“Avoid ibuprofen in covid-19 care”

Scientists and senior doctors have backed claims by France’s health minister that people showing symptoms of covid-19 should use paracetamol rather than ibuprofen, which they said might exacerbate the condition.

The minister, Oliver Veran, tweeted on 14 March that people with suspected covid-19 should avoid anti-inflammatory drugs. “Taking anti-inflammatory drugs (ibuprofen, cortisone . . .) could be an aggravating factor for the infection. If you have a fever, take paracetamol,” he said.

His comments seem to have stemmed in part from remarks attributed to an infectious diseases doctor in southwest France. She was reported to have cited four cases of young patients with covid-19 and no underlying health problems who went on to develop serious symptoms after using NSAIDs in the early stage of their symptoms.

Jean-Louis Montastruc, a professor of medical and clinical pharmacology at the Central University Hospital in Toulouse, said that such deleterious effects would not be a surprise given that since 2019, on the advice of the National Agency for the Safety of Medicines and Health Products, French health workers have been told not to treat fever or infections with ibuprofen.

Experts in the UK concurred. Paul Little, professor of primary care research at the University of Southampton, said there was good evidence “that prolonged illness or the complications of respiratory infections may be more common when NSAIDs are used—both respiratory or septic complications and cardiovascular complications.”

Ian Jones, professor of virology at the University of Reading, said ibuprofen’s anti-inflammatory properties could “dampen down” the immune system, slowing the recovery process. He added it was likely, based on similarities between SARS-CoV-2 and SARS I, that covid-19 reduces a key enzyme and could contribute to the pneumonia seen in extreme cases. “Ibuprofen aggravates this, while paracetamol does not,” he said.

Drug company Roche has won approval from China for its anti-inflammation drug Actemra (tocilizumab) to treat patients with severe complications. Some doctors in Italy claim to have successfully used the drug, which blocks the inflammatory molecule interleukin-6. There is speculation it might prevent fatal “cytokine storms,” in seriously ill patients that can cause organ failure.

Ibuprofen may “dampen down” the immune system, slowing the recovery process in patients with covid-19, virology experts warn

Michael Day, London
Cite this as: BMJ 2020;368:m1086

- Primary care networks: LMC leaders vote to reject revised agreement on directed enhanced services
- TB expert is suspended for 12 months for possessing extreme pornography
- Covid-19: junior doctor calls on colleagues to gather supplies for staff working long hours
**SEVEN DAYS IN**

**GPs call for same covid-19 personal protective equipment as hospital doctors**

GPs have called for practices to be given the appropriate personal protective equipment (PPE) for treating patients with suspected or confirmed covid-19.

Fay Wilson, medical director of the Badger out-of-hours cooperative, which covers Birmingham and Solihull, told The BMJ that practices had received PPE but it was not adequate. “We’ve been given what I call ‘cosmetic PPE,’ which is the pinny, the gloves, and the little surgical mask—like you get in a doctor’s kit for the under 5s. Whereas the hospitals have got the proper thing. If we want there to be healthcare workers next week, and next month, we need to protect them now,” said Wilson. She added that GPs should have the same FFP3 respirator masks as hospital staff.

But Martin Marshall, chair of the Royal College of General Practitioners, said, “There are concerns about whether [GPs PPE] will be adequate as the guidance changes.” He added that the college is in close contact with the NHS and UK’s public health authorities to “ensure they factor this into their preparedness plans.”

A Department of Health spokesperson said, “We maintain large stockpiles of personal protective equipment. These are being released in a controlled manner.”

---

**Covid-19**

**CQC agrees to suspend routine inspections**

The Royal College of General Practitioners welcomed a decision by the Care Quality Commission to immediately suspend all routine inspections to allow healthcare providers to focus on the covid-19 crisis.

The decision came after the college’s chair, Martin Marshall, wrote to Ian Trenholm, CQC chief executive, urging the regulator to give practices “temporary respite” from the regulatory process. The college said that the CQC’s decision would enable teams to dedicate their time to providing frontline care.

**GPs ask for no sanctions if they stop normal practice**

GP leaders called for assurances that they would not face contractual sanctions if a pandemic forced them to suspend normal practice. Delegates attending a special conference of local medical committees on 11 March, unanimously voted in favour of a motion that called on the BMA’s General Practitioners Committee in England to negotiate changes to protect practices. The motion said that practices should be able to “prioritise frontline work” and suspend other requirements.

**Government to pay vlogs to combat misinformation**

The UK’s Department for International Development committed £500 000 towards a fund to pay influential “vloggers” on YouTube and Facebook to fight the spread of misinformation about covid-19. The money will be paid to the H2H (Humanitarian to Humanitarian) Network and will focus on providing accurate information to younger audiences in Asia and Africa. It will seek to drown out false claims and conspiracy theories on social media, touting “cures” such as drinking bleach or rubbing mustard and garlic into the skin, which pose a serious risk to health.

**Global conferences cancelled after US case**

Medical conferences around the world were cancelled after a meeting in Massachusetts was linked to 70 suspected cases of covid-19. The Massachusetts Department of Public Health announced earlier this month that 15 suspected cases in the state had a direct connection to a meeting of staff from the biotech company Biogen, held in Boston in late February. Two days later the state governor, Charlie Baker (below), declared a state of emergency. At the time of writing the state has six confirmed and 89 suspected cases of covid-19.

**All medical schools are closed in Portugal**

Portugal closed all of its medical schools to help slow the transmission of covid-19. The decision was aimed at reducing contact between students and teachers who treat patients. Around 12 500 students are affected. Around 12 500 students are affected. Around 12 500 students are affected.

**Clinical leadership**

**New postgraduate programme is launched**

Trainee doctors in northwest England will be able to access formal clinical leadership and management training through a £1.8m contract awarded to Edge Hill University Medical School (above) and the Royal College of Physicians. The new Postgraduate Medical Education and Leadership Development Programme, funded by Health Education England North West, will allow up to 600 higher specialty trainees each year to undertake a module to equip them with clinical supervision and leadership skills in the NHS.

---

Abi Rimmer, The BMJ Cite this as: BMJ 2020;368:m1055
MEDICINE

New treatments
NICE approves migraine drug for 10000 in England
A drug to prevent chronic migraine could soon become available on the NHS for around 10000 people in England. In draft guidance NICE recommended fremanezumab (Ajovy, Teva Pharmaceuticals), citing evidence presented by the manufacturer, which found that the drug reduced the number of monthly migraine days more than placebo for episodic and chronic migraine. The drug is priced at around £5000 a year, although a confidential commercial arrangement has been agreed with the company to make it available to the NHS at a discounted price.

Sexual health
HIV drug PrEP will be available around England
The Department of Health and Social Care will fully fund delivery of the preventive HIV treatment pre-exposure prophylaxis (PrEP) throughout the whole of England, it announced. Local authorities will receive £16m in 2020-21 to deliver the treatment. All people at a high risk of contracting HIV will be able to receive PrEP from their local sexual health clinic to reduce their risk of getting the virus. The full roll-out follows the three year PrEP impact trial, which has recruited over 20000 participants.

