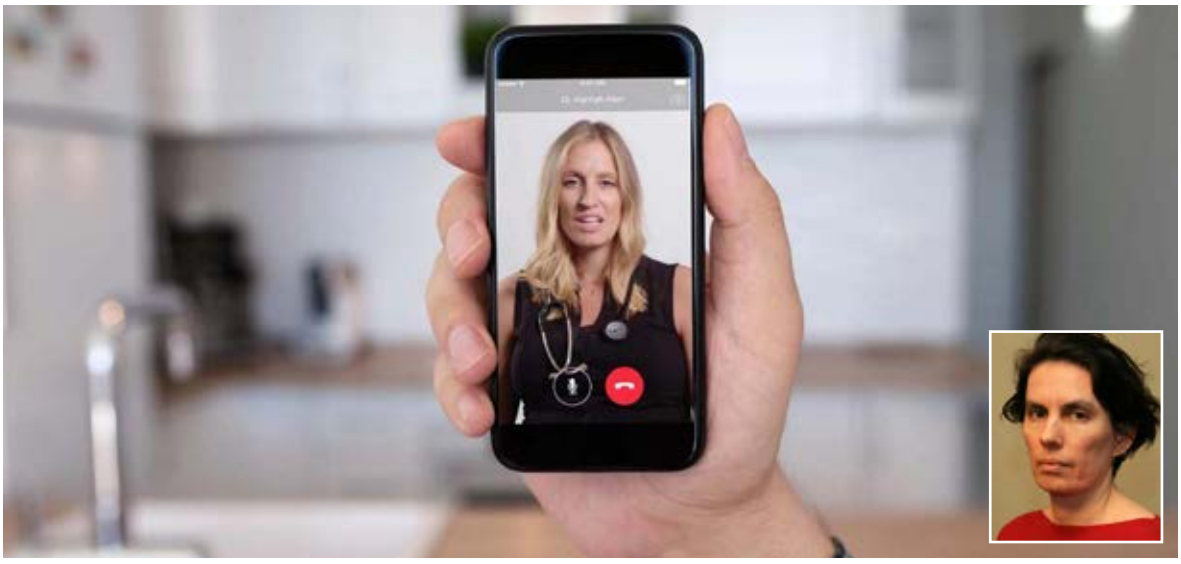
this week

WHATSAPP page 381 • **CARE MODEL** page 382 • **CONSULTANT CONTRACT** page 384



GPs warn against smartphone service

A GP practice has warned patients about the risks of joining GP at Hand, saying it could destabilise other services.

The online service, a partnership between Lillie Road Medical Centre in west London and the technology company Babylon, launched late last year and offers a mix of "virtual" GP consultations via smartphone and face-to-face appointments.

A post on the website of the Nightingale Practice in Hackney, east London, told patients on 1 March it had noticed that some had registered with GP at Hand, possibly not realising that this deregisters them from their local surgery. It goes on to warn that if too many patients leave it could "create a second class, low budget service for the most needy members of our community by diverting funding into a service which cherry picks young healthy patients."

It adds that the £87.53 received for every registered patient would transfer to the west London practice. To stay afloat, practices rely on retaining patients on their lists who rarely visit and it was these who were targeted by GP at Hand.

The practice said that GP at Hand patients who needed urgent appointments or home visits might be told to ring NHS 111 and could be directed to emergency departments as they no longer had a local surgery. "This puts inappropriate pressure on local emergency services," said the practice.

Sarah Williams, GP partner at the Nightingale Practice, said doctors were worried about the impact of GP at Hand on their incomes. She said it was unfair the smartphone service was able to exclude certain patients, because it was a fundamental principle of general practice that all patients, regardless of how potentially expensive they were to care for, were accepted.

In a letter to the Nightingale doctors, Matthew Noble, associate medical director of Babylon, said, "The truth is very far from your suggestion that GP at Hand, or indeed any practice, receives the same annual fee per registered patient. Global sum funding [the majority of the funding that NHS practices receive] is based on weighted list sizes. What this means is that there is a sixfold difference in global sum payment per patient because of age and sex alone, with 15 to 44 year old men attracting an average of £31 and women over 85 attracting £207."

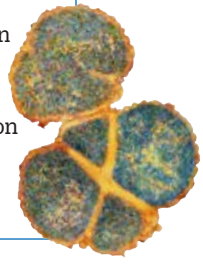
A City and Hackney CCG spokeswoman said the Nightingale Practice's statement was not part of a wider initiative.

Abi Rimmer, *The BMJ* **Cite this as: *BMJ* 2018;360:k1045**

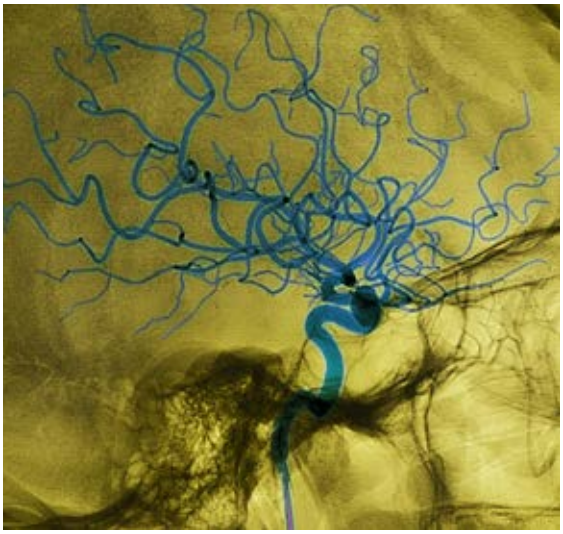
Sarah Williams (inset), of the Nightingale Practice, fears the GP at Hand service is unfair as it can cherry pick patients

LATEST ONLINE

- Patient safety would be undermined if manslaughter review hampers reflective practice
- Surgeon who shared his experiences of inappropriate behaviour escapes sanction
- Government proposal could make vaccination programmes harder to approve



SEVEN DAYS IN



SIMON FRASER/SPL

Vascular surgery network "would save lives"

More patients would receive urgent surgery sooner if a vascular networks model were to be implemented across England, according to a report from NHS Improvement's Getting It Right First Time (GIRFT) programme.

The model would save lives by reducing the likelihood of patients having life threatening strokes, transient ischaemic attacks, aortic aneurysm ruptures, and arterial blockages, said the report. Seventy NHS trusts conduct vascular surgery and many already collaborate within a local network. But there is no standard model.

A nationwide, vascular surgery "hub and spoke" network of specialist units treating every vascular surgery case as "urgent" could prevent more than 100 deaths and reduce disability by substantially reducing the risks associated with blocked arteries, the GIRFT analysis predicts. Fewer strokes and reduced emergency readmissions would save between £7.6m and £16m, said Mike Horrocks, professor of surgery at Bath University before his recent retirement, and author of the report.

Susan Hill, Royal College of Surgeons' vice president, said the Vascular Society had recommended such a reconfiguration for many years.

