal of the American College of Cardiology* has found.

Current UK guidelines from the National Institute for Health and Care Excellence recommend that beta blockers are prescribed to all patients who have had an MI, irrespective of the amount of damage done to the heart muscle.

The study found that beta blocker use was not associated with lower all cause mortality in the following year among patients with MI but without heart failure or systolic dysfunction. The researchers said that this result adds to increasing evidence that routine prescription of beta blockers may not be indicated in patients with a normal ejection fraction or without heart failure after an MI.

One of the study authors, Chris Gale, professor of cardiovascular medicine at the University of Leeds and consultant cardiologist at York Teaching Hospital Trust, told *The BMJ* that “doctors should not change their practice at the moment,” noting that the study was observational although large. “But the finding is a call to arms for a randomised controlled trial to finally answer the issue,” he said, adding that such a trial was planned but was awaiting funding.

Rob Henderson, honorary secretary of the British Cardiovascular Society and consultant cardiologist at the Trent Cardiac Centre in Nottingham, agreed that it was probably premature to change practice. But he told *The BMJ*, “It is another piece of evidence that questions the role of routine beta blockers in all patients who have had a heart attack.”

Henderson added, “This study suggests that, in people who don’t have heart failure or significant heart muscle damage, beta blockers may not be beneficial. That’s important, as there is a cost issue: although beta blockers are cheap, they are given to a lot of patients. Secondly, beta blockers carry a risk of side effects which people may find unpleasant.”

Researchers examined data from the UK’s national MI register, the Myocardial Ischaemia National Audit Project. The cohort study included 179810 people who had acute MI but not heart failure or left ventricular systolic dysfunction.

Jacqui Wise, London

Cite this as: *BMJ* 2017;357:j2635

Experts agreed that routine use of beta blockers post MI needed further scrutiny

- Emergency departments are struggling to meet asthma care standards, audit shows
- Junior doctor is struck off over false research claims
- Parents of child with rare genetic disorder lose life support appeal
SEVEN DAYS IN

Next government “should not abandon STPs”

The next government should back the sustainability and transformation partnerships (STPs) in England, regardless of which political party wins the general election, a senior adviser on health policy has urged.

Speaking at a King’s Fund event on the next steps for implementing STPs, Hugh Alderwick, senior policy adviser at the fund, said that the partnerships between local councils and NHS services remained the most credible option for improving the delivery of health and care in England and should not be abandoned after 8 June.

But Alderwick, who said that he had read every one of the 44 STP plans while conducting research into their progress, also warned that it was not credible to expect them to “do everything” within the next two years. Instead, he advised each of the 44 geographical STP areas to focus on a small number of key priorities in the short term.

The plans for integrated working, which involve substantial reconfiguration and service closures in some areas, are being overseen by NHS England and have been backed by the Conservative Party. But the Labour Party has been more cautious and has pledged to halt and review any plans that are looking at closing health services and to ask local people to help redraw them.

Gareth Iacobucci, The BMJ Cite this as: BMJ 2017;357:j2591

General election

May focuses on Brexit when grilled over NHS funding

Theresa May was accused of overseeing a “chronic underfunding” of the NHS during a pre-election debate hosted by Channel 4. An NHS midwife asked May to justify funding policies that had left some staff “at their wits’ end.” May insisted that the government was committed to building a “first class national health service” but said that NHS funding was linked to a strong economy, and she emphasised the importance of securing a good deal from Brexit.

NHS pressures

Overnight bed occupancy hits record high

Overnight hospital bed occupancy in the NHS in England hit a record high from January to March 2017, figures from NHS England showed: 91.4% of overnight general and acute beds were full in those three months, substantially exceeding the recommended 85%. Clare Marx, president of the Royal College of Surgeons, said that the numbers were “exceptionally worrying,” warning, “We are running short of space in hospitals.”

NHS could face £500m Brexit bill

The Nuffield Trust, a healthcare think tank, said the NHS could face a bill of almost half a billion pounds if retired British people living in other EU countries decide to return to the UK because their right to healthcare in those countries is withdrawn after Brexit. The trust also warned that the social care sector could be 70 000 workers short by 2025-26 if migration of unskilled workers from the EU stops after Brexit.

Research news

Teens with injuries from alcohol need support

Adolescents who are admitted to hospital for alcohol, drug, or violence related injuries have a similar risk of suicide in the next 10 years as people who have self harmed and should be offered the same support from mental health professionals, a study in the Lancet found. The study, funded by the Department of Health, examined data from around a million adolescents admitted to an emergency department with injuries from self harm, drugs, alcohol, violence, or an accident.

Non-invasive postmortems using CT scans are feasible

Postmortems using a minimally invasive computed tomography (CT) technique with targeted coronary angiography successfully identified the cause of death in 92% of cases, a study published in the Lancet found. Researchers from the University of Leicester argued that the technique could be used instead of invasive autopsy in most sudden natural deaths investigated by coroners.

Eating disorders

GP are told to refer eating disorder cases immediately

GPs should refer patients with eating disorders such as anorexia or bulimia for specialist treatment immediately, guidance from NICE advised. Patients should be seen close to home whether they are an inpatient or a day patient, it said, and GPs should not use single measures such as body mass index or duration of illness to determine whether to offer treatment for an eating disorder. Dieting, eating behaviour, and physical symptoms such as malnutrition should also be considered, it said.

