

# comment

There's little doubt that health checks targeted at people living in deprived areas are a medical fig leaf attempting to cover austerity economics

**NO HOLDS BARRED** Margaret McCartney

PPA COLUMNIST OF THE YEAR

## Why is it so hard to do what works?

**I**t's hiding in plain sight. Poor people live less long than those who are rich, and people with a learning disability are more likely to die sooner than people without. GPs have been urged to respond to this in the way the contract knows best: by offering health checks and a checklist of items to be ticked.

In Scotland the Keep Well programme, aimed at people in deprived areas, has demonstrated only minimal or marginal benefits but is still used in some areas.

Health checks for people with learning disabilities often detect symptomatic conditions. This is itself a concern, as doing health checks once a year may generate a stock delay in a system where people or carers may wait for an invitation rather than having prompt attention to symptomatic issues. And, while clinical review is often a case of simply good practice, health checks for people with learning disabilities can identify unmet needs, but they haven't been shown to reduce mortality and morbidity.

Can medicine correct these inequalities? The ASSIGN risk calculator, for example, has been developed to consider deprivation as a risk factor for cardiovascular disease. It means that we're effectively treating poverty with statins. The real world benefit of encouraging lifestyle interventions has not been demonstrated, and the effects of austerity may have a far larger role in determining mortality.

Meanwhile, people with learning disabilities are more likely to have epilepsy and are more likely to die earlier if they do. This is an area with high potential for



improvement, yet the lack of randomised controlled trials on the best treatments for this group of people has been well noted for years. In 2015 a Cochrane review found that "very few high quality studies" had been performed among this group despite as many as 44% of people with a learning disability having epilepsy.

We have premature mortality—but not enough high quality evidence to know whether what we're recommending at

health checks for people with learning disabilities and epilepsy will improve outcomes.

There's little doubt that health checks targeted at people living in deprived areas are a medical fig leaf attempting to cover austerity economics. It's hardly feasible that health checks will square the circle of deprivation. The premature mortality associated with deprivation has complicated causes, and it's likely to have complicated answers. Repeating known failures will not help.

We're fiddling with health checks while people die. For people with learning disabilities, the ongoing deficit in knowledge on best treatments for epilepsy—despite the risk of sudden death—is needless. There's no lack of opportunity to obtain better knowledge.

Stopping things that don't work, and acting on the knowledge that we don't know what does work: why is that so difficult?

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References are in the version on [bmj.com](http://bmj.com).

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# Why we should avoid handover hostility

No patient has died from lack of manners, but rudeness among staff can affect performance

**A**s I arrived in resus the tension was palpable. A familiar interplay was evolving in the paediatric bay: the “handover standoff.” On one side stood a tired transfer team, accompanying an intubated toddler with intracranial pathology. They had spent a couple of hours doing complex tasks in a stressful environment while organising beds, personnel, and transport—the critical care transfer ballet so often staged in hospital. To me the transfer team seemed to have done an excellent job and were now well placed to receive our plaudits. Perhaps even a cup of tea.

Instead they faced a wall of various healthcare professionals. Stern questions were being fired at the transfer team—staccato clippings barely disguising the receiving team’s apparent annoyance. The transfer team swiftly adopted a backfoot

stance, aggrieved at the insinuation that they had not performed to the highest possible standards. “Who told you to come to resus?” “We were told the child was 3, not 2.” “You’ll just have to wait—this isn’t what normally happens.”

Such interplay is so common that I would suggest it is the norm between teams handing over care. I have seen it when patients are delivered from theatres to the intensive care unit, and vice versa; when paramedics roll into the emergency department; when helicopter emergency care crews deliver beautifully packaged patients who not so long before had been intertwined with bits of mangled metal. I have seen the rolled eyes, heard the undermining language, and sensed the thinly veiled dissatisfaction. And, I confess, in addition to witnessing handover hostility, I can remember occasions where I have been the perpetrator.



**Dealing with hostility is a distraction that occupies our mental “bandwidth”**

## Deleterious effects

Who cares? The clinical bit is what counts, right? No one ever died through lack of manners. But I do care, because I am frustrated—frustrated at seeing this behaviour for years without understanding the causes.