NHS hospitals
Improved performance welcomed as pressure rises
Monthly NHS performance figures from February showed that 21932 fewer people waited for over four hours on a trolley, as well as improved attainment against the four hour target and 255 fewer emergency hospital admissions through A&E each day. They also showed a drop in daily A&E attendances. John Appleby, director of research at the Nuffield Trust, said that this was welcome and bucked the usual trend for this time of year. But he warned that the NHS “remains under significant pressure,” especially as the covid-19 outbreak intensifies.

Clinical trials
Danes to sanction non-reporting trials
Sponsors that fail to report clinical trial results in Denmark could be fined or even face prison sentences as part of a crackdown on non-publication of results, said the Danish Medicines Agency. The move follows a statement published by the agency in November 2019 highlighting that non-commercial sponsors in Denmark such as universities had published the results of only 23.6% of their clinical trials of medicinal products on the European database. The statement reminded sponsors to “publish all relevant protocols and results of clinical trials.”

Cite this as: BMJ 2020;368:m1073

COVID-19

There are currently 8175 mechanical ventilators operational in the NHS in England with plans to increase this to just under 12 000 over the next few weeks with more being sought.

[Simon Stevens, NHS England chief executive]

THE AUTOMOBILE ASSOCIATION?

No, wrong one. This is Alcoholics Anonymous, the support programme run by and for people with alcohol use disorder. Launched in the US 85 years ago, it’s based around attending group meetings with peers and following a 12 step programme to recovery.

DOES IT WORK?

This has been notoriously difficult to prove. A 2006 Cochrane Collaboration review of eight studies concluded that there wasn’t enough evidence to judge whether AA worked better than other interventions. But this week, Cochrane published an updated systematic review, which has made things clearer.

TELL US, STEP BY STEP . . .

The review analysed 27 studies (21 of which were randomised) including more than 10000 participants—a wider and more robust evidence base than before. It concluded that attending AA meetings leads to increased rates and lengths of abstinence from alcohol compared with other treatments. The 12 step plan improved rates of continuous abstinence at 12 months compared with other interventions, and this effect remained consistent at 24 and 36 months.

DID IT DO AS WELL ELSEWHERE?

On metrics such as drinking consequences, drinking intensity, and addiction severity, AA was “at least as effective” as other interventions such as treatment plans from therapists or doctors. It is also much cheaper than other approaches, given that meetings are free to attend.

DOES THE RESEARCH COME WITH HEALTH WARNINGS?

The researchers acknowledged that, although AA can be effective, it won’t work for everyone. And because attenders self-select this might mean they are more motivated than people who don’t.

SHOULD UK MINISTERS TAKE NOTE?

Alistair Campbell, former aide to Tony Blair and a recovered alcoholic who has attended AA meetings, told a Commission on Alcohol Harm hearing that alcohol has “a cultural hold” on the UK and urged the government to make tackling it a priority. But with the Treasury under fire for freezing alcohol duty in the budget, perhaps a 12 step approach to coherent public health policy might help.

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2020;368:m1056

SIXTY SECONDS ON . . . AA

Cite this as: BMJ 2020;368:m1056
Outbreak could last a year and put 7.9 million in UK hospitals

The covid-19 outbreak is expected to last until spring 2021, with around 80% of the population infected and up to 15% (7.9 million people) requiring admission to hospital in the UK, Public Health England has said in a briefing document for the government.

The document—based on reasonable worst case scenarios and seen by the Guardian—said that of the five million people who work “in essential services and critical infrastructure”—including one million NHS staff and 1.5 million social care staff—500 000 could be off sick at any one time.

PHE said the 15% hospital admission figure was determined using data from other countries. The agency also warned that laboratories were “under significant demand pressures,” so were unable to test all those with symptoms.

- The government is reportedly in talks to use private hospital beds. Trade unions and the Labour party have called for the unused beds—estimated at around 8000 from 570 hospitals—to be requisitioned.
- A US clinical trial is testing for side effects of a virus-free vaccine on 45 young and healthy volunteers. The participants will receive various doses of the vaccine, which was developed by the National Institutes of Health and biotechnology company Moderna. It is estimated that the potential vaccine will take a year to 18 months to assess.

Boris Johnson said that he would not ban mass gatherings, but he advised people against them and said public services such as police and ambulances would not be available for large events.

Change in approach

These measures represent a major change in approach by the government, which had previously only told people with symptoms to isolate at home for seven days and suggested that people over 70 may have to self-isolate.

This change comes after a modelling study, carried out by the MRC Centre for Global Infectious Disease Analysis at Imperial College London, assessed the previous plan in light of two new pieces of information: a refined assessment of what the NHS could cope with; and updates from clinicians in the UK and Italy, showing that ICU requirements were nearly twice what was anticipated.

Neil Ferguson, the study lead, said, “The combination of those things means we can conclude that, even with the interventions announced last week, there would be a risk of ICUs being overwhelmed. And that is why we need to act now

Social distancing begins as model points to 260000 potential deaths

The government has been forced to change its plan of attack for covid-19 after modelling showed that, although the plan might reduce peak healthcare demand by two thirds and cut deaths by half, it would still result in 260000 deaths and overwhelm the health system—most notably in intensive care units.

The government has announced that everyone should now begin social distancing, meaning avoiding physical contact as much as possible. Households should also quarantine themselves for 14 days if anyone has a symptom, while those at high risk for severe disease—including pregnant women, people over 70, and those with certain health conditions—should isolate themselves for 12 weeks.

The prime minister, Boris Johnson, said, “Now is the time for everyone to stop non-essential contact with others and all unnecessary travel. We need everyone to start working from home where they can. You should avoid pubs and restaurants.” He said he would not ban mass gatherings, but he advised against them and said public services such as police and ambulances would not be available for large events.

Trainees will not move jobs in April

Postgraduate trainees will not rotate to new roles on 1 April as planned because of the covid-19 pandemic, training organisations have announced.

A joint letter to trainees from the four UK training bodies and the GMC said that postgraduate medical trainees would make a major contribution to the NHS during the pandemic. It said the planned rotation would involve more than 20000 doctors across the UK at a time when the NHS would be facing an increasing burden.

“It has therefore been decided that all planned rotations due to take place during the ‘delay phase’ of covid-19 will cease, with trainees being asked to stay in their present working environment, unless local arrangements allow otherwise or wider clinical circumstances require it,” the letter said. “Rotations may only occur where departmental inductions, appropriate
with more intensive interventions to prevent that from happening.”

The researchers compared what would happen if the government followed its plan, slowing but not stopping transmission, with a second scenario where it would implement intensive interventions. They found the first plan—combining home isolation of people with symptoms and social distancing of people over 70—would lead to a three to four month peak during the spring and summer and would reduce healthcare demand and deaths, but also to 260 000 deaths and a health system unable to cope.