Ingrid Torjesen, London Cite this as: *BMJ* 2018;360:k993

Public attitudes

Satisfaction with NHS hits new low

The public's satisfaction with the NHS fell by six percentage points last year to 57%, the lowest since 2011, the British Social Attitudes survey has shown. At the same time, dissatisfaction grew to 29%, up from 22% in 2016. Dissatisfaction was driven largely by concerns over staff shortages, long waiting times, lack of funding, and government reforms. Satisfaction with GP services also slumped in 2017 to 65%, down from 72% in 2016, and the lowest rating since the survey began in 1983.

Acute care

Emergency admissions rose 24% in past decade

The National Audit Office found that emergency admissions to hospitals in England rose by 24% in the past 10 years, from 4.69 million in 2007-08 to 5.82 million in 2016-17. The average annual cost of dealing with such admissions was £13.7bn in 2015-16, around 10% of the entire annual NHS budget. The watchdog also reported a 12% rise in emergency admissions of people aged 65 or older in the past four years.

Public health

Inequality in life expectancy is widening

Differences in life expectancy in England between the most and least deprived groups are increasing, particularly among women, data analysed by the Office for National Statistics show. The ONS said that the findings indicated that people living in deprived areas were not sustaining the general reduction in mortality observed in the first decade of the 21st century. The ONS and Public Health England are investigating the more recent mortality rate pattern further, to clarify whether a substantive change has occurred since 2011.

NHS should help cut pollution, says CMO

England's chief medical officer urged the NHS to act as an example to the rest of the country by reducing its pollutant footprint. "We all know the environmental impacts of pollution, but what is less recognised is the impact on health," said Sally Davies (below), launching her latest annual report looking at the effects of air, light, noise, and chemical pollution on health. The report made 22 recommendations, including studying the long term effects of low levels of pollutant exposure.

Menthol tobacco ban is good for public health

A survey of 325 smokers of menthol cigarettes found that 40% tried to quit smoking and that 12% succeeded after Ontario banned menthol cigarettes on 1 January 2017. The quit attempt rate was much higher than the proportion (14.5%) of the smokers who predicted that they would try to quit before experiencing the ban, found a study in *JAMA Internal Medicine*. In addition, 29% of smokers reported using other flavoured tobacco or e-cigarette products after the ban, but only 6% predicted they would switch.

Confidentiality

Call to halt data disclosure to Home Office rejected

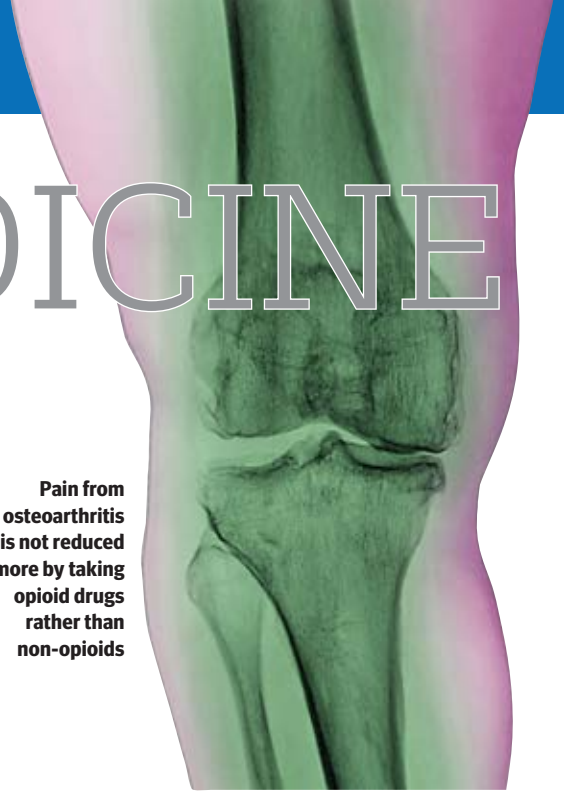
Government ministers have rejected calls from MPs to halt the disclosure of confidential NHS patient data to the Home Office so it can trace potential immigration offenders. John Chisholm, chair of the BMA's medical ethics committee, said the decision would have "dangerous repercussions" and damage trust between doctors and patients. "It's not only dangerous to deter patients from visiting a doctor for their own health but it could pose a wider public health risk," he said.

Workforce

Most juniors doctors take a break from training

Over half of junior doctors take a break during their training, a BMA survey found. The survey in autumn 2017 received 2164 responses. It found that 26% of respondents had taken a break to travel, 24% for maternity or paternity leave, 21% to work as a locum, and 19% to improve their health and wellbeing. Jeeves Wijesuriya, chair of the BMA's junior doctors committee, said it was vital that employers helped trainees return to work.

MEDICINE



Pain from osteoarthritis is not reduced more by taking opioid drugs rather than non-opioids

Research news

Opioids are no better for osteoarthritis pain

The results from a randomised controlled trial in 240 patients with chronic back pain or hip or knee osteoarthritis pain found that over 12 months opioids were no better than non-opioid drugs at reducing pain that interfered with activities such as walking, work, and sleep. The *JAMA* study found that pain intensity was lower in the non-opioid group and that drug related adverse symptoms were more common in the opioid group.

Compensation

Spire loses legal battle over Paterson insurance

Spire Healthcare, at whose private hospitals the rogue breast surgeon Ian Paterson carried out hundreds of botched or unnecessary operations, has lost a legal battle to force its

insurers to pay £20m towards the cost of compensating his victims. Spire agreed to contribute £26 950 000 to a £37m compensation fund covering private and NHS patients. Its insurance covered it against medical negligence claims up to £10m for any one claim, with an overall limit of £20m. But the Court of Appeal has ruled that all the claims arising from Paterson's actions constituted a single claim, limiting the insurers' liability to £10m.

Screening

PSA test doesn't reduce prostate cancer deaths

Results of a trial published in *JAMA* that included more than 400 000 men from the UK showed that a one-off prostate specific antigen test does not save lives. Lead author Richard Martin said, "The results highlight the multitude of issues the PSA test raises, causing unnecessary anxiety and treatment by diagnosing prostate cancer in men who would never have been affected by it and failing to detect dangerous prostate cancers." While the UK has no screening programme for prostate cancer, men aged over 50 can ask their GP for a PSA test. This advice should be updated, said the researchers.

Epilepsy

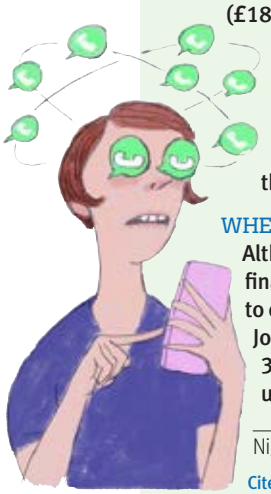
Cannabis compound may help curb seizures

Researchers have said that cannabidiol may help to reduce seizures in children with drug resistant epilepsy. Pooled data from 17 observational studies showed that seizure frequency fell by at least 50% in just under half of the patients and disappeared in nearly one in 10 (8.5%) in eight of the studies. Half the patients in 12 studies experienced improved quality of life, the researchers reported in the *Journal of Neurology Neurosurgery and Psychiatry*.