Perhaps it is a phenomenon born of onerous workloads. We are all stressed. Morale in hospitals seems lower now than ever. And despite this we’re generally not a workshy bunch.

Is it insecurity in the face of critical illness? A complex problem we now have to take over but don’t feel comfortable with managing? But

# Getting real about care closer to home

There’s a growing consensus about how we must change to ensure sustainable future health services. Its essence is: let’s focus more on public health, prevention, and wellbeing; enhance primary and wider community support for people with long term conditions; and, during acute crises, help patients spend less time in hospitals—or none at all—repurposing resources and staff away from hospital buildings.

In England we see such ambitions and rhetoric in political pronouncements and in key documents such as the *NHS Five Year Forward View*, sustainability and



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**These grand ideas aren’t new, but they remain unmatched by grand actions**

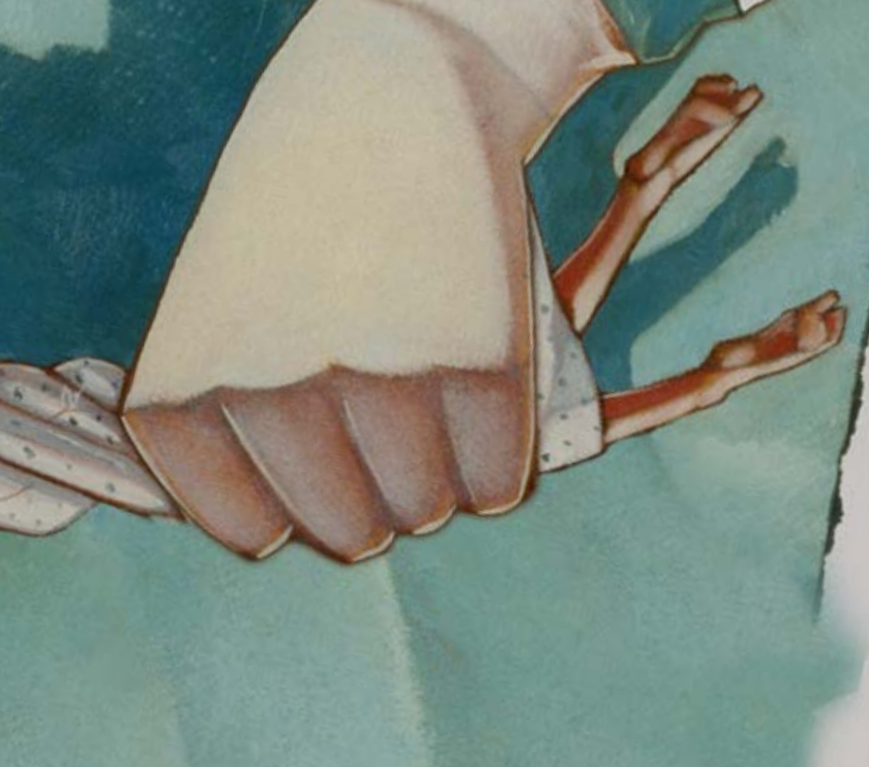
transformation plans (STPs), and position papers from professional organisations.

These grand ideas aren’t new, but they remain unmatched by grand actions. This isn’t surprising, when service leaders must balance imagined future benefits against tangible current pressures in broke, full acute hospitals—admitting that they can no longer hit high profile and politically sensitive performance targets.

The health announcements in the chancellor’s March 2017 spring budget further exposed this dissonance. First, Philip Hammond promised an extra £100m for GPs

based in emergency department triage—even though upstream conventional primary care, with the potential to help keep patients away from them, is experiencing workforce and workload crises and has 100 fewer GPs this year despite plans to recruit 5000 more.

Social care was promised a further £2bn uplift over the next three years. But this announcement was clearly labelled in terms of reducing delayed transfers from—you guessed it—acute hospitals. Senior NHS leaders encouraged these hospitals to “get lippy” about use of the social care money. Little mention, then, of supporting people and their carers to stay at home in the first place,



handover hostility is not the preserve of the clinically inexperienced. It is also well practised by those in the senior echelons.