The second plan, which the government announced on Monday, involved a mix of social distancing of the entire population, home isolation of people with symptoms and their family, and possible school closures. Ferguson said this plan allowed people to “reverse transmission” but this would “only last for a few months in the first instance, at which point we might be able to take a breather if we have driven down cases.”

“Not out of the woods”

He added, “We are not out of the woods, and the likelihood is that, if we go back to normal and don’t have other interventions, then we will have to repeat the same cycle. The only exit strategy for this is really vaccination or other forms of innovative technology that allows us to control transmission.”

England’s chief medical officer, Chris Whitty, said his announcement last week that only people admitted to hospital would be tested had upset healthcare staff. In the latest update he said, “The thing which would be transformational would be a test to see if you have had the disease. This is being developed by Public Health England.” He added that healthcare workers will be tested in the next stage of increasing test capacity.

**FIVE MINUTES WITH . . .**

**Kai Zacharowski**

Advice for doctors from the European Society of Anaesthesiology’s president on getting through the pandemic

“Don’t panic. That’s the most important thing. “The second is hygiene. Keep a distance from people of at least a metre and avoid handshaking. Of course, doctors have to look after patients, but if a patient has symptoms it makes sense not to be very close to them. And obviously wash your hands and do not touch your face.

“Eventually, probably 60% or 70% of the UK will be infected—including doctors—but the question is how fast will they be? We have learnt quite a large number of people won’t have any symptoms. So if you start testing everyone, you could induce a panic. We also have a shortage of tests, so they should only be used under certain criteria, such as if the patient has had direct contact with someone who is proved to be infected and if they have symptoms.

“If you have an infected doctor who has no symptoms, and patients who are in need of help, then I’m not sure it’s the right decision to tell that doctor not to come to the hospital. That doctor could work as long as they protect their patients which is possible if you have certain measures in place like nose and mouth protection and good hand hygiene.

“There is always going to be a percentage of people who will need treatment in an intensive care unit. Probably every 10th patient will have respiratory failure and need treatment in intensive care. Therefore, the most important thing is to have a controlled infection rate. If you can flatten the curve of infection that will help the NHS. If the infection rate is high, the intensive care beds in the NHS won’t be sufficient. That’s what we saw in Italy—having so many patients who need treatment in intensive care but being unable to provide it. You have to suddenly triage and say, ‘I will treat this patient, but I can’t treat the other one.’ It’s awful for doctors.

“There are probably not enough intensive care beds in the UK. This pandemic might be a signal to reconsider whether this is appropriate for 2020.”

Abi Rimmer, The BMJ Cite this as: BMJ 2020;368:m1092

supervision, and support can be guaranteed.”

There are two potential exceptions. First, trainees could be deployed to areas of major clinical need, the letter said. Second, in any areas and specialties where rotation is possible without creating issues, it will be discussed.

To minimise the effect this decision will have on trainees’ ability to attain the capabilities they need to progress, the training bodies said they would ensure the circumstances were taken into consideration in the annual reviews of competency progression and in recruitment and selection processes.

“Difficult period”

The letter said, “We will work with NHS service providers to ensure education and training requirements are delivered after this difficult period.”

Sheona MacLeod, deputy medical director for education reform at Health Education England said, “HEE is working with partners to ensure we are doing everything we safely can to maximise the contribution current students and trainees can and will make to frontline services and dealing with the coronavirus outbreak.”

Abi Rimmer, The BMJ Cite this as: BMJ 2020;368:m1088

**ONE OF THE WORST THINGS WE SAW IN ITALY IS HAVING TO PRIORITIZE PATIENTS WHO NEEDED INTENSIVE CARE**

**FRANK AUGSTEIN/PA**

Intensive care units are having to triage patients who needed intensive care. In the UK, it might be a signal to reconsider whether this is appropriate for 2020.
Trainee doctors and covid-19: your questions answered

We are determined to ensure the longer term needs of doctors in training are not compromised

Will my training be disrupted? In a joint statement, UK training bodies and the GMC have said there will be increased requirements for trainees and trainers to support the management of acutely unwell patients. “This might result in disruption or cancellation of training activities and trainees being directed to alternative tasks and/or locations to support the covid-19 response,” it said. “This could mean trainees in non-acute areas being asked to support urgent and unplanned care, such as medical admissions and the subsequent management of those patients, but may also in exceptional circumstances include providing support to clinical teams in other disciplines.”

Will my exams be cancelled? Some royal colleges have taken the decision to cancel their exams. The Royal College of Physicians (RCP) announced on 12 March that six MRCP (UK) PACES exams had been cancelled owing to growing concerns about the continuing outbreak of covid-19. These exams were due to take place in Dudley, UK, as well as overseas. The RCP said, “We would like to apologise for any inconvenience this might cause, but the safety and security of our candidates, patients, hosts, and examiners are of paramount importance when reaching important decisions such as this.”

The Royal College of Radiologists has cancelled some exams that were scheduled to take place in Singapore and Hong Kong. The college said that it hoped to continue with all exams in the UK, but this decision will be under constant review.

On 11 March, the Royal College of Psychiatrists confirmed that it still intended to run the Paper B written exam in the UK, Ireland, and Chennai. It said that the situation was being monitored regularly and that candidates would be notified by email if anything changed. The college has cancelled exams in Hong Kong, Singapore, Oman, and Malta. In a joint policy statement published on 13 March the royal surgical

Anaesthetist is second doctor this year to be re-registered

An anaesthetist who was struck off for dishonesty in 2012 has been restored to the register after convincing a tribunal that she is now fit to practise without restrictions.

Mona Hosny is the second doctor who had been struck off for misconduct to be allowed back on the register in 2020. Reinstatement is fairly rare, and in 2019 only two doctors who had been erased for misconduct succeeded in applications for restoration.

Hosny, who qualified in Egypt in 1991 and obtained full UK registration in 2006, was suspended in 2011 for creating a fake reference purporting to be from “Dr A,” the clinical lead for anaesthetics at a UK hospital, and sending it to five recruitment agencies.

Hosny has shown full insight into her foolish behaviour Tim Bradbury, tribunal chair panel suspended her for 12 months.

At a review hearing a year later she faced a new allegation. She admitted she had submitted job applications that failed to disclose she was subject to a suspension that was not yet in force, pending an appeal. The appeal was later unsuccessful. The 2012 panel struck her off, concluding that “her repeated dishonest conduct, her lack of insight and her propensity to act recklessly might amount to an attitudinal problem.”

After her erasure she returned to practise in Cairo, becoming a consultant anaesthetist. She also worked as a locum in Kuwait and the UAE and at a charity hospital in Egypt.