Transparency

Diaries from Lansley years must be released

The government will have to release the ministerial diaries of Andrew Lansley (left), health secretary from 2010 to 2012, the period when the Health and Social Care Act became law and gave GPs 80% of the NHS budget. Simon Lewis, a journalist, requested the diaries from the Department of Health under a freedom of information request and was given a redacted version, but the Information Commission required full disclosure of the information. The department refused, but three Appeal Court judges ruled unanimously in favour of full disclosure and “transparency in public administration.”

3 June 2017 | thebmj
**Medicine**

**Stroke risk**

*Stroke risk factors in pre-eclampsia are identified*

Women with pre-eclampsia face a raised risk of stroke during pregnancy and post partum if they have infections, particularly of the urinary tract, chronic high blood pressure, or clotting or bleeding disorders, a study found. US researchers looked at data on women admitted to hospitals in New York state from 2003 to 2012. They identified 88 857 with pre-eclampsia, of whom 197 had pregnancy associated stroke. Most of the strokes occurred post partum after women had been discharged home, and more than 10% were fatal.

**Trump watch**

*Trump’s bill would leave 23 million uninsured*

The number of US people without health insurance will be 23 million higher by 2026 if the bill to repeal and replace major portions of the Affordable Care Act is enacted, a report concluded. An analysis by the non-partisan Congressional Budget Office calculated that the bill, approved by the House of Representatives earlier this month, would increase the number of uninsured people to 51 million by 2026, compared with 28 million if Barack Obama’s act remained intact.

**Trump plans to slash Medicaid funding**

President Trump outlined plans to cut federal funding for Medicaid, the government health insurance plan for poor and disabled people, and to substantially cut funding for poverty programmes and medical research. The $4.1 trillion (£3.16tn) budget for the fiscal year 2018 is part of a long term fiscal plan that the Trump administration said would cut more than $1tn from social safety net programmes over the next 10 years. When combined with cuts to other programmes the plan is intended to reduce federal spending by $3.6tn overall.

**Global health**

*WHO must find new ways to raise funds*

The new director general of the World Health Organization said that it must focus on new ways of fundraising. In his first press conference after his election by the World Health Assembly on 23 May, Tedros Adhanom Ghebreyesus was asked about the implications for WHO of the $19bn (£14.7bn) cuts to the US diplomacy and aid budgets. Tedros, former minister of health in Ethiopia, said that securing money from organisations such as the Gavi Vaccine Alliance should be a higher priority than securing funding from individual countries.

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**Cholera**

Some 417 people died in the cholera outbreak in Yemen from 27 April to 27 May 2017. But reported new cases fell to 2529 a day from 21 to 27 May, down from 3025 a day the previous week.

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**Sixty seconds on...**

**GP numbers**

So, GP numbers are down again? Yes and no.

Come on, surely they either are or they aren’t? Take a deep breath: this is a statistical minefield. The decline to which you refer is a fall of 46 (40 085 to 40 039 reported by NHS Digital in England’s GP headcount excluding locums) from the end of last December to the end of March this year. But if we look at full time equivalent GPs (again, excluding locums) the number rose by 36 (33 387 to 33 423) in the same period.

Hardly seems worth making a fuss. Indeed, especially as NHS Digital specifically cautions against making the comparison. The March 2017 figures are the first to be collected on a quarterly basis, so nobody quite knows how seasonality affects those leaving and those joining the workforce.

What’s the trend using figures we can compare? Glad you asked. If we compare the end of March 2016 with the end of March 2017, the GP headcount has risen from 41 985 to 42 250, while the full time equivalent figure has fallen from 34 914 to 34 372. These figures include locums, which is why they aren’t the same as those above.

But is this a valid comparison? Hard to say. NHS Digital treats the data as “experimental statistics” and has made changes in gathering them. So while comparisons quarter to quarter are dogged by seasonality, year to year ones are affected by changes in data collection methods.

Is there a take home message? It’s clear that numbers of full time equivalent GPs, which is what matters, aren’t matching rising demand. A year ago NHS England announced extra money to boost the workforce by 5000 over five years, but this has yet to show in the data.

Will data now be collected so that we can tell? Let’s hope so. Statisticians are right to want to improve the ways they gather data, but if that destroys the time series, it’s self defeating.

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Nigel Hawkes, London

Cite this as: BMJ 2017;357:j2597

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**Cite this as:** BMJ 2017;357:j2617

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Women with blood clotting disorders and pre-eclampsia warrant close monitoring.
Manchester doctors describe aftermath of bomb blast

Doctors in Manchester are still dealing with the aftermath of last week’s bomb attack as a number of patients remain in critical care in the city’s hospitals.

As of 6 am on Tuesday 30 May, NHS England disclosed that 50 people were still being treated in eight hospitals in Manchester, including 17 patients in critical care. In total 116 people had received inpatient care after the suicide bomb attack at the Manchester Arena on 22 May, which killed 22 people.

With emotions still raw after the attack, a consultant orthopaedic surgeon who spent 48 hours treating injured patients at Salford Royal Hospital said that he was subjected to racial abuse while travelling back to work to treat more victims of the attack. Naveed Yasin (below), who spoke of the “horrific” injuries that he treated including penetrating injuries from shrapnel, told the Sunday Times that he had been called a “brown, P*** bastard” and a “terrorist” while driving back to work.

Despite being taken aback by the abuse, Yasin said, “Manchester is better than this. We Mancunians will rebuild. We will rebuild the fallen buildings, the broken lives, and the shattered social cohesion we once had.”

Other doctors at hospitals that received casualties reflected on the importance of staff being familiar with major incident plans when such an attack takes place.