I have no answer, but does it actually matter anyway? Well, yes, it may. A 2007 study showed that a single brief hostile encounter resulted in cognitive disruption and an immediate reduction in task performance, not only in the person on the receiving end but also in those who witnessed the hostile behaviour. And a 2015 study found that exposure to rude behaviour had a deleterious effect on the diagnostic and procedural skills of neonatal

intensive care staff. Dealing with hostility is a distraction that occupies our mental “bandwidth,” a concept to describe the finite nature of our cognitive processing power. When mental bandwidth is taken up by our emotive response to hostility, our performance takes a nosedive.

Managing critically unwell people is always a challenge, irrespective of our seniority or experience. Perhaps a free and easy way to improve performance would simply be to be kinder to one another?

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although this is at the core of social care's purpose.

Hammond promised an additional £325m of capital expenditure for “leading” STPs (again, more on buildings rather than on staff and services in people's own homes). Some £800m in funds held by clinical commissioning groups and earmarked for primary and mental health was then repurposed by NHS England to meet hospital deficits and pressures.

Opinion polls show that responsive, urgent care tops public concerns about the NHS. Politicians and journalists reinforce this by discussing it predominantly in terms of hospitals and beds. This high

visibility and the narrow focus on acute care performance become a distorting, overvalued idea.

If we're serious about a shift towards the preventive and coordinated care we claim to want, we can't keep pumping all additional new funds into supporting hospitals. We'll need to relax our expectations of hospital performance and be honest about what they can no longer offer, let alone improve.

Maybe in the autumn statement we'll put our money where our mouth is. Platitudes don't help patients.

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**BMJ OPINION** Mary Higgins

## The echoes of adverse events

The “domino effect” describes the many groups that are affected when an adverse outcome occurs. Usually the first victims are the patient and their family and friends, the second victims are the staff, and the third victim is the organisation.

Recently I watched a fantastic talk about the domino effect that introduced alternative third and fourth victims—the third victims being the families and friends of healthcare workers, and the fourth victims future patients.

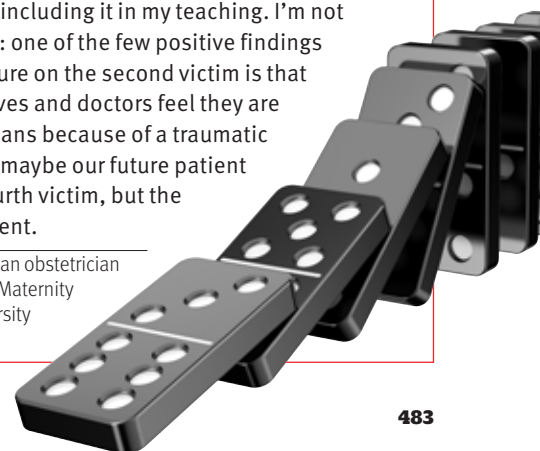
I've thought a lot about this since then. I've thought about how many times I have brought work home to my family, how many times I come home, at last, to people I love but can't talk to because of something that has happened at work. It seems unfair that, given the time my work takes me away from them, it reaches into family time as well.

**It's hard not to be biased by negative experiences, especially if patients are actively seeking my clinical opinion**

I have also thought about the fourth victim: the future patient. I can see how my previous patients will always cast a shadow over my future ones, and not always to my or their benefit. When a woman requests no prophylaxis in the third stage of labour and my response is based on the last woman I cared for who had a postpartum haemorrhage, for example. My preference for as safe a delivery as possible needs to be balanced with the patient's wish to deliver her baby with minimal interventions. It's a tightrope that we often navigate in obstetrics, where women are often caught between their wish to have as normal a birth as they can, while also being informed of all their options. When I'm talking to women about different scenarios, behind each of these are the ghosts of women and babies I have cared for. It's hard not to be biased by negative experiences, especially if patients are actively seeking my clinical opinion.

However, remembering these adverse events can also be constructive. Having learnt from a mistake I will be determined that it will not happen to me again, but also that others might also learn by my talking about it and including it in my teaching. I'm not alone in this: one of the few positive findings in the literature on the second victim is that many midwives and doctors feel they are better clinicians because of a traumatic incident. So maybe our future patient is not the fourth victim, but the fourth recipient.