Cite this as: *BMJ* 2018;360:k1059

FGM

Between October and December last year **1760** women and girls in England attended the NHS where female genital mutilation (FGM) was identified or treated, **1030** of them for the first time. *[NHS Digital]*



SIXTY SECONDS ON . . . WHATSAPP

OOH! I LOVE WHATSAPP

You're not alone. A recent survey showed around a third of UK clinicians use WhatsApp or a similar messaging tool. It is free and offers "a simple, secure, reliable messaging and calling service," say its owners, Facebook. But you're going to have to learn to unlove it.

WHATSUP?

On 25 May, the EU General Data Protection Regulation will come into force. It's a complex set of rules designed to give back control of personal data to residents. Despite approaching Brexit, the UK will enforce it.

HOW DOES IT AFFECT WHATSAPP?

Lots of ways. The most obvious is that any information on WhatsApp is shared with Facebook, which is against the rules. After an outcry, the app agreed to stop sharing EU users' data for the time being, but has failed to come up with a longer term way of legitimising sharing under the regulation.

AND DOCTORS?

Until and unless WhatsApp and Facebook can satisfy the regulations, it's clearly inappropriate for doctors to share any clinical information using the service.

ARE THERE ANY ALTERNATIVES?

Lots, but none that stands out as the market leader. Careflow Connect, Medic Bleep, MedCrowd, Silo, Hospify, Streams, and Forward are contenders. A guide is being prepared by Mona Johnson of NHS England.

COULD DOCTORS END UP IN COURT?

The regulation is written with organisations, not individuals, in mind. Hospitals, in their role as employers, are more likely to be hit, not with jail but big fines—up to €20m (£18m). That will be an incentive for them to ensure doctors are compliant. Trusts will also be obliged to give data to patients who ask for them, another reason for taking care to know where they are stored.

WHERE CAN I GET ADVICE?

Although the regulation was finalised two years ago, clear advice to doctors is scant, says Bernardette John in a *BMJ* editorial (see page 389). But 25 May is close, so it's urgently needed.

Nigel Hawkes, London

Cite this as: *BMJ* 2018;360:k1041

Medical model of care "needs updating to tackle inequality"

"We need to embed health trainers, community health workers, and others in primary care" Jonathon Tomlinson, GP

The NHS should shift its focus away from the medical model of care and place more emphasis on tackling social determinants of health, a panel of experts has said.

An overemphasis on medical care would not defeat "the five giants" of want, disease, ignorance, squalor, and idleness that the NHS and the welfare state were founded to tackle, said speakers at the 2018 Nuffield Trust Health Policy Summit on 1 March.

The panel—Jonathon Tomlinson, an inner London GP, Nick Timmins, senior associate at the Nuffield Trust, and Clare Tickell, chief executive of Hanover Housing Association—urged the NHS to engage more with other agencies to tackle problems such as childhood poverty and poor living conditions.

Tomlinson, who practises in Hackney, east London, said that doctors working in deprived areas saw lots of chronic pain, depression, and anxiety among their patients. In his experience, these were largely driven by social not medical factors.

He said that enactment of Michael Marmot's principles for tackling health inequalities, including heavy investment in early years and tackling childhood poverty, would make the biggest difference to improving people's health and wellbeing.

Misdiagnoses on a massive scale

He added, "We need to confront this diagnostic problem of seeing every symptom as a medical problem and embed health trainers, community health workers, and others in primary care so we're not making misdiagnoses on a massive scale. And we need to keep lines of communication open between people doing different things, as we've all got interesting perspectives of the same problems."

Speaking from the floor, Martin Marshall, vice chair of the Royal College of General Practitioners, backed Tomlinson. "Leaders [from the Academy of Medical Royal Colleges] are getting together to challenge the deficiencies that are inherent in the medical model, around overdiagnosis, overtreatment, wasteful use of resources," he said. "The medical model is so dominant, so seductive, that unless we challenge it in a very

Industry must "cut calories in savoury food by 20% to tackle childhood obesity"

Public Health England has challenged manufacturers and restaurants to reduce the calorie content of food that contributes significantly to children's energy intake by 20% by 2024. It said that meeting the target would save the NHS £4.5bn and social care £4.48bn.

PHE's programme, announced on 6 March, part of the government's childhood obesity strategy, aims to cut calories in foods that are not already covered by the sugar limits imposed in 2016. Products covered include pizza, ready meals, readymade sandwiches, processed meat products, and savoury snacks.

Alison Tedstone, PHE's chief nutritionist, said, "We know that we need to get to these foods because they are the lion's share of [children's intake of] calories. Sugar was a way in, but we need [to tackle these foods] to start getting traction on childhood obesity." She added that not just children would benefit from the programme. "It will help the whole family: you don't have a special pizza for your kids."

She added, "This is not about healthy options. A few healthy options will not help to solve the nation's obesity problem. We need the regular everyday products to change," she said.

Tedstone also announced that PHE was for the first time publishing estimates of the excess calories children were consuming. These showed that overweight and obese children were consuming up to 500 more kilocalories a day than needed.

PHE has also launched a campaign to encourage adults to consume no more than 400 kilocalories at breakfast and 600 kilocalories at lunch and dinner. "This is not replacing official guidance," Tedston said. "This is a handy rule of thumb. It's about having one number in your head when you go and buy a sandwich at lunchtime."

MEETING the target would save the NHS **£4.5bn** and social care £4.48bn

Wider package

Russell Viner, of the Royal College of Paediatrics and Child Health, said that PHE was right to challenge the food industry, but added that the new measures had to be part of a wider package that included "early education on the importance of a balanced diet, encouraging children and young people to exercise regularly, preventing new fast food shops near schools, and a ban on junk food advertising before 9 pm."

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2018;360:k1067

PHOTOFUSION/REX/SHUTTERSTOCK

concerted way, we're not going to be able to develop an alternative."

Tickell urged NHS leaders to involve housing associations more in decision making. She said that colleagues in the housing sector had "found it almost impossible to talk to people in health" when trying to influence policies such as the design of healthy new towns.

Timmins, who presented a brief history of the welfare state with reference to his book, *The Five Giants*, said that NHS founder Nye Bevan was minister for both health and housing when he introduced the welfare state. "Bevan was rock solid about the importance of housing," said Timmins. "That clearly got lost down the years."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2018;360:k1034

Colleges create new standards to improve medical registrar role

The three UK colleges of physicians have introduced a set of criteria to improve the working lives of medical registrars.

The role has long been perceived as one of the most difficult in hospitals because of the level of responsibility for managing acute patients, especially at nights and weekends. In light of these concerns, plus rota gaps and falling recruitment, the Joint Royal Colleges of Physicians Training Board (JRCPTB) has launched a set of 20 quality criteria aimed at improving the role.