Colin Wasson, consultant anaesthetist and medical director at Stockport NHS Foundation Trust, which treated 10 patients after the attack, told The BMJ that a recent simulation had highlighted the importance of keeping the emergency department clear in such scenarios.

“Having done a simulation and then been

GP is suspended for 12 months for treatment failures

An experienced GP who wrongly diagnosed addiction to painkillers in a patient and then failed to suspect an ectopic pregnancy when she returned with abdominal pain has been suspended for 12 months by a medical practitioners’ tribunal in Manchester.

Shahabuddin Syed, who qualified in India but has worked in the UK since 1971, largely in Kent, was found guilty of serious misconduct in his treatment of all four patients considered in the case. He was also found to have been rude to a social worker who had called him out to see one of the patients.

The social worker had asked Syed to visit an elderly woman, referred to as Patient A, who had recently been admitted to hospital after experiencing delusions and whose records also showed a recent urinary tract infection.

The woman was having “abnormal thoughts,” Syed was told, but on seeing her he did not inquire about these.

The woman’s circumstances “necessitated action, which you did not take,” the tribunal chair, Jayne Wheat, told Syed. “Instead, you were rude to, and dismissive of, Miss B (the social worker), who had Patient A’s best interests at heart.” He did not consider differential diagnoses, the hearing found, and he neglected to order testing for urinary tract infection. Police and social services had to be called to the woman’s house later
through a real thing, it made a massive difference,” he said. “I have never been involved in something of that magnitude. Knowing your particular role was critical because you cannot spend time working out what everyone needs to do.”

**Novel injuries**

Wasson said that the first thing the hospital did when the incident was declared was to disperse patients from emergency and intensive care throughout the hospital. All staff were needed, from anaesthetists to surgeons, as well as physicians to accept patients from emergency units onto the wards.

He said, “It’s safe to say we haven’t seen these types of injuries before. But how you manage a penetrating injury is a core skill for any of us. A single penetrating injury is not an uncommon event, but we were having patients with multiple bits of shrapnel in their bodies.” The approach was the same as for a road traffic incident, he said: prioritising life threatening injuries.

Wasson said that the response in Stockport was a team effort. “It wasn’t just those who were on the front line—the whole hospital rose to the challenge,” he said. “The collective response was really impressive.”

He added that staff had undoubtedly been affected by the events. “I’m sure a lot of people went home and had a cry afterwards, as it was impossible not to be affected by the tragic circumstances we were managing,” said Wasson.

The Royal Bolton Hospital received 15 patients who had been caught up in the bomb blast. Some were treated in its emergency department for minor injuries, and eight were admitted—seven into orthopaedics and one into general surgery. This hospital is located further out of town, and none of the patients sent there had life threatening injuries.

Jeremy Jarratt said: “Obviously, there are some added risks for these patients—the risk of blood-borne diseases and the degree of contamination. There is a protocol for treatment in terms of them having a baseline viral screen for hepatitis B [and] C and HIV. All of the patients were given hepatitis B prophylaxis, all were given tetanus, and all were given antibiotics.”

**The collective response was really impressive**

Jarratt told *The BMJ* that the major incident plan had run smoothly. “We were fortunate, in that we didn’t have any immediate life threatening injuries and our volume was relatively low, so it was quite easily manageable by the teams we had in place,” he said. “Everyone was focused on the job in hand, which was triaging, assessing, and treating these patients as they came in.”

Ingrid Torjesen, Anne Gulland, London

Cite this as: *BMJ* 2017;357:j2628

Steve Gill

The Nottingham University Hospitals consultant discusses his role as a guardian of safe working

“**D**uring the junior doctor contract negotiations I, a consultant in intensive care medicine, was in charge of our rota for junior doctors in critical care.

“Though I didn’t feel that the implementation of the contract was done well, I did see some positives on offer and thought that there was potential for the idea of exception reporting [reporting of work done outside agreed hours]. I thought that taking on the guardian role could be a good way to rebuild some of the bridges to our junior doctor colleagues—to make them feel like part of the team.

“We’re a big trust, with two guardians of safe working each with 400 trainees, about a third of whom are currently on the new contract.

“Though I rarely sit down for a whole day to focus on guardian duties, I feel like I have got relatively protected time and I’m well supported by our medical HR department and the medical education team.

“What we’re doing now is still educating and supporting people so that they know how to use the processes. Some trainees are a bit suspicious: they are worried that if they exception report then the information will be used against them. Some of the consultants worry that it’s a burden on their time. We hope people realise that there are significant benefits to exception reporting. For example, we changed the rota for one specialty to acknowledge the fact that the foundation doctors were coming in half an hour early to prepare for a ward round. We have also persuaded HR to put some locums and staff grade doctors into a department that was understaffed and overworked.

“**I have two roles in managing exception reporting. The first is to look for patterns and for frequent reports. I also get involved if there is a disagreement between the trainee and the educational supervisor, which so far has been very rare. So most of the time I am looking at the patterns and the numbers, seeking to understand and resolve the underlying issues, in partnership with medical HR and the different specialties.”**

Cite this as: BMJ 2017;357:j2596

**Steve Gill**

The Nottingham University Hospitals consultant discusses his role as a guardian of safe working
Senior doctors face burden of work related illness

Many doctors feel that the NHS, as an employer, has not looked after their health. Matt Limb reports

Senior UK doctors have disclosed a huge burden of work related ill health and feelings of being unsupported by the NHS, a study has found.