Mary Higgins is an obstetrician at the National Maternity Hospital, University College Dublin





## OBITUARIES

### David Howel Bayton

General practitioner Monmouthshire and Ceredigion; former medical officer DVLA, Morriston (b 1928; q 1952; MRCS Eng; DObst RCOG), died from a head injury after a fall on 24 February 2016



David Howel Bayton was a partner in the Coach House Practice, Caldicot, Monmouthshire, from 1959 to 1973. After his wife's death in 1970 he decided on a 9-5 post while his three children were growing up. He was appointed as the second medical officer at the DVLA in Swansea and was heavily involved in the initial development of its medical department, especially in keeping statistics. At the end of the 1970s he returned to general practice, this time in the small Welsh coastal town of New Quay. On retiring after nine years, he took up bee keeping, continued gardening and reading, and went on numerous holidays—many in the company of his long term companion, Barbara Jones. David leaves three children and seven grandchildren.

Evan Aled Bayton

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### Bob Berrington

General practitioner and regional adviser (general practice) Anglia Region (b 1937; q Sheffield 1961; MBE, FRCGP), died from sepsis secondary to renal failure on 30 December 2016



Robert Berrington ("Bob") practised in Alconbury for most his professional life. During the early 1970s he was a trainer, course organiser for Peterborough, and then regional adviser for the then Anglia region. He was chair of the English and the UK regional advisers' committees and served on groups with the Royal College of General Practitioners and the then regulator for general practice, the Joint Committee on Postgraduate Training for General Practice (JCPTGP). He created management programmes for GPs in the 1980s and engaged with university departments of education. In 1987 he was awarded the MBE for services to general practice. He leaves three children by his first wife, Anne. He also leaves his widow, Pat, and two stepsons.

Arthur Hibble

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### Douglas B Brewer

Emeritus professor of morbid anatomy University of Birmingham (b 1919; q 1943; MD, FRCPath), died from consequences of falls on 20 December 2016



Douglas Bertram Brewer studied medicine in Cardiff, although he took the University of London examinations. After service in the Royal Army Medical Corps, he became a pathologist, first in Cardiff and from 1948 at the University of Birmingham, where he was appointed professor of morbid anatomy in 1967. He was internationally known as a renal pathologist. His book, *Renal Biopsy* (1964 and 1973), was one of the earliest in the specialty. Experimental and clinical research especially into the kidney was a dominant theme in his academic career, initially in the groups directed by Professor John Squire. Douglas continued active research after retiring in 1984, almost until his death. He also learnt German, reaching degree standard. He leaves his wife, Mary, and three daughters.

Alexander J Howie

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### Vera Alma Sullivan

Consultant psychiatrist (b 1921; q Queen's University Belfast 1946; MD, DPM, MRCPsych), d 29 March 2016



Vera Alma Sullivan was based with the Southern Health and Social Services Board from 1959 until 1989 and became one of the first female consultant psychiatrists in Northern Ireland. Her role throughout focused on the psychiatric needs of adults, children, and adolescents. This involved seeing patients in hospital, clinics, borstal, or training school, and prisons at the Maze and Armagh. Much of her working life took place during the political unrest of the Troubles. Her work throughout was closely complemented by her husband, the Reverend Cecil Owens. In her retirement, she retained many interests and kept abreast of medical developments by thoroughly enjoying publications, including *The BMJ*. Predeceased by her husband, Vera leaves her two daughters and their families.

Rosalind Hirst, Joyce Newcombe

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### Gavin Beddie Taylor

General practitioner Peterhead (b 1930; q Aberdeen 1954; MRCP), died after a short illness on 22 December 2016



Gavin Beddie Taylor served as a medical officer with the Royal Navy on HMS *Messina* and was involved in Operation Grapple, which tested the performance of nuclear weapons dropped from aircraft. This took him to Christmas Island, where in 1957 he witnessed the testing of Britain's hydrogen bomb. On his return to civilian life he joined his father in the Peterhead Group Practice. With the development of North Sea oil from 1972 onwards, the industrial component of the practice increased greatly. In 1976 the expanding practice moved to a purpose built health centre. After retiring in 1990 Gavin enjoyed travelling, skiing, and golf, but latterly he developed spinal stenosis requiring a laminectomy, which was to curtail these activities. Gavin leaves his wife, Margaret, and two daughters.