Private workstations

The criteria, which cover general internal medicine registrars and acute internal medicine registrars, set out standards that the colleges expect hospitals to meet. They include ensuring that trainees have easy access to private workstations, appropriate rest periods, and access to food and drink facilities.

David Black, medical director of the joint board, said, "We know that coming into the medical registrar job is tough and it can be extremely challenging.

"But there is more that hospitals can do to support their medical registrars and the feedback we get is that if you have a supportive clinical, educational, and functional environment, people will cope better with these difficult jobs.

"If every hospital pursued this, they would make the working lives of medical registrars better."

Black said that other stakeholders included NHS Employers, NHS Improvement, NHS England, and UK education providers. "I think this shows that the people at the top of those organisations realise how important it is to get it right for the medical registrar," he said.

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2018;360:k1010

FIVE MINUTES WITH . . .

Alice Hartley

The urology trainee talks about the Royal College of Surgeons of Edinburgh's anti-bullying campaign

"In 2014 the GMC's trainee survey highlighted that surgery was one of the worst specialties for bullying. The Royal College Surgeons of Edinburgh formed a working group to look at how prevalent it was. It realised that bullying extended beyond trainees: it was a problem for staff grade doctors and consultants as well.

"Then, in 2015, a membership survey found that almost 40% of respondents had been victims of bullying in their career. As a result, in 2016 I was asked to chair the #LetsRemoveIt campaign against bullying and undermining.

Undermining behaviour

"One of the problems with bullying in the NHS is that a lot of people don't even realise that they're being bullied—they just think this is what happens in the healthcare environment. Although outright bullying, such as throwing instruments in theatre, does still happen, it's a lot rarer. Undermining behaviour is more common and more subtle: it can be little digs at people or corridor conversations.

"Because bullying doesn't just happen in the classic 'consultant surgeon bullying trainees' scenario, it can affect everyone. Our website has a lot of case studies, and we list the definitions of bullying, harassment, and undermining.

"We also have a section called 'Are you a bully?' which has been one of the most popular sections. What we're trying to say is that, while there will be some cases of very severe bullying, overall we're probably all guilty of it to some extent because the behaviour is so institutionalised.

A LOT OF PEOPLE DON'T REALISE THEY'RE BEING BULLIED—THEY THINK THIS IS WHAT HAPPENS IN HEALTHCARE

"We also have presentations that people can download to give at their hospitals, and an e-module that can be used for free. There's also a one day workshop that can be delivered locally.

"The next stage of our work will be to get our resources to chief executives, HR managers, and medical directors. Unless it comes from them, this isn't going to work."

Alice Hartley is a urology registrar at City Hospitals Sunderland NHS Foundation Trust

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2018;360:k1035

Anaesthetist wins disciplinary injunction as police investigate deaths of patients

Police and the General Medical Council are investigating a consultant anaesthetist on suspicion of having inappropriately hastened the deaths of several patients.

Andrew Gregg, a consultant with North West Anglia NHS Foundation Trust, was originally investigated over the death in Peterborough City Hospital

SHUTTERSTOCK/REX

(below) of a 41 year old man with acute myeloid leukaemia. "Patient A" died in January 2016 two hours after doses of sedative and analgesia were increased.

"Death inappropriately hastened"

The trust excluded Gregg from work and notified police after a trust investigation concluded there was a case to answer that the death had been inappropriately hastened. The police investigation, completed in November 2016, agreed, but the Crown Prosecution Service (CPS) decided there was not enough evidence for a prosecution.

The trust then became aware of another case of a patient who came into Gregg's care after a heart attack in 2013. Patient B

The trust identified 17 other cases of concern

was sedated and died within 4.5 hours. After Gregg's arrest in March 2017, the trust reviewed his cases over an eight year period and identified 17 other cases of concern. Five of these are under police investigation.

The police inquiries came to light after Gregg, who denies all the allegations, won a High Court injunction stopping the trust from launching disciplinary proceedings over the deaths of Patients A and B before the CPS decides whether to charge him over Patient B's death. A decision is not expected before June.

In July 2017 Gregg's solicitors told the trust that he would put himself in a "most invidious and potentially highly prejudicial position" if he were asked in the disciplinary proceedings to comment on his management of Patient B when he could still face criminal proceedings. When the trust decided not to adjourn the disciplinary proceedings, Gregg applied to the High Court. The judge, Justine Thornton QC, granted the injunction.

In a statement Gregg said, "I am grateful to the Medical Protection Society for securing this outcome, which ensures my position is maintained and my rights protected pending investigations which quite properly are being carried out."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2018;360:k1042

NEWS ANALYSIS

Good intentions gone bad: the disappointments of NIHR

Big pharma broke its promise to bolster medical research in the UK, reports **Nigel Hawkes**

David Cooksey: "I'm horrified at what's going on" with drugs prices

John Pattison: "The objective was to help pharma to stay in the UK"

Drug companies have failed to keep their side of the bargain struck in the ambitious UK biosciences strategy, says its principal author, David Cooksey.

Speaking at a seminar about medical research in the UK and the 2006 creation of the National Institute for Health Research (NIHR), he said that he was "hugely disappointed" by what had happened since the strategy was published in 2003 by the Biosciences Industry Growth Taskforce, which he chaired. The aim of the report was to make the UK a better place for innovation in the biosciences, and the report had strong industry involvement.

"During the gestation of the report I had a huge come-on from the pharmaceutical companies for what I was trying to do," Cooksey said. "But they have largely removed themselves from basic research. To me, that is a huge disappointment.

"AstraZeneca now has only 7500 people working in the UK; Pfizer has closed the Sandwich laboratory; and Roche, who promised Gordon Brown [then chancellor] that they would put 30% of their research into the UK, didn't." He was also strongly critical of the industry's pricing policies.

Generating UK growth

Cooksey, a venture capitalist, has championed efforts to improve relations between the NHS and the industry since Brown identified bioscience as one of the UK's best chances of generating income and growth.

John Pattison, former director of research and development at the Department of Health, said, "The whole objective was to help pharma to stay in the UK. But you couldn't have a working party called 'Helping Pharma to Stay in the UK'—so we came up with the Bioscience Industry Taskforce."

The implicit deal was that the research capability of the NHS would be improved as well as its ability to conduct clinical trials, while the industry did its part by sustaining and growing its own research.

The meeting, at the London offices of the University of Liverpool, was designed to elicit the history of the NIHR's creation from those directly involved. Sally Davies, chief scientific adviser to the health department from 2004 to 2016, largely credited Cooksey's second report, a 2006 review of health research funding, for establishing a budget for the NIHR, now £1bn a year and Europe's largest national research funder.

But the organisation had not been

New consultant contract "needs more flexibility to attract young doctors"

The new consultants' contract should include flexibilities to boost morale and retention of young doctors, including options for sabbaticals and extra annual leave, a senior medical leader has argued.

Clifford Mann (right), clinical adviser to NHS England's accident and emergency improvement plan, said the contract is a chance to re-engage demotivated staff. "Why don't we give the profession the signals within the contract that people are taking the issues we've been talking about seriously?" Mann, a former president of the Royal College of Emergency Medicine, asked at a meeting hosted by *The BMJ* at the Nuffield Trust's Health Policy Summit on 2 March, which focused on how the NHS could become a "millennial friendly" employer.