She had also applied for employment without disclosing that she was the subject of GMC proceedings and had interim conditions on her registration. The 2011 fitness to practise

The BMJ

21 March 2020 | the bmj

Cite this as: BMJ 2020;368:m1039

Cite this as: BMJ 2020;368:m1039
Pension changes protect doctors from extra work penalties

Most doctors will no longer be out of pocket for doing extra work, after the government pledged to increase the threshold income at which clinicians’ tax-free pension allowance is tapered.

The threshold is being raised from £110 000 to £200 000—a move announced on 11 March by the chancellor, Rishi Sunak, in his budget.

Sunak said, “To support the delivery of public services, particularly in the NHS, the two tapered annual allowance thresholds will each be raised by £90 000. This means that from 2020-21 the ‘threshold income’ will be £200 000, so individuals with income below this level will not be affected by the tapered annual allowance, and the annual allowance will only begin to taper down for individuals who also have an ‘adjusted income’ above £240 000.”

Strengthening the NHS
In his first budget speech Sunak said that, in addition to the already announced NHS settlement of an additional £34bn a year going to the NHS by 2023-24, the government would add a further £6bn to “strengthen the NHS” in England.

That money, also announced previously, had been intended to go towards creating 50 million more GP surgery appointments a year, 50 000 more nurses, and wider commitments on hospital car parking.

Doctors’ representatives welcomed the pensions news but said it did not solve all of the problems. Vishal Sharma, chair of the BMA’s pensions committee, said, “An increase in the threshold income of all workers to £200 000 demonstrates that the government has heeded the warnings from the BMA. The vast majority of doctors are now removed from the effect of the taper and will no longer be ‘paying to go to work.’”

But he added, “Many doctors with incomes far below the new threshold income will face tax bills as a result of exceeding the standard annual allowance, which remains at £40 000.”

Adrian O’Dowd, London
Cite this as: BMJ 2020;368:m1042

GOVERNMENT would add a further £6bn to ‘strengthen the NHS’ in England
As the coronavirus outbreak continues to spread, doctors and healthcare systems are facing a multitude of challenges at all stages of the pandemic. Longer versions of these updates can be found on bmj.com.

Janice Hopkins Tanne; Erika Hayasaki; Mark Zastrow; Piyanka Pulla; Paul Smith; Acer Garcia Rada

**USA**
- The United States has declared a national emergency as covid-19 spreads to 49 states. The White House told citizens to avoid gatherings of more than 10 people over the next 15 days.
- President Donald Trump announced $50 billion to help combat the virus, and powers to waive laws and restrictions to make care more available—for example, through telehealth and allowing doctors to practise in a state they are not licensed in.
- Vice president Mike Pence said the focus was on the partnership between the government, private companies, and commercial and public laboratories to make widespread testing available. About 2000 laboratories would soon be able to process the tests.
- Trump said that the Food and Drug Administration had approved a new test from manufacturer Roche and that half a million of the kits would be available by 22 March, and five million within a month. Deborah Birx, the White House response coordinator for covid-19, said the tests would provide answers within 24 to 36 hours.

**SPAIN**
- The national government has declared a state of emergency, assuming sole command throughout Spain’s state territories under the leadership of the Ministry of Health and taking control of all private medical facilities in the country. All public and private spaces can also be enlisted to help provide new temporary locations to care for the sick.
- In the wider Madrid region—home to half of the 9000+ cases recorded—large hospitals are already facing severe patient overloads. Dozens of health workers have been affected by contagion or quarantine, further exacerbating the situation.
- Scheduled surgeries and medical appointments that may be delayed have been cancelled. Primary care doctors are attempting to provide consultations by telephone, giving preference to the elderly and people with multiple pre-existing conditions.

**INDIA**
- The world's second most populous country has avoided the worst of the pandemic so far. Those confirmed as infected were either travellers from covid-19 affected countries, or close contacts, the Indian health ministry has said.
- Public health experts have questioned the government’s claim. They say that because only 52 laboratories across the country are testing for SARS-CoV-2, and that this testing is restricted to travel-related cases and their contacts, the country could be missing more widespread transmission.
- If wider “community” transmission occurs, the worry is that India doesn’t have the healthcare infrastructure to handle even the bare minimum scenario of 1% of the population being affected. The country has only 1.3 hospital beds for every 1000 people, against a WHO recommendation of 3.5 ICU beds. Mechanical ventilators are also in short supply.
JAPAN

• Cases in Japan have slowed since the Diamond Princess cruise ship—responsible for nearly 700 cases—was cleared, and the government shut all schools. But doctors worry that the true number of infections is unknown.
• Japan currently has capacity to conduct about 6000 coronavirus tests a day, and its health officials hope that number will rise to 7000 a day by the end of March, said Sahara Yasuyuki, the country’s senior assistant minister for global health, in a 10 March news conference.
• Yet the number of actual tests being administered is currently more than half of that daily capacity. Masahiro Kami, executive director of Japan’s Medical Governance Research Institute, a non-profit group, is concerned that only people showing the most severe symptoms are being tested.
• Japan has the largest number of elderly citizens in the world. “Isolating them in a hospital can be a great stress, and some people die,” said Kami. The only way to deal with these problems is to keep them from getting infected and increasing testing. “The government takes this lightly,” he told The BMJ.

SOUTH KOREA

• The pace of new cases has slowed dramatically, however, clusters continue to break out.
• The peak in February saw several hundreds of cases per day in Daegu city and its surrounding province, with most cases linked to a religious sect. The surge stretched hospitals, with 2,300 people left waiting for admittance at one point in early March, and at least two cases of people dying while waiting for a hospital room.
• Sixteen out of 100 nurses at Pohang Medical Center resigned between 29 Feb-1 Mar “due to various personal reasons compounded by overwork”, reported the Yonhap national wire agency. Daegu Medical Centre put out a plea for doctor and nurse reinforcements, with 250 physicians responding.
• However, regions were never put into lockdown. Authorities called for voluntary social distancing and isolation, which was largely heeded by the public. Korea also enacted aggressive testing—up to 18,000 conducted per day—contact tracing using CCTV and credit card transactions, and making public the movements of infected patients via text alerts.

AUSTRALIA

• Case numbers remain relatively low: but there is worry that a country currently in summer will be harder hit as winter sets in.
• GPs report fearful patients turning up without warning, ignoring official advice to call first and a lack of PPE for GPs to safely swab patients who meet the current criteria for testing.
• On 13 March, Australia’s chief medical officer Professor Brendan Murphy wrote to doctors stressing that the supply of test kits, reagents, and swabs “was deteriorating rapidly” with kits no longer being available in some regions under the current demand.
• For the next six months, there will be funding for GPs to provide telehealth consultations and triage to vulnerable groups such as the elderly, those with chronic conditions, pregnant women, and those who are immunocompromised, following a vocal campaign by doctor groups. This temporary relaxation of the Medicare rules should mean that far more care will be provided remotely in the coming weeks.
• The government has also pledged to roll out 100 dedicated “fever” clinics led by nurses and doctors. A number of GP practices have also set up “drive thru” clinics, with patients swabbed through the window of their cars.
Video consultations for covid-19
An opportunity for change in a crisis?