Pierre Fouin, Michael Williams

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### John David Thornhill

General practitioner Arnold, Nottingham (b 1952; q Sheffield 1980; FRCGP), died from acute myeloid leukaemia on 10 January 2017



John David Thornhill ("David") completed his vocational training in Chesterfield, in 1984, and became a partner in the Arnold Health Centre, Nottingham. In the late 1980s he became the practice's IT lead. He also joined a committee planning and overseeing the building of a nursing and residential home for local people, which opened in 1994 and was named "Thornhill House," after David's late father, who had been a local businessman. David remained a trustee for the home for the rest of his life. In 1994 David became a trainer on the Nottingham vocational training scheme and taught registrars for the next 17 years. David retired from practice at the end of May 2013. He leaves his wife, Karine; two children; and two grandchildren.

Brian Hammersley

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# Elizaveta Glinka

Russian born humanitarian who cared for children in war zones

Elizaveta Glinka (b 1962; q Second Moscow Medical Institute 1989), died in a plane crash on 25 December 2016

On Christmas Eve 2016, Elizaveta Glinka—an advocate for homeless people, terminally ill patients, and children suffering the horrors of war—boarded a Russian military transport plane in Moscow bound for Syria. Her mission was to deliver medical supplies, equipment, and gifts to Tishreen University Children's Hospital in Latakia, Syria.

Glinka, founder and executive director of the charitable foundation Fair Care, had been on numerous missions before, including to Syria and to areas of Russia hit by floods and forest fires. She had also travelled to the Donbass region of Ukraine to evacuate injured children so they could receive medical care in Russia.

## State prize

Just over two weeks before the flight Glinka had been awarded the state prize of the Russian Federation, among Russia's top civilian prizes, in recognition of her charity and humanitarian work. In a speech after receiving the prize from Russian president Vladimir Putin, Glinka said: "We never are sure that we will return alive because war is hell on Earth. I know what I am talking about. But we are sure that kindness, compassion, and mercy are more powerful than any weapons."

Around midnight on Christmas Eve, the military plane on which Glinka was travelling—a three engine Tupolev Tu-154—made a refuelling stop at Sochi International Airport in southern Russia. A few minutes after take-off the plane crashed into the Black Sea, possibly because of mechanical malfunction or pilot error. Some 92 people were on board, including 64 members of the world famous Alexandrov Ensemble choir, eight crew members, nine journalists, two federal civil servants, and Glinka. All died. Bodies have since been recovered and identified using DNA samples.

**When asked in 2014 whether she valued the lives of suffering children more than her own life, she said: "I am not a young woman. They are children and have not seen much yet"**



ITAR-TASS/Alamy

## Compassion and kindness

Glinka's husband of 30 years, Gleb, told *The BMJ*: "She loathed death and despised war and its consequences for non-combatants, the innocent, and helpless, especially children." He says that his wife studied medicine because "she believed that it was compassion and kindness that bound us to one another."

Elizaveta Petrovna Glinka was born on 20 February 1962 in Moscow. Her father was a military engineer; her mother a medical doctor. She studied medicine at the Second Moscow Medical Institute, graduating in 1989, and trained as a paediatrician. Gleb met and fell in love with Elizaveta on a trip to Moscow to visit his stepsister. In 1990 the Glinkas moved to Vermont in the US, where Gleb has a law practice.

In the US, Glinka acquired American citizenship and studied palliative care. In the late 1990s, while her husband was working in Kiev, she raised money to establish the first hospice in that city.

In 2006 she returned permanently to Moscow to care for her mother, who was in a prolonged coma after a stroke. Gleb joined his wife in 2008, when he was named director of the Moscow office of the American Bar Association.

Glinka resumed her work at the First Moscow Hospice and helped feed, clothe, and care for homeless people at Moscow's train stations while also introducing "street medicine." She established her charitable foundation,

Fair Care, funded by donations from ordinary citizens while declining government support.

## Eastern Ukraine and Syria

In 2013 Glinka was one of more than 50 doctors who signed an open letter, published in the *Lancet*, that warned of a medical catastrophe in Syria and called for medical and humanitarian access to the victims.