"A sabbatical re-energises the individual, re-energises your department"

The BMA has been in negotiations with the government about a new consultant contract since 2013.

New approaches

Mann said many countries, including Australia, New Zealand, Canada, and even Wales, had contracts that enabled doctors to take sabbaticals or long service study leave. "It re-energises the individual, re-energises your department. So why don't we do it?"

Mann also argued that having a contract that offered a pro rata uplift to annual leave depending on how many extra evenings, nights, and weekends were worked would help to improve work-life balance. He told the meeting, "If you can't put anything in the new consultant contract—which is what the current generation of trainees will be on within five years—then you will be sending a very negative message that you have failed to listen to the concerns around this table and the wider NHS staff groups, and that would be a massive opportunity missed."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2018;360:k1052

Listen to the roundtable debate in the podcast on bmj.com

created without a battle, she said. Opposition had come from hospitals, which feared the loss of research money, while the Medical Research Council was wary of being sidelined.

Keith Peters, president of the Academy of Medical Sciences from 2002 to 2006, recalled a meeting held before NIHR was fully established. "People there said it wouldn't know how to do a clinical trial and the money should go to the Medical Research Council," he said. "We all thought you were wrong. Well, we were wrong and you were right."

Davies said that if the power players, mainly men, had been challenged head-on, [NIHR} would not have worked. "We never said we were driving a massive change," she said, agreeing she had operated "under the radar."

Parts of the NHS had also opposed the NIHR, said Brian Edwards, a regional NHS manager at the time. The separate regions of the NHS had previously controlled their own research funds and thought that it would be a loss of autonomy to have to apply for money from the centre. "People used to spending their own money weren't necessarily happy," he said. "But those that were good at research did well."

Review of drugs pricing

Cooksey said drug prices were not acceptable, accusing companies of "pumping up" the costs of phase III trials to justify price increases. "I'm horrified at what's going on," he said. "It's not the regulators who are driving up drug prices, it's the pharmaceutical companies." A review of the system, including the role of patents, was needed, he said.

He said that the Dementia Discovery Fund, launched in 2015 by the then prime minister David Cameron to create new dementia drugs, was due to announce its closure shortly, having raised £250m. Most of the money had been raised by venture capital. But Peters questioned the fund's likely effectiveness, "I feel it's a mistake," said Peters. "Dementia research hasn't delivered, and the problem is a shortage of good ideas. Top-down initiatives won't solve that."

While the seminar was not about what the NIHR should do in the future and none of the current leadership was present, Davies said it should not become an independent organisation. "If it were outside the health department, ministers would no longer have any ownership of it. Inside, it listens to ministers. It's worth doing that because of the support they give to the budget," she said.

Pattison gave an example. When it emerged that the NHS was spending only £80 000 a year on prostate cancer research he received a call from Yvette Cooper, then junior minister of health at the office of Alan Milburn, the health secretary. Pattison recalled: "She said, 'Can you find £1m to put into prostate cancer research? If you can, Alan and I will support an extra £5m for your budget at the next review.'"

"Dementia research hasn't delivered. The problem is a shortage of good ideas. Top-down initiatives won't solve that"
Keith Peters

Nigel Hawkes, London

Cite this as: *BMJ* 2018;360:k1021

DOUGLAS MILLER/GETTY IMAGES

THE BIG PICTURE

Hero's return

Roger Bannister is cheered by fellow trainees at St Mary's Hospital in Paddington, on 7 May 1954—the day after becoming the first man to run a mile in under four minutes.

It's an image that combines both lives of the world beating athlete, who later became a renowned neurologist and who died last week, aged 88.

As a medical student at Oxford University, Bannister used his medical knowledge to devise his own training regime and investigate the mechanical aspects of running. His dedication bore fruit when on an Oxford sports field he ran a mile in 3 minutes 59.4 seconds, beating rivals from Australia and the US to the long coveted achievement.

However, in many interviews since that auspicious day, he said his athletic track record paled into insignificance for him when he finally fulfilled his ambition to qualify as a doctor.

Over the years, he discovered his particular research interest and expertise was in the autonomic nervous system, founding the Autonomic Research Society, and becoming editor of *Autonomic Failure: A Textbook of Clinical Disorders of the Autonomic Nervous System*.

Nearly 10 years after his retirement in 1993, Sir Roger, as he had become, was given a diagnosis of Parkinson's disease. He told BBC Radio Oxford: "I have seen, and looked after, patients with so many neurological and other disorders that I am not surprised I have acquired an illness. It's in the nature of things, there's a gentle irony to it.

"Just consider the alternatives—that is the way I look at it. One of my pleasures in life, apart from running, has been walking. Intellectually I am not [degenerating] and what is walking anyway?"

Alison Shepherd, *The BMJ* **Cite this as: *BMJ* 2018;360:k1080**

Reactions to the Hadiza Bawa-Garba case

Readers around the world express their concerns

Since November, the *BMJ* has received more than 120 responses to our coverage of the Hazida Bawa-Garba case—our most popular research papers attract about 15. Although most came from the UK, the case has drawn comments from doctors worldwide including those in Australia, Egypt, France, India, and New Zealand. They are predominantly medical professionals, with journalist Nick Ross, and his three high profile contributions, a notable exception.

Almost all rallied behind Bawa-Garba, while expressing compassion for Jack Adcock's bereaved parents. Supporters with personal knowledge were Lyvia Dabydeen, consultant paediatric neurologist, who worked with Bawa-Garba at Leicester Royal Infirmary; Martin P Samuels, consultant paediatrician at Royal Stoke University Hospital and Great Ormond Street Hospital, who acted as a defence expert in the criminal trial; and Jonathan Cusack, consultant at Leicester and Bawa-Garba's clinical and educational supervisor, who gave evidence to the Medical Practitioners Tribunal Service.

Themes that came up repeatedly included possible racial bias, Islamophobia, and misogyny;

"The use of a doctor's e-portfolio to condemn her sends an unequivocal message to doctors: Lie"

RICHARD H SMITH

Protest outside the GMC building

egregious examples of "far worse" doctors who are still practising; and frank admissions by doctors of their own mistakes leading to patient death. Christoph Lees, an obstetrician from Imperial College London, wrote: "What is missing is an understanding that doctors who make mistakes are almost always doing so in an effort to 'do the right thing' and are very rarely acting deliberately recklessly, and an empathy that the consequences of a severe adverse outcome may spell the end of a career or lead to a permanent and deleterious change in practice."