The rapid spread of covid-19, and the fact that healthcare facilities could be sources of contagion, has focused attention on models of care that avoid face-to-face contact between clinician and patient. There has been particular interest in video consultations, which are being rolled out in many countries as part of digital health strategies. How appropriate are video consultations for dealing with the coronavirus crisis—and what are the challenges of scaling up this model at speed?

Randomised trials (most of which were underpowered) have shown that consultations conducted through a video link tend to be associated with high satisfaction among patients and staff; no difference in disease progression; no substantial difference in service use; and lower transaction costs compared with traditional clinic based care. However, almost all this evidence pertains to highly selected samples of outpatients with chronic, stable conditions and is largely irrelevant to the current situation.

Organisational studies have shown that introducing video consultations is complex and disrupts long established processes and routines. Some clinicians are concerned about technical and clinical quality, privacy, safety, and accountability. Justified or not, these reservations can be a major barrier to expanded use.

Appropriate video consultations
Not all situations are appropriate for video consultations. For self isolating clinicians, video is certainly appropriate. For patients consulting about covid-19, video could be useful for people with heightened anxiety (as it may be more reassuring than a phone call), those with mild symptoms suggestive of coronavirus (for which visual cues may be useful), and those with more severe symptoms (when it may reduce the need to visit a potentially contagious patient). There may be a trade-off between staying at home and coming to clinic—for example, in frail older patients or immunosuppressed patients.

Other appropriate types of consultations include chronic disease reviews, counselling or other talking therapy, administrative appointments, some medication reviews, and triage when telephone is insufficient. Video consulting to patients’ homes is unlikely to be appropriate for severely ill patients, when a full physical examination or procedure cannot be deferred, or when comorbidities affect the patient’s ability to use technology (unless relatives are on hand to help).

Video should supplement, not replace, the telephone, for which there is a considerable evidence base, and some guidance. It may form part of a wider strategy of remote care for covid-19 that includes automated triage, isolation of potentially contagious patients, and electronic monitoring in intensive care units.

Improved dependability, lower cost, better audio and video quality, and products that mirror clinic workflows rather than imposing a “conference call” ethos, have helped to make video consultations an easier and more scalable option. However, they are often attempted on platforms designed for video conferencing. As well as being poorly aligned with clinic routines, there may be a need for downloads that breach information governance policies. Some bodies may not have the bandwidth to scale across all services.

Important lessons
The general literature on spread and scale-up of innovations has some important lessons for those seeking to mainstream video consultations quickly. We must be clear that the change is not merely using new technology but introducing and sustaining major changes to a complex system. The implementation process is likely to be difficult and resource intensive. It will need both national and local strategic leads. It should be championed by respected opinion leaders, with attention paid to the overall narrative or “organising vision” within which the change is framed.

Professional bodies and defence societies have an important role in establishing more contemporary definitions of good clinical practice. If the required pace of change were slower, a quality improvement collaborative might be an excellent catalyst for spreading video consultations within primary care, but time is not a luxury we have. Experience in the Scottish video consultation programme suggests in-person support may be needed to tackle technical and operational issues in the early stages of implementation. Training of all staff, and guidance for clinicians and patients on how to make the most of a video consultation, is likely to help adoption. Resources should be made available for staff to be released from other duties to deliver and monitor the change.

Finally, given the clinical, technical, organisational, and policy questions raised by this service model and the natural experiment we are probably about to witness, we recommend a research call to ensure we maximise the lessons learnt.

Cite this as: BMJ 2020;368:m998

Find the full version with references at http://dx.doi.org/10.1136/bmj.m998
# Post-SSRI sexual dysfunction

An important iatrogenic condition, recognised by regulators

Sexual difficulties after treatment with selective serotonin reuptake inhibitors (SSRIs) were first reported to regulators in 1991, but it was only in 2006 that these symptoms were formally characterised as a syndrome, now known as post-SSRI sexual dysfunction.¹ ²

In May 2019, the pharmacovigilance risk assessment committee of the European Medicines Agency concluded that post-SSRI sexual dysfunction is a medical condition that can persist after discontinuation of SSRIs and serotonin-norepinephrine reuptake inhibitors (SNRIs). A month later, EMA recommended that product information on all relevant antidepressants should be updated to reflect reports of long term sexual dysfunction after treatment.³

**Debilitating symptoms**

Post-SSRI sexual dysfunction is under-recognised and can be debilitating both psychologically and physically. Symptoms include genital numbness, decreased sex drive (libido), erectile dysfunction, failure to become aroused or orgasm, pleasureless or weak orgasm, and premature ejaculation. The sensory changes may extend beyond the genital area to a more general dampening of reactivity, sometimes termed emotional numbing.⁴

One of my patients described it like this: “I feel misunderstood by the medical professionals, disabled because I feel unwell, and when people are talking about sex I don’t feel like I’m a part of sexual life—I’m left out.” His description shows the serious effect this condition has on patients’ emotional wellbeing.

We currently know little about the mechanisms underlying sensory changes associated with SSRIs. Genital numbness may be mediated through the action of SSRIs at sodium channels in the cell membrane.⁵ ⁶

Antidepressants that act on sodium channels are widely used to treat neuropathic pain, for example. Post-SSRI sexual dysfunction has been reported by patients of all ages, of both sexes, and from all ethnic groups. Case reports show that it can begin after a few doses or become apparent only after years of exposure and can persist for decades afterwards. Some patients report a degree of spontaneous recovery with time (sometimes several years), while others experience brief remissions (for days). This suggests that these effects do not stem from permanent damage.⁷ ⁸

Prevalence and incidence are both currently unknown, as is the risk of post-SSRI sexual dysfunction among patients taking antidepressants.⁹ Only a few people are warned about the possibility of long term sexual side effects when these drugs are prescribed, and controlled studies examining this outcome are lacking. The condition is difficult to diagnose with certainty since no clear and reproducible diagnostic criteria have been evaluated or agreed. Diagnosis currently relies on symptoms alone, and symptoms are highly variable, both in severity and persistence. Underdiagnosis is likely, not least because of patchy awareness of the condition among healthcare workers. Many patients describe difficult experiences when approaching healthcare providers about their symptoms. Diagnosis is further complicated by the variable course of symptoms, which may appear only when antidepressant treatment is tapered or stopped.⁷

**No treatment**

No effective treatment exists for post-SSRI sexual dysfunction. Drugs acting on various dopamine and serotonin receptors have been tried anecdotally, along with phosphodiesterase inhibitors. None have reduced symptoms.⁴ Post-finasteride syndrome is closely related to post-SSRI sexual dysfunction, which occurs in men taking 5α reductase inhibitors (such as finasteride) to stall hair loss or to treat urinary symptoms caused by prostate enlargement.¹⁰ The two conditions share several clinical features including genital anaesthesia, loss of libido, erectile dysfunction, and ejaculatory difficulties.