In recent years Glinka became well known in the Russian press. She was generally admired but did have some critics who accused her of self promotion and criticised her chic clothes and Mercedes. In an interview in *Snob* magazine, she asked: "But does working with the homeless necessarily warrant wearing rags?" Glinka's relationship with Russian government officials was also sometimes criticised.

In the 2014 interview she described war as "scary" and admitted being afraid on some of her missions. When asked whether she valued the lives of suffering children more than her own life, she did not answer directly. She said: "I am not a young woman. They are children and have not seen much yet."

Gleb Glinka says that his wife's charity, which operates with eight staff members plus volunteers, will live on.

Glinka leaves her husband, Gleb; two sons; and a foster son.

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# Regulating the new legal highs

Prohibition of new psychoactive substances is both difficult and costly, **Shakila Rizwan and Andrea Vernall** look at New Zealand's attempt to regulate instead

**M**any countries are experiencing a surge in the recreational use of new psychoactive substances.<sup>1</sup> The most common approach to this problem is to prohibit known or broadly defined chemical classes.<sup>2</sup> However, this has been difficult to implement, particularly as manufacturers rapidly develop new substances to replace prohibited compounds.<sup>3,4</sup> The New Zealand government decided to adopt a different approach, creating a pre-market approval regulatory system for new psychoactive substances, the Psychoactive Substances Act 2013.<sup>5</sup> The UK recently introduced a similar law, the Psychoactive Substances Act 2016.<sup>6</sup>

## Aims and controversies

Although the intent of the New Zealand law is to regulate the legal market for new psychoactive substances and draw the development and demand away from more harmful drugs, the act has proved controversial.

Under the act, a psychoactive substance can be introduced to the market only if it is scientifically proved to pose “no more than a low risk” of harm. This strategy puts the onus of proof on manufacturers and distributors. However, the act does not define “low risk,” deliberately leaving the interpretation to the manufacturer. The current act (amended May 2014) also prohibits the use of animal testing to demonstrate low risk after intense campaigning from animal rights groups.<sup>10</sup>

No psychoactive substance will be completely safe because of varying pharmacological effects in different people. If animal testing cannot be

used the question arises as to how manufacturers can establish low risk, other than by using human subjects. A large proportion of users of new psychoactive substances are young adults,<sup>1</sup> so how does one determine the drugs' effect on the adolescent brain, at a time when it is still developing? No new psychoactive substances have been approved for sale since the act was introduced, leading opponents to label it as “prohibition in disguise.”<sup>11</sup>

The act has also been criticised for failing unambiguously to define the term psychoactive substances. It broadly defines them as “substances, mixtures, preparations, articles, devices, or things that are capable of inducing a psychoactive effect, by any means, in the people who choose to use them.”

The UK act has faced similar criticism for ambiguity in its definition of “psychoactive,” which it describes as anything which “by stimulating or depressing the person's central nervous system... affects the person's mental functioning or emotional state.” Taken at face value this definition is very broad. The Advisory Council on the Misuse of Drugs in the UK has called the UK act “unworkable” because it believes that “the psychoactivity of a substance cannot be unequivocally proven.”<sup>13</sup>

## International approaches

Many countries, including the UK and New Zealand, have historically used temporary control measures (emergency scheduling) of specifically defined compounds to allow time to assess risk and complete the legislative process for new recreational drugs. In 2012, Japan's Ministry of Health, Labour, and Welfare confronted the problem by categorising structures



**Synthetic cannabis products on sale in Onehunga, Auckland, before the new regulations**

according to possible pharmacological activity.<sup>14</sup> Since March 2013, the manufacture, import and sale of 759 compounds classified as “designated substances” has been banned under Japan's Pharmaceutical Affairs Law—psychotropic substances not controlled under the Narcotics and Psychotropics Control Law because their pharmacological effects have not yet been proved scientifically.<sup>14</sup>

However, the prohibitionist approach has shown little evidence of success in combating the rise in the recreational use of controlled drugs and new psychoactive substances and in improving public health outcomes. The New Zealand and UK acts signal a change in tactics from regulatory authorities.

Portugal has gone further and partially decriminalised drug use. Since 2001, production and supply of drugs remain illegal but anyone in possession of less than a defined 10 day supply of a defined substance escapes criminal charges.