Written reflections

A few readers were concerned and surprised that the BMA had, at the time of writing, not publicly expressed a view on the GMC's actions. The BMA has since done so. Many were worried about the use of Bawa-Garba's written reflections in the trial—as Margaret McCartney wrote in a response to her own *BMJ* article: "More broadly, recorded reflections (such as e-portfolios) are not subject to legal privilege under UK criminal law. As a result, these documents might be requested by a court if it is considered that they are relevant to the matters to be determined in the case."[1]

Johan M van Schalkwyk, perioperative physician at Auckland City Hospital, concluded: "The message is this: Lie. Unless you are certain that your e-portfolio is completely protected against legal might, this is your only sensible recourse. Lie with enthusiasm. Lie constructively. Lie consistently. Lie even to yourself." As Clare Dyer and Deborah Cohen explain in a feature (see bmj.com), Bawa-Garba's reflections "did not actually go on to form part of the evidence before the court and jury." Respondents to ethicist-barrister Daniel Sokol's *BMJ* column largely agreed that coaching may be more helpful than written reflections for improving performance.[2]

Systemic failures were a great cause for concern, as was the question of what doctors should do when faced with an unsafe working environment. But the GMC was the main target of criticism; some called for a full investigation into its functioning. Retired physician, writer, and broadcaster Michael O'Donnell shared his insider knowledge of the organisation and questioned its fitness for purpose. A much expressed view was that the GMC has dealt a blow to doctors' duty of candour and patient safety and may have lost the profession's trust.

Jonathan Coates, a GP in Newcastle, wrote: "Instead of placing the blame with those ultimately responsible for these systemic failings, this appeal seems to vindictively target the individual clinician who happened to be the last link in the chain. For the tabloid press to do this is bad enough, but the GMC?"

Abandoned. shafted, tormented

Nick Ross made a further request of the GMC: "Since neither Bawa-Garba's consultant nor her NHS trust were on trial, their roles largely slipped into the shadows. To put it bluntly (forgive me, but I am a journalist at heart): she was abandoned by her consultant, shafted by her employer, tormented by the courts, and finally persecuted and made unemployable by you. I wonder if you looked behind the court decision at the staffing levels and the workload on that fateful day—an absent consultant, a woeful shortage of trained nurses, no rest break, and so on—and whether you would consider them to be prudent and acceptable. If so, perhaps you would be kind enough to publish them so that we can all see what the GMC regards as a safe working environment."

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Cite this as: *BMJ* 2018;360:k1031

EDITORIAL

Are you—and your devices—ready for the General Data Protection Regulation?

Doctors urgently need guidance, training, and fully compliant channels for sharing sensitive data

Often described as the most important development in data privacy regulation for 20 years, the General Data Protection Regulation (GDPR) is intended to strengthen data security for individuals.[1] It will be implemented across Europe from 25 May. With violations set to generate fines for organisations of up to 4% of annual turnover or €20m (£18m), whichever is greater, the GDPR is not something doctors or the NHS can afford to ignore.

Patients will be able to request access to, location of, amendment to, and erasure of their data. Transparency and accountability are vital if compliance is to be achieved. Adherence to guidance from the UK's Information Commissioner's Office (ICO), NHS, and regulatory and professional bodies is essential. However, such guidance has been slow to materialise and has so far failed to provide clear recommendations, meaningful training, or signposting to GDPR compliant solutions for health professionals in the front line.

Sensitive data

Doctors already use smartphone apps for clinical communications[2-6]—and everything from online calendars to Dropbox, Google Drive, and PDF creator apps. With data in so many locations it will be difficult for trusts to identify where information is stored when faced with a patient's "subject access request." Another concern is that many apps have the right to access all data on users' devices.[7] All such data on a clinicians' device are potentially sensitive.

WhatsApp (owned by Facebook) is facing a pan-European investigation regarding its failure adequately to address concerns about sharing user data across Facebook companies.[8 9] It is clearly not an appropriate channel for sensitive clinical communications. Doctors and other health professionals should stop using WhatsApp immediately for any communications with clinical content.

Guidance on the use of instant messaging in clinical settings from NHS England states that clinicians may be required to defend themselves against regulatory investigation and sanctions if insufficient steps are taken to safeguard patient confidentiality.[10] But the practicalities of working within GDPR are not usefully explored, and no compliant solutions are suggested, even though several exist. Indeed, the guidance observes, "instant messaging can have clinical utility," and the advice to "review links to other apps that may be included with the Instant Messaging software and consider whether they are best switched off"[10] is not possible in relation to links between WhatsApp and Facebook.

Future device owners

Also missing is the basic advice—that all devices used to access or discuss patient identifiable data using apps must have all clinical data erased permanently before discarding, selling, or trading-in. Concerns regarding the threats posed to patient data by the use of an app that does not conform to the required "Advanced Encryption Standard 256-bit (AES-256)"[10] pale into insignificance next to the prospect of any future owner of a device accessing the previous owner's gallery of clinical images.

Anonymisation of clinical digital images is more complex than simply cropping a photo and deleting or omitting the name or patient number. Digital photos have supplementary records embedded, including the date, time, and geographical coordinates of the image, and the make and model of the device used to take them.

Jobbing clinicians are not using popular apps for communication and collaboration because they no longer care about confidentiality. Many have simply not processed the genuine risks and implications and remain unaware of alternative GDPR compliant corporate solutions. These include Forward, Careflow Connect, Hospify, Med Crowd, MedicBleep, Siilo, and Cupris.[11] Clinicians are unclear about what they should do or why they must take great care around the selection of apps and other technical solutions they bring to work. Compliant channels for communication and collaboration are an urgent priority if the NHS is to be ready for GDPR in May.

To mitigate imminent risks the NHS's top priority must be to direct all healthcare workers to appropriate, "approved," GDPR compliant solutions for clinical communications, collaboration, and the processing of patient data through their digital devices. Practical, meaningful training is essential to ensure clinicians can identify risks and make informed choices and regular, concise, technical updates or briefings are also essential.

Clinicians must lobby NHS information governance leaders now to ensure that working requirements for data sharing and collaboration are met in a way that protects patients, promotes safe care, and complies fully with the GDPR. And before May.

Doctors should stop using WhatsApp immediately for any communication with clinical content

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Cite this as: *BMJ* 2018;360:k941

Find the full version with references at http://dx.doi.org/10.1136/bmj.k941

The managers tackling the GP recruitment crisis through local campaigns

Anne Gulland looks at three initiatives aiming to beat the national shortage of general practitioners

General practices face an increasing challenge in their struggle to recruit doctors. Last year the Public Accounts Committee reported that, despite the government's aim to recruit 5000 extra GPs by 2021, the number working in England had actually fallen.

These national workforce gaps have led to some imaginative local thinking about ways to attract new staff.

When Lincolnshire Local Medical Committee produced a series of targeted advertisements to drive up GP recruitment in the area, its medical director, Kieran Sharrock, was keen to focus on the county as a great place to live rather than just on jobs. "When you're talking about general practice, where the job is quite similar wherever you work, you have to really sell the lifestyle," he says.

The campaign focused on issues such as housing and schools. "I speak to doctors and ask them what they could get for £300 000," he says. "Here in Lincolnshire you can get a four bedroom house. And the schools are excellent."

Brand awareness

Like Lincolnshire, Northamptonshire also suffers from a lack of brand awareness, as marketing professionals might say.