Hundreds of doctors near the end of their careers reported experiencing chronic physical or mental stress, and many said that the NHS did not respond well when they became ill.

The researchers said that more GPs than hospital doctors reported problems and that older doctors in particular “need support to be able to continue successfully in their careers.”

The research was carried out by the UK Medical Careers Research Group at Oxford University’s Nuffield Department of Population Health and was published in the Journal of the Royal Society of Medicine.

The researchers analysed the responses of 3550 doctors who graduated in 1974 and 1977 to a survey on work’s effects on their own health and wellbeing. The authors wrote, “Their comments reveal a huge burden of ill health which many respondents attribute to aspects of their work, the working environment, or the difficulty of achieving a sustainable balance of work and home commitments.

“Many doctors felt that the health service as an employer had, in their own experience, not been good at responding to doctors who became ill or who were subject to difficult and demanding personal circumstances.”

In response to the question, “Do you feel that working as a doctor has had any adverse effects on your own health or wellbeing?” 44% of doctors answered yes. More GPs (47%) than hospital doctors (42%) said that this was the case. Three quarters of doctors who answered yes cited “stress/work-life balance/workload” as an adverse effect, and 45% mentioned illness. Adverse effects cited included problems such as sleep loss, weight problems and heavy drinking, and adverse effects on relationships and family life.

Episodes of burnout and depression were often attributed to the stress and workload that doctors faced.

Doctors also complained that frequent policy changes and increased bureaucracy added to the pressures on them, citing NHS cuts and repeated reorganisations in the 1980s and 1990s.

Doctors often thought that physical illness such as stroke, heart disease, hypertension, and migraine were caused or aggravated by stress.

Some doctors said that they had received good support when they needed it, but many did not.

In response to the statement, “The NHS of today is a good employer when doctors become ill themselves,” 28% of doctors agreed, 29% neither agreed nor disagreed, and 43% disagreed. More women (49%) than men (40%) disagreed with this statement. More GPs (49%) disagreed than hospital doctors (37%).

Doctors also reported specific job related physical illnesses, such as repetitive strain injuries from carrying out procedures.

Many doctors who had since retired reported that their health had then improved substantially.

CHOOSE GENERAL PRACTICE AS A CAREER

Between 1999 and 2015 Oxford University researchers surveyed 9161 doctors, asking about their future specialty choices three years after they had graduated from medical school

1 Rise
In 1999 more than half (59%) of doctors agreed with the statement, “General practice is more attractive than hospital practice for doctors at present.” By 2005 this had risen to 77%.

2 Fall
But by 2015 only 36% of respondents agreed that general practice was more attractive than hospital practice.

3 Enthusiasm
In 1999 just under half (49%) of doctors who were intending to become GPs said that enthusiasm for, and commitment to, the specialty was very important. By 2015 this figure had risen to 65%. There was also a rise in the corresponding figures for doctors intending to work in hospital medicine, from 61% in 1999 to 91% in 2015.

4 Work-life balance
For doctors who chose general practice, wanting a job with acceptable hours and working conditions “retained a huge level of importance” over the 16 year study period. This aspect was less important to doctors who chose hospital practice.

5 Exposure
“When the attractiveness of general practice to current medical graduates is undoubtedly affected by their beliefs about GPs’ work-life balance and their exposure to general practice in their training,” the researchers concluded.
Postgraduate training will be more flexible under new standards

New standards for medical curriculums will improve the flexibility of postgraduate training, the General Medical Council (GMC) has said.

The GMC published a new framework for the approval and provision of postgraduate medical education and training across the UK on 22 May. The new standards say that medical curriculums should support flexibility and the transferability of learning, making it easier for trainees to switch specialties or take a break.

The publication of the standards came after the GMC issued its flexible training review in March. The review called for an end to the “snakes and ladders” experience of trainees wanting to switch between specialties.

Charlie Massey, chief executive of the GMC, said that the new standards would give doctors more choice as their interests in medicine develop, “while at the same time meeting the changing patterns in the health needs of patients, ensuring they receive high quality care.”

A key part of the new standards is a generic professional capabilities framework. The framework covers broad areas of professional practice, such as communication and team working. The GMC and the Academy of Medical Royal Colleges have jointly produced explanatory guidance to help royal colleges integrate generic professional capabilities into their updated curriculums.

Massey said, “Medical training in the UK is high quality, but as well as producing doctors who are technically proficient it is important they are equipped with the broader professional skills they need to become and stay good professionals.

“Developing and honing these skills is something that we believe should continue right the way through a doctor’s career, and something that we want to stimulate as much as possible as part of our ongoing work to champion and support professionalism in medicine.”

Commenting on the new standards, Jeeves Wijesuriya, chair of the BMA Junior Doctors Committee, said that the association welcomed the “move away from a granular competency heavy study programme to higher level capabilities.” However, he said it was important that trainees were still able to understand what they actually need to do to improve.

Wijesuriya added, “The measures to improve the transferability of skills within a study programme, for example when a trainee changes specialty or if a doctor returns to training in a new specialty, is to be supported.”

“Overall, the assessment standards are an improvement, and the BMA looks forward to working with the GMC and other stakeholders in the development of further detailed guidance on this topic,” Kate Lovett, dean of the Royal College of Psychiatrists, welcomed the inclusion of mental health in the new curriculum standards. “This is a much needed and long awaited addition to the training of all doctors in the UK and a further step along the way to acknowledging the importance of mental health in all patients,” she said.