## KEY MESSAGES

- The New Zealand Psychoactive Substances Act was introduced to regulate the escalating growth of new psychoactive substances
- The act requires manufacturers to prove their product poses a low risk of harm without animal testing before legal manufacture, importation, and sale
- The act has been criticised for not clearly defining low risk or psychoactive substances
- Since implementation, a decrease in the incidence of medical emergencies related to synthetic cannabinoid use has been reported





JASON OXENHAM/STRINGER

The prohibitionist approach has shown little evidence of success

risen,<sup>26</sup> and methamphetamine seizures increased by more than nine times between 2013 and 2015.<sup>32</sup>

### Implications for medical research

There is a stigma surrounding scientific research into the use of cannabinoids for medical purposes because synthetic cannabinoids are thought of as drugs of abuse. It is not clear whether the ban on testing new psychoactive substances in animals extends to all central nervous system related research or just safety testing of substances intended for recreational use. As we work with cannabinoids and cannabinoid-like molecules, we are concerned that research into potential treatments for conditions such as brain injury, pain, schizophrenia, multiple sclerosis, and Alzheimer's disease will be hampered by the legislation, particularly the ban on animal testing. UK researchers have expressed similar concerns, although the UK act does not ban animal testing and does a much better job at defining and encouraging scientific endeavour.<sup>29</sup>

### The future

The Psychoactive Substances Act is an innovative effort to regulate the exponential growth of new psychoactive substances, requiring manufacturers to scientifically prove their product has no more than a low risk of harm without using animal testing before it is made available to the public. Once low risk psychoactive substances are approved for legal sale, health surveillance and quality control need to be implemented and maintained, which is not addressed in the New Zealand act.

Despite the ambiguity around the definition of low risk and what constitutes a psychoactive substance, this innovative regime highlights that the New Zealand government recognises that the prohibition of chemically defined new psychoactive substances is not effective.

It will be interesting to see whether any other countries follow New Zealand's path.

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Decriminalisation has led to a decrease in the rate of continued drug use among all adults, drug induced deaths, and imprisonment on drug related charges, and a rise in visits by users to addiction clinics.<sup>15 16</sup>

Portugal has become the poster child of advocates and reformers who argue that problem drug taking is better dealt with as a medical rather than a criminal issue.<sup>17 18</sup> Some countries, including the Netherlands, Uruguay, Ecuador, the Czech Republic, Costa Rica, and Argentina, as well as a few US states, have followed suit and either completely decriminalised all or specified drugs—for example, cannabis in the Netherlands and Uruguay.<sup>19</sup> However the emergence of new psychoactive substances has been challenging to absorb into Portugal's partially decriminalised model as biological effects are so ill defined. It has introduced new legislation, seen by some as a backwards step, prohibiting trade in a list of defined chemical compounds designated new psychoactive substances.<sup>31</sup>

While the UK Act makes tentative efforts towards decriminalisation by excluding anyone in possession of certain psychoactive substances, such as Spice (a synthetic cannabinoid), from criminal charges, New Zealand's tone and direction is towards regulation.

### Effect on public safety

Introduction of the Psychoactive Substances Act has sparked concerns about public safety and risk. Synthetic cannabinoids became banned when

the act was implemented because they had not been proved to be low risk. This pushed these substances into the black market. Users often still illegally purchase synthetic cannabinoids from the internet because stockpiles were created before the act was introduced. There have been at least 350 prosecutions under the New Zealand act for offenders possessing, selling, or distributing psychoactive drugs since 2013.

Black market products can be more harmful to users because they do not necessarily conform to safe manufacturing processes or safety regulations. The products are often unlabelled or have unknown dose and potency.

The number of presentations to mental health services related to synthetic cannabinoid use has roughly halved since the act was implemented.<sup>25</sup> However, the reduced consumption of synthetic cannabinoids may have contributed to the recent growth of the illegal manufacture and use of methamphetamine. Several drug addiction services have reported an increase in synthetic cannabis users reverting back to methamphetamine. Prosecutions under the Misuse of Drugs Act for possessing, supplying, administering, or dealing in methamphetamine and amphetamine have



## PAYING FOR THE NHS

**We cannot depoliticise the NHS**

Godlee discusses how we might pay for the NHS (Editor's choice, 11 February).