Better recognition of post-SSRI sexual dysfunction is the first step towards essential research into this condition to quantify true prevalence and to identify pathophysiological mechanisms and potential treatments. This is an iatrogenic condition triggered by widely used medications. Symptoms are well described, but we need rigorous research to help disentangle the effects of medication from those of any underlying mental health condition, including depression. Most importantly, recognition of post-SSRI sexual dysfunction by the European drug regulator means prescribers must inform patients of the risk when discussing possible treatment with an SSRI or SNRI so they can make a fully informed choice about their options.
CORONAVIRUS

On the frontline: Italy’s response to covid-19

Marta Paterlini reports from a country in lockdown after becoming the second hardest hit by the pandemic

“Patient 1” can breathe on his own after more than two weeks in intensive care for severe pneumonia. The 38 year old marathon runner, admitted to hospital on 21 February, is believed to be the source of local transmission of SARS-CoV-2, in Italy, now the country with the second highest number of deaths from the virus in the world.

The resulting state of emergency lockdown, which began in northern Italy and expanded to the whole country, will last until at least 3 April in an attempt to contain a contagion that has, at the time of writing, infected more than 24 747 people (including at least 2026 healthcare staff) and killed 1809. The fatality rate of 7.2 is now higher than in China (3.8).

Massimo Galli, chief physician for infectious diseases at Luigi Sacco Hospital in Milan, told The BMJ, “I am convinced the virus circulated undetected for at least four weeks before the outbreak we experienced in the original ‘red zone’ in Codogno.” Galli is working on the isolated virus sequencing data of three patients who had recently returned from China.

“It is tested in hospital who dies in hospital is tested” says Capua. “How and whether every person who dies in hospital is tested can have an impact on the numbers.”

At the beginning, the communication system has been always decentralised. Remember that the Italian healthcare system has been always decentralised. At the beginning, the communication between the state and the regions was poor, creating confusion.”

Italy has been responsive with the European Commission and other countries to follow Italy’s lead. “Let’s remember that the Italian healthcare system has been always decentralised. At the beginning, the communication between the state and the regions was poor, creating confusion.”

In numbers
At the time of writing, data from the Istituto Superiore di Sanita, the leading scientific body of the Italian national health service, show the clinical status of 2539 cases is known: 25% are critical or severe, 30% have mild symptoms, and 10% are asymptomatic (the rest are either pauci-symptomatic or the severity is not specified). Of these, 21% have been admitted to hospital, while the median age of the 1545 patients in intensive care is 69 with no cases under 18. However, a significant percentage of patients are under 30, which confirms how crucial this age group is in transmitting the virus.

Italy has been responsible with testing, even asymptomatic people. Pierluigi Lopalco, an epidemiologist at the University of Pisa, told The BMJ, “At the beginning this overdoing made sense, because we had to understand what was going on.” Other countries only tested patients with symptoms who had recently returned from China.

Ilaria Capua, a virologist and director of the One Health Center of Excellence at the University of Florida, told The BMJ that the European Commission should define criteria to harmonise data on incidence and mortality. A discrepancy between countries exists in distinguishing deaths from other causes while being infected with coronavirus. “The biggest problem is there are no guidelines,” says Capua. “How and whether every person who dies in hospital is tested can have an impact on the numbers.”

She adds that Italy has the highest number of deaths from antibiotic resistance in the EU. Pathologists will need to distinguish between SARS-CoV-2 as the primary pathogen or an opportunistic pathogen that may pave the way to more severe respiratory infections caused by multidrug resistant bacteria.

Falling short
Italian doctors describe a warlike scenario in hospitals, with fewer places available than there are patients in critical condition. Lombardy, the most affected region in the country, has around 1000 beds available for patients in need of intensive care, but they are near to saturation.

Italy is also experiencing a chronic shortage of healthcare workers. On 9 March the government announced a plan to add 20 000 doctors, nurses, and other hospital staff to meet demand. Retired doctors may be called on, as well as students in the final year of specialist training.

Meanwhile, medical authorities are encouraging doctors who have come into contact with coronavirus patients to continue to work unless they show symptoms or test positive. Specialists such as gastroenterologists and cardiologists have been asked to work outside of their fields.

Ricciardi has urged neighbouring countries to follow Italy’s lead. “Let’s remember that the Italian healthcare system has been always decentralised. At the beginning, the communication between the state and the regions was poor, creating confusion.”

Marta Paterlini, journalist, Stockholm
Cite this as: BMJ 2020;368:m1065
INVESTIGATION

What lies behind the cannabis industry’s support for wider patient access?

The BMJ has uncovered links between companies and campaigners lobbying for wider medical use of the drug and a parallel campaign to create a lucrative recreational market in the UK. Jonathan Gornall reports

When Charlotte Caldwell arrived at Heathrow on 11 June 2018 with a six month supply of cannabis medication to treat her son Billy’s epilepsy, it was no coincidence that journalists and TV crews were on hand for the press conference that followed the inevitable seizure of the drug by customs officers.

The stunt, along with the press conference and the subsequent outpouring of media outrage that her son had been denied treatment, had been orchestrated by Steve Moore, the former chief executive of David Cameron’s failed Big Society initiative.

Caldwell revealed Moore’s role in an article published under her name on the website Vice in July 2018. “A friend,” she wrote, had put her in touch with him. He in turn had put her in touch with Tilray, a Canadian medical cannabis company, and had then fought her corner, organising press coverage and negotiating on her behalf with the Home Office. Moore confirmed his involvement, telling The BMJ: “I was very involved in the case of Billy Caldwell.”

But Moore’s interest in cannabis is not limited to the drug’s medicinal use. His involvement in the Caldwell case is indicative of the increasingly blurred lines between groups and individuals campaigning for wider access to cannabis for medical reasons and those pushing for the legalisation of cannabis for recreational use.

Vested interests?

Moore is strategic counsel for the Centre for Medicinal Cannabis, “the UK’s first … industry membership body for businesses and investors operating in cannabis based medicinal products and cannabidiol wellness markets.” He is also the co-founder and strategic counsel of Volteface, an advocacy organisation set up in 2017 to lobby for the legalisation of cannabis in the UK for recreational use. Legalising the drug, Volteface maintains, would “take an estimated £2.5bn a year out of the hands of criminals and the black market and bring this money into the regular economy,” in the process creating “estimated tax revenues of £1bn per year which can be spent on public services.”

Some suggest that the debate is being fuelled by a growing breed of new companies, ranging from large scale cannabis growers and distributors in Canada to UK and international investment groups, which are manoeuvring to take advantage of a widely anticipated shift in the UK’s cannabis regulatory landscape.