Medical colleges and faculties will update all 103 existing postgraduate medical curriculums against the GMC’s new standards, with a target to complete the process by 2020. The GMC says that it expects a small number of medical colleges and faculties to seek approval for new curriculums during 2017.
A doctor who cares for 750,000 people, seven days a week, in Sudan’s war ravaged Nuba Mountains has scooped a $1m (£777,000) humanitarian prize that was set up to mark the Armenian genocide. The $1m will go to charities of the winner's choice.

Tom Catena, a Catholic missionary from the US, is the only medic in the remote, violence plagued region and can see as many as 400 patients a day. He regularly has to dive into makeshift, dug-out bomb shelters along with patients, for whom he provides everything from paediatrics and general surgery to psychiatric care.

Accepting the Aurora prize for awakening humanity in the Armenian capital, Yerevan, Catena said, “When the bombs are raining down, I think that any job must be better than this—even being an accountant. But, when one little kid unexpectedly pulls through, it’s all worth it.”

The health of Catena’s patients has been placed in a downward spiral by the ongoing civil war between Sudan’s government and the Sudan People’s Liberation Movement. Patients have been known to walk for seven days to receive treatment for injuries from bomb attacks and for ailments ranging from leprosy and tuberculosis to bone fractures, malnutrition, and malaria.

“The most difficult part of my job is having to watch my patients die,” Catena said. “Children hit by incendiary bombs with 60% burns; women with breast cancer who have no access to the right drugs; or women with pre-eclampsia. I’m currently dealing with a measles epidemic.”

He often has to use outdated, decades old treatments and contend with limited electricity and running water. He said, “My goal is to publicise the plight of the people in the Nuba Mountains who have suffered so much for so many years. My dream is to set up a teaching hospital in the bush, so that more people will be able to help treat those who need it.”

Three Armenian doctors volunteered to cover for Catena while he travelled to Armenia to accept the prize.

One of the judges, Vartan Gregorian, president of the Carnegie Corporation and a Nobel prize winner, said, “In a sometimes very dark and extremely violent world, these people are real heroes, who shine a light and offer hope.”

Catena will donate the award to the African Mission Healthcare Foundation, the Catholic Medical Mission Board in the US, and Aktion Canchanabury in Germany.

Michael Day, Yerevan, Armenia
Cite this as: BMJ 2017;357:j2626
Meet the doctors running for parliament

Over 30 constituencies have a candidate who is medically qualified. Eight of the doctors standing for parliament tell Abi Rimmer what they hope to achieve and why doctors make good politicians

**James Davies, former GP, standing for re-election as Conservative MP for Vale of Clwyd**

“Life as an MP is surprisingly similar to that of a GP—at least some of the time. Constituent casework often involves similar issues to those tackled by a GP, and surgeries can be remarkably similar too. During the last parliament there were several doctors serving as MPs. The experience I have had of my medical colleagues is that they are effective politicians, able to contribute valuable expertise to parliamentary processes and to empathise with their constituents. Parliament is increasingly composed of those who have worked in the ‘real world’ as opposed to career politicians, and this is good for democracy.”

**John Dean, consultant cardiologist, National Health Action Party candidate for Central Devon**

“When the NHS is on its knees someone needs to stand up—and that is what I am doing. I hope that I will attract enough support to demonstrate to the next government that people do not support the continued dismantling of the NHS. Doctors are in a unique position to represent their communities in parliament. Our daily work brings us into contact with people from all walks of life, from the High Court judge to the homeless drug addict. We frequently see people at the lowest points in their lives. No other group in parliament has this level of insight into human need and vulnerability.”

**Laura Davies, neurosurgery trainee, Labour candidate for Shrewsbury and Atcham**

“I think it’s important for politicians to come from a diverse range of backgrounds, as different people bring different skills and attributes to parliament, which can only enhance democracy. What motivated me to enter politics also motivated me to go into medicine: the desire to help people and improve people’s lives. I was once told that as a politician I could save more lives than I ever could as a doctor, and that has always stuck with me. It’s important to remember in the hustle and bustle of a busy campaign that people’s lives are changed by the decisions that politicians make.”

**Philippa Whitford, consultant breast cancer surgeon, Scottish National Party candidate for Central Ayrshire**

“As one of the most senior doctors in the House of Commons, I have tried to use my 33 years’ experience in my roles as the Scottish National Party’s Westminster health spokesperson, member of the health select committee, and in health related debates.

As an MP for the SNP I want to make sure that there is a clear voice in parliament for the people of Central Ayrshire, making sure that the government hears their concerns about how the decisions it has made are affecting real lives. Rational voices are needed to speak up against a damaging and extreme Brexit, which would aggravate NHS workforce issues, undermine academic research, and delay our access to new drugs.”

**Scott Mabbutt, second year trainee in obstetrics and gynaecology, Green candidate for Northampton South**

“I am at work on my full rota in my second year of obstetrics and gynaecology specialty training, and campaigning in the evening. Practically this is fine, as we would normally canvass in the evening and weekends anyway, but all of the other campaign work—emails, leafleting, media, hustings, social media—is happening outside working hours. My wife has been incredibly understanding. I hope to make politics more accessible. People feel distant from their politicians and feel that their interests don’t align. By standing in my home town and covering the hospital I’ve worked in for most of my career I would try to change that.”