A policy on health service spending is meaningless without a policy on health creation. Most disease is not random. Our chances of getting ill or dying are greatly increased by social and psychological adversity, some of which is preventable by early intervention.

This means that we need massive public investment in comprehensive perinatal health, paid parental leave, children's centres, and early years education. But we must also recognise that insecurity—especially in housing and employment—damages health through the physical stress it causes. Michael Marmot's book *The Health Gap* chronicles this in scientific and accessible detail.

NHS funding cannot be taken out of politics because its costs depend so much on the impact of other policies, especially those that aggravate inequalities.

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## OFF LABEL ANTIDEPRESSANTS

**Robust systems are needed for off-label prescribing**

Off-label prescribing is an area of concern for many GPs (Research, 25 February). Requests for off-label prescribing from secondary care specialists are also growing, not just regarding use of antidepressants.

We need robust systems to ensure that prescribing drugs off licence is undertaken by the initiating specialist (who should have counselled the patient or parent) rather than passed on to a third party with the accompanying patient expectation that a prescription be issued. The BMA provides a guidance template letter that can



## LETTER OF THE WEEK

**Brexit will put further pressure on the NHS**

The UK's departure from the European Union will have wide ranging consequences, including doctors leaving the country (This week, 4 March). As a member of the EU for over 40 years, the UK is fully linked with Europe in all sectors of its society. This includes the NHS, which faces major risks if it fails to tackle the challenges that Brexit poses.

The NHS has faced shortages in its clinical workforce for many decades and has relied heavily on doctors, nurses, and other health professionals who were trained overseas to fill the gaps. This reliance will not end in the foreseeable future. Jeremy Hunt, the health secretary for England, has announced that the government will support the creation of an additional 1500 medical student places at England's medical schools, but these students won't complete their medical courses and postgraduate medical training for over 10 years.

The recruitment of medical staff trained overseas has been facilitated by EU legislation on the mutual recognition of the training of health professionals. This means that health professionals trained in one EU country can work in another EU country without undergoing additional training. Whether this recognition of clinical training will continue is unclear, placing further pressure on recruitment and exacerbating shortages of health professionals.

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be used by GPs to raise concerns about such requests. Local prescribing support teams should also help to ensure safe practice.

Systems must be supportive rather than adversarial and should take into account increasing workloads and pressures on primary care and reduced budgets for secondary care. Electronic prescribing in shared systems might help. Avoiding harm and providing efficacious treatment is everyone's aim.

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## ALCOHOL INTERVENTIONS

**Encouraging results from Scotland**

McCambridge and Saitz do not mention the Scottish alcohol brief intervention programme in their otherwise authoritative review (Analysis, 4 February). In Scotland 569 792 brief interventions were delivered between 2008 and 2015, with an estimated 43% of potential beneficiaries being reached.

Encouragingly, some key health indicators have improved over that period, with alcohol related

mortality falling by approximately 30%. Estimating the programme's contribution to population health is difficult, but it is popular with practitioners and policy makers.

McCambridge and Saitz's paper was a carefully considered evaluation of a complex problem; the teaser on *The BMJ* cover—"Alcohol and brief interventions don't mix"—was not. The paper makes a strong case for improvement and evaluation, not for the abandonment of alcohol screening and brief intervention in general practice.

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## COLORECTAL CANCER

**Urgent improvements needed for Lynch syndrome**

NICE recommends testing for Lynch syndrome in all people newly diagnosed as having colorectal cancer (Seven days in medicine, 4 March). Several issues hinder good treatment of Lynch syndrome in the UK.

Current practice in diagnostic testing is variable.

Known carriers are inadequately managed, with poor awareness of the condition in the NHS. Patients are not seen quickly enough. Care is often not personalised or followed up adequately.

Management is often not consistent. Carriers require coordinated, timely, and good care to reduce their cancer risk.

We call for a national registry of people with Lynch syndrome; a quality assured colonoscopic surveillance programme for affected people; and a dedicated clinical champion for hereditary colorectal cancer in each multidisciplinary team to oversee local service delivery.

A multifaceted strategy is required to improve outcomes for people at high risk of colorectal cancer.

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