The county's three acute trusts have joined forces to deliver a joint recruitment campaign, alongside St Andrew's Healthcare, a mental healthcare charity, and the University of Northampton.

Angela Hillery, chief executive of Northamptonshire Healthcare NHS Foundation Trust, says, "In terms of recruitment we are all up against the same issues and fishing from the same pool so we decided to put in a collective effort."

As in Lincolnshire, the campaign focuses on both work and lifestyle, highlighting hospitals as well as attractive countryside and affordable housing. It focuses in particular on recruitment pinch points, such as older adult services, psychiatry, and emergency medicine.

Alexander O'Neill-Kerr, psychiatrist and medical director at Hillery's trust, says that the county is just "the place you pass through on your way to London" and suffers as trainees tend to gravitate towards the capital. To tackle this, the county has sought to develop general practice placements that offer more varied career paths. "We're working with Leicester University to offer a new type of community placement that will allow people to move from a general practice to a community mental health team to palliative care and get a rounded experience of working in the community," he says.

Showcasing innovation

Sunderland GP Alliance, a federation that covers 40 practices, is also running a recruitment campaign. "We're about 20 to 30 GPs short across the city," says chief executive, Jon Twelves. "If we can make a dent in that and fill one or two vacancies that have been running for a considerable amount of time that will be good."

One of the campaign's key elements is showcasing the innovative work of the federation, which is one of NHS England's multispecialty community provider vanguards.

The federation has also adopted several other initiatives designed to make Sunderland attractive to GPs. It is running a golden hello scheme in which 20 GPs will each receive £20 000 for taking up new positions.

It has also introduced a career start scheme aimed at GPs up to two years after qualification. The scheme provides a training budget and up to two paid sessions a week to pursue specialist interests or leadership. New GPs also have dedicated time for support from their host practice for case review and audits. "It's an excellent way for new GPs to transition into full time employment," Twelves says, "and has led to the appointment of 16 GPs in the past two years or so, a significant number in the context of our patch."

However, Twelves says that, even if this local campaign is a success, the underlying recruitment problems facing general practice will not go away. "The problem fundamentally is a structural one," he says. "There aren't enough people being trained as GPs. It's my role to help solve the problems in Sunderland. I don't have the power to solve problems nationally."

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Cite this as: *BMJ* 2018;360:k991

MEDICINE AND THE MEDIA

A million more happy pills

Given the news reports, you might think the *Lancet*'s recent study was the last word on drug treatment for depression, but **Kate Adlington** finds that the debate is far from over

"Pop more happy pills," said the *Sun*'s front page on 22 February. It referred to the first major network meta-analysis comparing 21 antidepressants for acute depression in adults, published in the *Lancet*. All were found to be more effective than placebo for short term treatment.

"Antidepressants: major study finds they work," said the BBC. "The drugs do work: antidepressants are effective, study shows," announced Sarah Boseley in the *Guardian*, in contrast to her coverage of a previous meta-analysis almost a decade ago: "Prozac, used by 40m people, does not work say scientists."

Many news outlets called for more prescribing: "Antidepressants should be given to a million more Britons," instructed the *Telegraph*. But what about overtreatment, let alone the practical and financial implications?

Prescribing practice

More importantly, what about the evidence? The study did not consider prescribing practice; neither did it mention a million untreated people. In fact, the paper's coauthor John Geddes had mentioned this figure in an interview with the *Guardian*: "It is likely that at least one million more people per year [in the UK] should have access to effective treatment for depression, either drugs or psychotherapy." The headlines missed his nuance, and the legitimacy of his numbers has been questioned.

Press coverage was rich in generalisation, despite the limitations given in the *Lancet*'s press release. The *Sun* said that "pills were up to 113 per cent more likely to tackle depression than no treatment at all"—but only amitriptyline had the highest odds ratio of 2.13. And few news reports differentiated mild depression from the more severe symptoms of most study participants.

Largely they also omitted to mention the small effect sizes, side effects, the predominance of pharma sponsored trials, or other treatment options such as psychotherapy or cognitive behavioural therapy.

The *Daily Mail* later devoted two pages to caution. James Davies, a member of the Council for Evidence-based Psychiatry which publicises the risks of psychiatric drugs, emphasised that the average length of prescription for people taking antidepressants is much longer than the two month courses studied.

Professional endorsement

The study finding morphed into a media message that all antidepressants are effective in all depression. Nonetheless, the psychiatric and research communities seemed cautiously to confirm that the positive media coverage was justified.

Carmine Pariante, for the Royal College of Psychiatrists, decreed, "This meta-analysis finally puts to bed the controversy on antidepressants." Results from many previous antidepressant studies have been scattered and inconsistent (an "evidence myth constructed from a thousand randomised trials").

The network meta-analysis made the largest amount of published and unpublished data to date available for scrutiny. Allan Young, psychiatry professor at King's College London, is on balance confident about the findings. "Network meta-analyses are now widely accepted but depend on the data put in," he told *The BMJ*. "This study used a large amount of high quality data so it can be trusted."

Practical advice came from Helen Stokes-Lampard, chair of the Royal College of General Practitioners: "Although antidepressants are of proven benefit—as this study shows—no doctor wants their patients to become reliant on medication; so, where possible, GPs will explore alternative treatments, such as talking therapies or CBT." But given long waiting times for NHS psychological and mental health services, antidepressants could help in the short term.

> Many people dispute that depression can be treated with drugs rather than by resolving underlying social determinants

Ideological debate

The ideological debate about the use of antidepressants has long been fervent and polarised. Many people, including some psychiatrists, dispute that depression can be treated with drugs rather than by resolving underlying social determinants. Few declare their financial or ideological interests when commenting on research. It is unlikely that any study will settle the matter for these opponents; the London consultant psychiatrist Derek Summerfield suggests (see p 400) that doctors prescribe antidepressants "by reflex" when they can't help a patient's "social predicament."

The study may well move the debate forward for patients. The hashtags #medsworkedforme and #medsdidntworkforme were trending soon after publication. Geddes and Andrea Cipriani, another of the authors, told *The BMJ*, "Perhaps the most striking media outcome for all of us was the Twitter conversation. This seemed to reflect the true lived experience of people with depression and we find the tweets both humbling and moving. A step forward to fight stigma in mental health."

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Cite this as: *BMJ* 2018;360:k1069

HEAD TO HEAD

Should we recommend acupuncture for pain?

yes

The effects represent important improvements in quality of life over usual care, and with minimal risk

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Guidelines in most developed countries recommend acupuncture for treating pain. The UK is an exception, with only Scotland recommending it for chronic pain.

In the US, acupuncture is recommended for back pain, but in the UK it is no longer included in NICE guidelines for low back pain. The 2009 guideline on early management (CG88) was the first to recommend acupuncture, but it was removed in the controversial 2016 update.

Acupuncture remains in the NICE guideline on headaches, and is the only treatment recommended for prophylaxis of chronic tension type headache. Curiously, this guideline calculates that the anticonvulsant topiramate is twice as good as acupuncture in preventing migraine, even though direct comparisons with drugs favour acupuncture.