**Chris Jones, retired consultant forensic psychiatrist and currently a guardian of safe working, Labour candidate for Norwich North**

“I think medical training and practice give doctors a unique insight into the lives of other people and the problems they face. The need to empathise and understand people from every part of our society at every stage of their lives and work with them as individuals gives doctors experience that translates directly to the work of an MP. My first priority would be to hold government to account for delivering a real change in attitude to mental health. I’ve become more involved in politics as I have realised that doing my best for patients means more than working within a flawed system—we have to change the system as well.”
1 Philippa Whitford, consultant breast cancer surgeon, Scottish National Party, Central Ayrshire
2 Daniel Goodare, emergency medicine doctor, Lab, Dumfries and Galloway
3 Anita Lower, oncologist, Lib Dem, Newcastle upon Tyne North
4 Alasdair McDonnell, GP, Social Democratic and Labour Party, South Belfast
5 Paul Williams, GP, Lab, Stockton South
6 Ann Myatt, dermatologist, Con, Batley and Spen
7 Adam Carter, junior doctor, Lib Dem, Rotherham
8 James Davies, GP, Con, Vale of Clwyd
9 Victor Babu, surgeon, Lib Dem, Aberconwy
10 Ben Loryman, emergency medicine consultant, Green, Lincoln
11 Caroline Johnson, consultant paediatrician, Con, Sleaford and North Hykeham
12 Laura Davies, neurosurgery trainee, Lab, Shrewsbury and Atcham
13 Andrew Hardie, GP, Con, West Bromwich West
14 Teck Khong, GP, UKIP, Harborough
15 Chris Jones, psychiatrist, Lab, Broadland
16 Nik Johnson, paediatrician, Lab, Huntingdon
17 Scott Mabbett, junior doctor, Green, Northampton South
18 Dan Poulter, hospital doctor, Con, Central Suffolk and North Ipswich
19 Diana Warner, GP, Green, Filton and Bradley Stoke
20 Liam Fox, GP, Con, North Somerset
21 John Dean, consultant cardiologist, National Health Action Party, Central Devon
22 Sarah Wollaston, GP, Con, Totnes
23 Andrew Murrison, Royal Navy medical officer, Con, South West Wiltshire
24 Jon Osell, GP, Green, South Dorset
25 Catherine Royce, surgeon, Lib Dem, Romsey and Southampton North
26 Louise Irvine, GP, National Health Action Party, South West Surrey
27 Rebecca Cooper, public health consultant, Lab, Worthing West
28 Phillip Lee, GP, Con, Bracknell
29 Tania Mathias, hospital doctor, Con, Twickenham
30 Neeraj Patil, consultant in emergency medicine, Lab, Putney
31 Rosena Alin-Khan, emergency medicine doctor, Lab, Faversham and Mid Kent
32 Alastair Gould, GP, Green, Faversham and Mid Kent

“Over 30 medically qualified doctors are standing in the 2017 general election.”

“‘The NHS is on its knees, someone needs to stand up’

Alasdair McDonnell, former GP, standing for re-election as Social Democratic and Labour Party MP for South Belfast

“As a doctor I didn’t care about a patient’s political beliefs, colour, or creed. All I saw was someone who needed my help. I take that same approach to being an MP: I am here to serve my constituents, regardless of their background or if they voted for me or not. I think it is vital to have politicians who have worked outside politics and who have real world experience. I have treated people at their most vulnerable and understand the importance of a modern and universal healthcare system that is free at the point of use. I will always passionately defend that principle.”

Diana Warner, GP, Green Party candidate for Filton and Bradley Stoke

“As an MP I hope to achieve widespread acknowledgment of the huge impacts of the wider determinants of health. As a Green Party and Medact member, to me these determinants relate to such things as healthy environments, reducing the gap between the rich and the poor, giving people access to good housing and food, and introducing policies that promote community and healthy lifestyles at work and at home. We also need to tackle global warming and increase security by the only ways shown to work—through peace building initiatives and meeting people’s basic human needs. War means we have already lost.”

Abi Rimmer, BMJ Careers

Cite this as: BMJ 2017;357:j2601
Cannabis as medicine

Evidence supports reform to allow prescription of therapeutic cannabinoids

From its first recorded uses in China through to the early 20th century, cannabis has had a place in the pharmacopoeia. Queen Victoria’s personal physician, Russel Reynolds, opined in the *Lancet* in 1890, “Indian hemp, when pure and administered carefully, is one of the most valuable medicines we possess.”1

In a similar vein, calls have been made to reconsider the role of cannabis in today’s society. Two well informed British politicians recently told The BMJ, “We have heard striking testimonies from patients... that cannabis has ‘given them their life back.’”2 Added to this, the international position on cannabis as a potential medication has changed, with international agencies and many governments relaxing a prohibitionist stance.

Dual use

Internationally, there has been an important shift away from prohibitionism, allowing cannabis to be used for both medical and recreational purposes. The conflation of these two uses, however, confuses therapeutic application. A multitude of legislative and policy positions is possible for cannabis, from complete prohibition through to regulated legal supply (as occurs with alcohol). For strictly pharmaceutical use, however, the choice is binary: either it is licensed like any other medicine or it is not.

Cannabis is now available for medical uses in 29 states in the US (although illegal at federal level), Canada, the Czech Republic, and Israel but decriminalised far more widely. Decriminalisation allows doctors to discuss the risks and benefits of use in much the same way they might for any medicine: within their area of expertise and the evidence available, according to GMC guidelines.3

Evidence supports the kind of reform already occurring in US states and internationally. The UK is lagging behind

Product diversity

The central importance of evidence in the practice of medicine is now well established. Doctors must discuss the benefits and risks of management options with patients so they can make an informed choice. This presupposes that the medication under consideration is a uniform substance with reproducible pharmacokinetic properties.