“I am sympathetic to patients who feel that cannabis and its extracts are useful for their medical condition and are frustrated that it is not legally available to them,” Ian Gilmore, director of the Liverpool Centre for Alcohol Research and chair of Alcohol Health Alliance UK, told The BMJ. “However, it is vital that there is complete transparency in those making the case and supporting patient groups.

“We must not drift into the situation we found ourselves in with tobacco and alcohol, where global companies seeking to maximise their markets distorted the arguments, often through third parties. We must protect patients from having groups with conflicts of interest building up unrealistic hopes.”

Both Volteface and the Centre for Medicinal Cannabis were co-founded and are funded by Paul Birch, a multimillionaire who in 2015 founded the shortlived British political party Cannabis Is Safer Than Alcohol (CISTA) to campaign for the legalisation of recreational cannabis. CISTA fielded 32 candidates in the 2015 general election but won no seats. It is now defunct.

“Big cannabis”

Birch’s cannabis advocacy group Volteface and Tilray, the Canadian company that supplied the cannabis for Billy Caldwell, are also linked. Brendan Kennedy, Tilray’s chief executive, has served as an adviser to Volteface.

Tilray is representative of a growing sector that can be characterised accurately as “big cannabis.” When it went public on the Nasdaq in 2018 it became the first cannabis company to be listed on a major US stock exchange, and in 2019 it bought Ontario based Natura Natural Holdings and its 155 000 square feet of cannabis greenhouses for $26bn. There was further blurring of the line between the proponents of the medical and recreational uses of cannabis when Volteface and the Centre for Medicinal Cannabis joined...
forces in 2018 to commission an opinion poll looking at public attitudes towards both. The poll, based on 2065 online interviews, found that 75% of the UK public would be open to using cannabis as a prescribed medicine and that 59% supported the legalisation of the drug for recreational use.

In November 2019 the Centre for Medicinal Cannabis spawned another trade body, the Association for the Cannabinoid Industry. Moore is strategic counsel for both organisations.

Some of the centre’s member companies operate not only in the medicinal and wellness sectors but also in the manufacture and sale of recreational products. One example is the Canadian based Supreme Cannabis Company, which owns brands such as Sugar Leaf and Blissco, whose products include pre-rolled joints.

**Canada and Europe**

The Supreme Cannabis Company is based in Toronto, Canada, where the drug was legalised for medical purposes in 2001 and for recreational use in 2018. It has invested in several cannabis brands in Canada and Europe.

Supreme Cannabis Company, in keeping with others, clearly sees the UK and European markets as having great potential. In June 2019 it launched London based Supreme Heights, an investment company “focused on opportunities in the UK and Europe’s CBD health and wellness space.”

The chief executive is Patrick Morton, a former investment bank analyst and co-founder of the 2018 investor conference Cannabis Invest UK. Supreme Heights did not respond to a request for comment from The BMJ about whether it was planning to emulate its Canadian parent company and invest in the recreational market in Europe and the UK if the regulatory landscape changes. However, in an interview published online in April 2019 Morton indicated that the growing acceptance of medicinal cannabis would inevitably pave the way for “massive” recreational opportunities.

“As the discussion enters the public sphere, more and more people will realise that cannabis provides nothing but positive benefits for society as a whole,” he was quoted as saying.

“It boosts government tax revenues, money isn’t wasted on prohibition, it creates jobs, and is beneficial to public health. Then, as we move on from medical cannabis, the conversation will turn to recreational cannabis. This is going to provide some massive, massive opportunities for business.”

Asked if he was comfortable with this apparent overlap between the stated aims of the Centre for Medicinal Cannabis and the recreational commercial ambitions of some of its member companies, Birch told The BMJ he supported “access to cannabis for those who would derive benefit from its use therapeutically and also for cannabis to be legal and regulated for responsible adult use.”

In addition to funding from Birch “and grassroots donations,” the advocacy group Volteface is funded by MXIF International Corporation, a Canadian company with London offices which invests in recreational cannabis.

Birch told The BMJ that the UK’s cannabis policies caused “significant harm to our society and that Volteface is the leading advocate for reform. Legally regulating the UK’s recreational cannabis market will restrict children’s access, divert vast sums of money from criminal gangs into the legal economy, and allow consumers to make informed choices.”

Moore declined to comment on whether his engagement with the Caldwell case was part of a conscious effort to normalise the conversation around cannabis, with keeping with Volteface’s agenda to see the recreational use of cannabis decriminalised.

But he said: “Decriminalisation in and of itself would not financially benefit any legal licensed cannabis companies and there is little indication that the government is considering any such reform.”

Neither view, however, appears to be shared by big cannabis.

**Opening the market**

The potential of the medicinal and recreational cannabis markets in the UK and Europe was highlighted in December in a market report published by Prohibition Partners, a marketing consultancy formed in 2017 “with a mission to open up the international cannabis industry through reliable data and intelligence.”

By 2024, it predicted, the UK’s medicinal market, “servicing nearly 340 000 active patients,” would be worth nearly £1.3bn. But, predicting that the recreational use of cannabis could be legalised by as soon as mid-2021, it estimated the value of that market by 2024 would be even greater—roughly £1.7bn, “with nearly three-quarters of a million people being regular recreational cannabis customers.”

Regulatory debate in Europe was currently “mostly focused on legislation for medical cannabis and CBD products,” the report added. But “as countries adopt medical cannabis programmes and economic studies show the benefits of a regulated market, many European states are opening up the recreational cannabis debate,” creating a potential market worth €65bn by 2028.

Stephen Murray, executive director of Prohibition Partners, told The BMJ that the debate about the medical use of cannabis was “normalising the conversation around cannabis, bringing it into social circles where it wouldn’t have been debated previously,” and that major corporate investors were becoming increasingly interested in the broad range of cannabis opportunities.

“You would be surprised by the number of pharmaceutical groups and FTSE 100 groups who have been working on cannabis opportunities for the past two or three years,” he said. “I’m often down in London’s Canary Wharf, in Switzerland, and in New York, meeting a lot of significant investment groups and financiers who are looking at making considerable entrances into cannabis, both medicinal and recreational.”

Prohibition Partners is one of several offshoots of European Cannabis Holdings, a UK private investment group “with a mission to make cannabis more accessible and acceptable.” The company recently

---

**A consultancy report estimated the value of the recreational market in Europe by 2028 would be roughly €65bn**
established Medical Cannabis Working Group” set up by Nutt, and a spokesperson for Drug Science confirmed it was in talks with the group’s medical cannabis clinics to discuss their role as potential treatment centres for Project Twenty21.

Before the demerger of European Cannabis Holdings its chief medical officer was Michael Barnes, honorary professor of neurological rehabilitation at Newcastle University. Barnes is now chief medical officer for the Lyphe Group, clinical director of Medical Cannabis Clinics, and director of education for the Academy of Medical Cannabis.

He was until recently also the chief medical officer of SOL Global Investments, a company based in Toronto, “with a focus on the cannabis industry in legal US states.” It is, he says, “one of the cannabis industry’s leading publicly traded companies with over $190m in assets.”