Cannabis, however, refers to a genus that includes a large number of flowering plants, of which *C sativa* is best known. This diversity of product is a major problem in the published literature on cannabis. Furthermore, the illegal nature of cannabis has made quantifying the use of the psychoactive compounds—predominantly Δ9-tetrahydrocannabinol and cannabidiol—nearly impossible. Medicinal cannabinoid is one suggested solution to help clarify discussions; the other is to use a company trade name to ensure specificity.

Within this limitation, substantial progress has been made in the evidence underpinning medicinal use of cannabinoids. Moderately strong evidence supports the use of medicinal cannabinoids by patients with chronic pain or spasticity.5 Evidence is weaker for other conditions, including epilepsy.

Cannabinoids have also been considered for the treatment of psychiatric conditions, although the potential for harm is greater in these patient groups. Epidemiological data identify statistically significant associations between psychosis, poor psychosocial outcomes, and cannabis use.6 The greatest potential for harm seems to be in early life,7 where use is associated with psychosocial decline. Both trials and cohort studies suggest cognitive impairments that may not resolve with abstinence.8

A recent report by the US National Academies of Sciences Engineering and Medicine sets out the social, legal, and potential medical benefits of cannabis and its derivatives and makes four main recommendations. For the purposes of using cannabis as a medication these can be distilled to: “improve the clinical science” and “change the regulatory landscape to allow this to happen.”9 Notably, the report identifies the need for “research grade cannabis products,” with sufficient diversity to examine the individual psychoactive components of interest and their effects.

The place of cannabis as a prohibited and purely harmful psychoactive substance should change. Evidence supports the kind of reform already occurring in US states and internationally. The UK is lagging behind. Doctors should be free to provide advice on the benefits and harms of medicinal cannabinoids. There is a standard regulatory route for compounds to be licensed as medication, and there is no reason medicinal cannabinoids should not follow this route.

Cite this as: *BMJ* 2017;357:j2130

Find the full version with references at http://dx.doi.org/10.1136/bmj.j2130
Occupational health should be part of the NHS

Integration would benefit people in and out of work, and the UK economy

Occupational health was not included in the NHS when it was formed in 1948, and this has not changed despite successive reports arguing that work is important for overall wellbeing.¹² The growing shortage of occupational health doctors adds urgency to calls for the specialty to be integrated fully within the NHS.

In 1948, funding for occupational health and the development of the specialty were driven principally by health and safety legislation. Workplaces were more physically hazardous than they are now. The duty to manage workplace hazards, including provision of health surveillance, rested then, as now, with the employer.

Fewer workplace hazards

In the past 70 years work has been made safer and the prevalence of occupational illnesses caused by exposure to specific workplace hazards has fallen. At the same time, emphasis has shifted from prevention of illness to overall wellbeing. There is stronger focus on disability and the adjustments required to enable work, coupled with a better understanding about the adverse health effects of prolonged absence from work.

This agenda was accelerated last year by publication of a government green paper on work health and disability.³ The consultation, which closed in February, asked for views on the current service, “Fit for Work.” This is telephone based but enables a few people to have a face-to-face meeting with an adviser, although not a specialist occupational health physician. The green paper recognises the importance of more comprehensive provision of occupational health to people of working age and proposes exploring service models that integrate occupational health into both primary and secondary care.

As far back as 2008 another government report had been prompted by a situation where markers of health such as longevity had consistently improved but many more people were claiming incapacity benefit because they were too sick to work.⁴⁵ A subsequent report in 2011, Health at Work, an independent review of sickness absence, emphasised the importance of early access to rehabilitation services to prevent long term incapacity and absence from work.⁶ Both reports raise concern about detachment of occupational health from mainstream healthcare.

The “fit note” soon followed,⁷ enabling general practitioners to tell employers what tasks people are fit to do, rather than simply signing them off sick. However, this may not be straightforward for people with complex needs or multimorbidity.

Specialist skills

Occupational health specialists have particular skills in evaluating physical and mental ill health together in the context of work. They have the ear of both employer and employee and the capability to empower both parties to find effective ways of achieving the mutually beneficial outcome of meaningful work.

Who should pay for occupational health services? Many large businesses, including the NHS, see a business benefit from providing occupational health for their staff, usually in the context of well developed health and safety protocols and policies to manage attendance. However, employees in small and medium sized enterprises have patchy access to occupational health, and unemployed people have no access.

Ill health among working people costs the UK economy £100bn a year, while economic inactivity costs the Treasury around £50bn a year, including £19bn in welfare benefit payments.¹ So the government also has a powerful economic incentive to pay for broader provision of occupational health services. The most obvious route would be to integrate occupational health into NHS care systems.

Full integration would require recruitment of many more occupational health doctors along with associated specialist nurses. But there is an ongoing crisis in both staffing and training.

A recent report from an all party parliamentary group highlights that 64% of occupational health specialists are now older than 50 and also notes a collapse in the number of trainees.⁴ In 2015, there were just 74 trainees across the whole of the UK.⁵ Only about 13 doctors achieve accreditation in occupational health each year, according to the Faculty of Occupational Medicine’s latest figures.

The 2016 green paper brings timely political attention to a problem that is important to individual health, public health, employers, and the UK economy. It makes proposals key to the future of occupational health. Integration of the clinical specialty of occupational health into the NHS is long overdue.

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Cite this as: BMJ 2017;357:j2334
Find the full version with references at http://dx.doi.org/10.1136/bmj.j2334

Modern work places are less hazardous than those in the past

Ill health among working people costs the UK economy £100bn a year
What happens when targets for waiting times change?

Targets can work but only in systems not stretched to the limit, finds John Appleby

In Soviet era Russia Pyotr Petrov, manager of the state run ball bearing factory on the outskirts of Magnitogorsk studied the new production target. The target came from the chief department for ball bearing production, part of the Ministry of Automobile and Tractor Industries. From now on the Magnitogorsk factory was to produce 200 tons of ball bearings a month. “200 tons! That’s a huge increase in the number of ball bearings,” Petrov thought, “...or is it?” At the end of the month the factory had managed to meet its target: one, 3.7 m diameter, 200 ton, ball bearing.

Poorly designed or badly policed targets can create perverse incentives (a giant ball bearing), but they can also provide the right motivation to improve performance. So what has been the real life experience of the NHS and its use of targets, particularly to improve waiting times?

Two targets become somewhat iconic: one arising from the Labour Party’s 2007 manifesto pledge that “by the end of 2008, no NHS patient will have to wait longer than a maximum of 18 weeks from the time they are referred for a hospital operation by their GP until the time they have that operation” and the other, a maximum wait in accident and emergency departments for patients of four hours (before being admitted, discharged, or treated).

The referral to treatment target covered two separate standards—that a minimum of 90% of patients admitted to hospital should wait less than 18 weeks from referral by their GP, and that 95% of those seen in outpatients (“non-admitted”) should have waited no longer than 18 weeks. In April 2012, a third overarching target was added covering patients still waiting for treatment—that 92% of what were called “incomplete pathway” patients should not wait longer than 18 weeks.

But in October 2015 a review of what had now become quite a complicated set of targets recommended dropping the two earlier standards as the new target essentially did the job—covering patients’ total waiting experience from referral to treatment and included all patients waiting, not just...
those seen in outpatients or admitted as inpatients. It also avoided the perverse incentive that once a patient still waiting had tripped over the 18 week limit, as soon as they were seen in outpatients or admitted into hospital, a trust would then automatically fail on the old targets as well.

**A relaxed approach**

As figures 1 and 2 show, by the time these targets were dropped, the percentage of patients who waited more than 18 weeks before being admitted or seen in outpatients had been on a rising trend since 2012, leading to breaches of the targets in 2014 and 2015. Since then, perhaps unsurprisingly as the targets have been dropped, the percentages of patients who waited more than 18 weeks for admission or being seen in outpatients have continued to rise—and now stand at 22.6% and 9.7% and respectively.

Meanwhile, the one remaining target—that at least 92% of patients still on waiting lists should not be waiting more than 18 weeks—has also been rising, to the point where at a national level the target has not been met for the past 12 months (fig 3). This fact is probably not unconnected to recent suggestions that this target will be “relaxed” in recognition of continued funding constraints. The story is similar for the four hour waiting time target for emergency departments (fig 4). Although generally met across the country, in 2011 the then target that 98% should be treated, discharged, or admitted within four hours of arrival was changed to 95% because the NHS complained that there was not enough leeway to deal with patients who, for clinical reasons, may need to wait longer than four hours.

Within four years, the proportion waiting over four hours had risen to meet the new target, and from December 2014 it has consistently been breached nationally. As with the referral to treatment target, it seems that the widespread inability of the NHS to meet the four hour target is likely to lead to its “relaxation.” Already the government has dropped the fining system for around 40% of hospitals with particular difficulties and suggested restricting the target to the most urgent cases.

Is there a lesson in all this? Perhaps it’s that targets can work but there are likely to be unintended consequences and, for systems already operating at their productive limits, universal failure.

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Cite this as: BMJ 2017;357:j2584

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The widespread inability of the NHS to meet the four hour target is likely to lead to its “relaxation”
The making of a WHO director general

Jacqui Wise looks at the difficulties of the World Health Organization’s first open election for director general and the background of its new leader, Tedros Adhanom Ghebreyesus

There are encouraging signs that WHO has learnt valuable lessons. For example, last year it set up a research and development blueprint to speed up the time needed to develop new vaccines and drugs in response to epidemics. Tedros says he will build on this work to ensure the organisation responds rapidly and effectively to emergencies and to make the agency transparent and accountable.

Chronic underfunding

Another huge challenge that Tedros faces is WHO’s chronic underfunding, with much of its income tied to specific projects. The situation is likely to get much worse as Donald Trump, president of its biggest donor is proposing deep cuts in US spending on all forms of foreign assistance. Tedros has said it was important not to rely solely on the traditional donors: “We need to expand the donor base. There are countries willing to contribute.”

Tedros, who at 52 is young for a director general, will have to work hard to improve the image of WHO. Last week an investigation by the Associated Press published in the New York Times reported that WHO spent $200m (£160m) a year on travel compared with $71m spent on AIDs and hepatitis and $61m on malaria. WHO responded by saying travel is essential for its global health work and that first class travel was now banned.

Katja Iversen, president of the group Women Deliver, was positive about the appointment. “It comes at a time when the world needs a fierce proactive leader and advocate for the health and rights of girls and women, including their sexual and reproductive health and rights. Tedros has a good track record on these issues.”

Tedros said the scale of his victory gives legitimacy to his tenure. “It will be tough. But when we work together we can achieve great things.”

Cite this as: BMJ 2017;357:j2605