Barnes’s expertise in the medicinal potential of cannabis is widely recognised. In 2016 he prepared a summary of research evidence for the All Party Parliamentary Group for Drug Policy Reform that formed the basis of a report calling for the legalisation of cannabis for medical use.

Yet The BMJ has learnt that in the eyes of NICE his link with SOL Global Investments disqualified him from membership of the its advisory committee appointed in 2019 to develop guidelines on the prescribing of cannabis based medicinal products.

A spokesperson for NICE said it would not comment on confidential correspondence but confirmed that “Professor Barnes was interviewed for a position on the cannabis guideline committee but was not appointed.”

Barnes told The BMJ that his rejection by NICE was “bizarre” as although he was at the time involved with SOL, “I said in my interview that I had no conflict of interest in the UK market, they just didn’t want me for the reason that I had a stated position on medical cannabis, which of course no one else on the panel had.” He was, he added, no longer involved with SOL. “I am not employed by them, not had anything to do with them for months, and have not been paid since July.”

Barnes told The BMJ that as chief medical officer of Lyphe Group he was involved only with the “purely medical arm” and had “no recreational involvement.” He had, he said, “never commented publicly on recreational cannabis policy as I have felt it would get in the way of the medical cannabis debate. I would not want a broader and entirely legitimate debate on recreational policy to slow down the introduction of a better medical cannabis prescription process.”

Wider uptake of cannabis for medical use is the objective of Project Twenty21, but whatever the outcome of Nutt’s initiative it may be compromised by the perceived conflicts of interest of its backers, which include three cannabis companies.

On its website Drug Science says it was founded “with a passionate belief that the pursuit of knowledge should remain free of all political and commercial interest,” yet a spokesperson told The BMJ that “a small group of medical cannabis companies are supplying products to the Twenty21 project, and also providing direct project funding.”

A spokesperson for Drug Science told The BMJ it was “a charity that pursues its goals independently of any commercial influence, yet we do work with commercial partners when they form part of a consortium, such as the current Medical Cannabis Working Group.” On occasion, “Drug Science may work also with a single company; the arrangements for such would be under the terms of an unrestricted educational grant, where the commercial entity has no influence over Drug Science’s processes or outcomes.”

Drugs Science, he added, “will not engage with companies whose aims, objectives, or ethics conflict with its own.”

“It’s like saying, if you are in pain a glass or two of wine might help
Marta Di Forti, psychiatrist

A spokesperson for NICE said it would not comment on confidential correspondence but confirmed that “Professor Barnes was interviewed for a position on the cannabis guideline committee but was not appointed.”

Barnes told The BMJ that his rejection by NICE was “bizarre” as although he was at the time involved with SOL, “I said in my interview that I had no conflict of interest in the UK market, they just didn’t want me for the reason that I had a stated position on medical cannabis, which of course no one else on the panel had.” He was, he added, no longer involved with SOL. “I am not employed by them, not had anything to do with them for months, and have not been paid since July.”

Barnes told The BMJ that as chief medical officer of Lyphe Group he was involved only with the “purely medical arm” and had “no recreational involvement.” He had, he said, “never commented publicly on recreational cannabis policy as I have felt it would get in the way of the medical cannabis debate. I would not want a broader and entirely legitimate debate on recreational policy to slow down the introduction of a better medical cannabis prescription process.”

Wider uptake of cannabis for medical use is the objective of Project Twenty21, but whatever the outcome of Nutt’s initiative it may be compromised by the perceived conflicts of interest of its backers, which include three cannabis companies.

On its website Drug Science says it was founded “with a passionate belief that the pursuit of knowledge should remain free of all political and commercial interest,” yet a spokesperson told The BMJ that “a small group of medical cannabis companies are supplying products to the Twenty21 project, and also providing direct project funding.”

A spokesperson for Drug Science told The BMJ it was “a charity that pursues its goals independently of any commercial influence, yet we do work with commercial partners when they form part of a consortium, such as the current Medical Cannabis Working Group.” On occasion, “Drug Science may work also with a single company; the arrangements for such would be under the terms of an unrestricted educational grant, where the commercial entity has no influence over Drug Science’s processes or outcomes.”

Drug Science, he added, “will not engage with companies whose aims, objectives, or ethics conflict with its own.”

“Big jump” to medicinal use
Other experts are unconvinced. Psychiatrist Marta Di Forti is a member of the government taskforce appointed to review evidence for the safety and efficacy of cannabis for the treatment of pain, which is due to report this spring. Based at the Institute of Psychiatry, Psychology and Neuroscience at King’s College London, Di Forti is concerned about the engagement of cannabis companies with patient groups and the “big jump” that medicinal cannabis should be made more widely available to treat a range of conditions for which evidence was still lacking.

As things stand, she said, “to go around saying that cannabis is wonderful for pain is like saying that if you are in pain a glass or two of wine might help. People advocating for cannabis use in pain or in any other condition who have been using cannabis at home are talking about getting relief from their discomfort and other redundancies thanks to a recreational substance.”

She added: “It’s a very important issue and I’m not dismissing it. But it is very easy for companies to offer an avenue of hope to patient groups, to say ‘would you like easier access to something that is making you feel better?’ and you can see how alliances can get formed.

“I am upset by this because some of these groups are vulnerable people with chronic conditions and looking for real relief and help.”

Jonathan Gornall, investigative journalist,
Suffolk jgornall@mac.com
Cite this as: BMJ 2020;368:m1002

21 March 2020 | the bmj
The true be-leaf-ers
The tangled connections between proponents of medicinal and recreational cannabis use

As Jonathan Gornall reveals in his investigation, there is a complicated network of relationships between those lobbying for greater availability of cannabis for medical and recreational use. This diagram presents the links between those calling for wider patient access to cannabis for medical use and the members of a parallel campaign to create a lucrative recreational market for the drug in the UK.

The medical debate is normalising the conversation around cannabis
Stephen Murray, Prohibition Partner

Project Twenty21
In November 2019 Drug Science announced it was launching “Europe’s first and biggest national medical cannabis registry.” Project Twenty21 aims to recruit 20,000 patients with one or more of seven conditions—anxiety disorder, chronic pain, epilepsy, multiple sclerosis, post-traumatic stress disorder, substance use disorder, and Tourette’s syndrome—to whom cannabis will be prescribed, free of charge, even though the evidence for its efficacy in most such cases is weak. The aim is to create “the largest body of evidence for the effectiveness and tolerability of medical cannabis … to demonstrate to policymakers that medical cannabis should be as widely available, and affordable, as other approved medicines.”

This is not, however, a randomised controlled trial, and efficacy will be assessed not by comparison with standard treatments but by “a health outcome questionnaire specific to each included indication … a general health-related quality of life questionnaire [and] patients’ impression of change.”

Perceived conflicting interests
The Lyphe Group says it is “a strategic partner and member of the newly