Sham acupuncture

The approach adopted by NICE compares the benefit of acupuncture over sham acupuncture, with the benefit of topiramate over a placebo, rather than directly comparing acupuncture with topiramate.

This approach assumes that sham acupuncture has no effect beyond an inert pill; however, a large meta-analysis on the differential effects of placebo treatments (in headache) shows that sham acupuncture (and sham surgery) are associated with higher response rates than oral placebos. So the baseline used for these comparisons is uneven. This explains why the NICE guideline on headaches recommends drugs before acupuncture in prophylaxis of migraine whereas the Cochrane review reports acupuncture is better (immediately after a course of treatment).

The biggest and most robust dataset for acupuncture in chronic pain comes from a meta-analysis by Vickers and colleagues of individual patient data from 20 827 patients. This shows moderate benefit for acupuncture compared with usual care (about 0.5 standardised mean difference (SMD) in pain) but smaller effects compared with sham acupuncture of about 0.2 SMD. Importantly, it also shows that 85% of the effect of acupuncture is maintained at one year.

The small, but highly statistically significant, effect of standard needling (acupuncture) over gentle needling (sham acupuncture) indicates the biological plausibility of the technique. But the true value in practice should be measured against usual care or other interventions. Critics dismiss the small effect over sham as bias associated with unblinded practitioners, but I have not heard any plausible mechanism proposed for an unblinded practitioner influencing the pain outcome assessed by a patient who continues to be blinded.

Better quality of life

Further evidence that should urge a more flexible approach from guideline developers comes from a study reporting methods for network meta-analysis on continuous (pain) outcomes. This study used data from the Vickers meta-analysis. A surprise finding was that for health related quality of life, sham acupuncture clearly outperformed usual care in all the types of chronic pain studied. Whether or not you consider these to be the effects of a theatrical placebo, they represent important improvements in quality of life over usual care, and with minimal risk.

Is it all about money? In hospitals, acupuncture seems to incur more staffing and infrastructure costs than drug based interventions, and in an era of budget restriction, cutting services is a popular short term fix. Group clinics in the community can provide more treatment at much lower cost, but they are vulnerable to the constant re-evaluations in commissioning services. Another challenge is the lack of commercial sector interest in acupuncture, meaning that it does not benefit from the lobbying seen for patented drugs and devices.

The pragmatic view sees acupuncture as a relatively safe and moderately effective intervention for many common chronic pain conditions. It can improve quality of life, and it has much lower long term risk for them than non-steroidal anti-inflammatory drugs. It may be especially useful for elderly patients, who are at particular risk from adverse drug reactions.

Competing interests: See bmj.com.

The practice is a safe alternative to drugs but is under-researched because it lacks commercial interest, writes **Mike Cummings**, but **Asbjørn Hróbjartsson** and **Edzard Ernst** argue there is no convincing evidence of clinical benefit and that the potential risks and service costs are unjustified

Listen to the authors debate the issue in the podcast on bmj.com

no

Health services funded by taxpayers should use their limited resources for interventions that have been proved to be effective

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Edzard Ernst, emeritus professor, University of Exeter

Doctors should not recommend acupuncture for pain because there is insufficient evidence that it is clinically worth while. In China, acupuncture was considered irrational and superstitious during 1700-50, excluded from the Imperial Medical Institute in 1822, and only revived after Mao's takeover. In the West, acupuncture remained a fringe phenomenon until the 1970s, when the counterculture movement disregarded scientific implausibility and embraced alternative healthcare. Today, clinical trials provide an informative basis for debate.

Small effect, high risk of bias

Overviews of clinical pain trials comparing acupuncture with placebo find a small, clinically irrelevant effect that cannot be distinguished from bias. Two systematic reviews of randomised trials reported the effect of acupuncture as standardised mean difference (SMD) 0.17 and "close to 0.20," corresponding to 4-5 mm on a 100 mm visual analogue scale, which is below the usual threshold for clinical relevance of 10-15 mm. Also, not one of 12 Cochrane reviews of acupuncture for pain reported a clinically important effect beyond placebo (on low back pain, rheumatoid arthritis, cancer pain, dysmenorrhoea, lateral elbow pain, endometriosis, peripheral joint osteoarthritis, prevention of migraine and tension type headache, shoulder pain, fibromyalgia, and pain in labour). The reviews on back pain, migraine, and tension type headache considered acupuncture a possible treatment option based mostly on trials with non-blinded patients, but effects beyond placebo were "small."

However, even this small apparent effect may be due to bias rather than acupuncture. Risk of inadequate patient blinding is high in placebo controlled acupuncture trials. Supposedly blinded patients interact repeatedly with unblinded acupuncturists—for example, in nine of 13 trials, patients could clearly distinguish the acupuncture and placebo procedures. So, differences in patient expectations, and in patients' reporting of subjective symptoms such as pain, are likely to result in small to moderate false positive results.

Acupuncture enthusiasts often emphasise "pragmatic" comparisons between acupuncture and usual care. However, unblinded pragmatic trials cannot differentiate possible true effects of acupuncture from placebo effects and bias. To inform us reliably of any causal relation between acupuncture and effect, we need to focus on adequately blinded "explanatory" acupuncture trials.

Harms and costs of theatrical placebo

Paradoxically, acupuncture enthusiasts often downplay the importance of acupuncture points, disregarding a clear distinction between acupuncture and placebo. However, if acupuncture is endorsed as a theatrical placebo we should be discussing the ethics of placebo interventions, not the elusive effect of acupuncture.

Acupuncture is often regarded as harmless, but needling may cause pain, haemorrhages, infection, pneumothorax, and even death. In Denmark, for instance, four cases of pneumothorax, one fatal, were disclosed in 2017. Such complications might be rare, but assessments of exact numbers are thwarted by unreliable data. Under-reporting of harm in acupuncture trials is extensive. For example, in a review of back pain, only 14 of 35 trials reported on harms (5% of patients receiving acupuncture and 0% of those receiving placebo).

The cost of acupuncture sessions ranges from £25 to £70, and the overall cost to the NHS may amount to £25m a year, though reliable figures seem unavailable. Health services funded by taxpayers should use their limited resources for interventions that have been proved effective.

More than 50 years ago the gate control model for pain signals provided a basis for hypothesising nerve stimulation and endorphin secretion as biological mechanisms for acupuncture. However, it has proved difficult to develop such hypotheses into a generally persuasive scientific theory, and mechanisms for perceived analgesic effects of acupuncture remain opaque.

In conclusion, after decades of research and hundreds of acupuncture pain trials, including thousands of patients, we still have no clear mechanism of action, insufficient evidence for clinically worthwhile benefit, and possible harms. Therefore, doctors should not recommend acupuncture for pain.

Cite this as: *BMJ* 2018;360:k970

PATIENT COMMENTARY

I was pregnant, in pain, and had run out of hope when I chose acupuncture

An acupuncturist helped **Kumari Manickasamy** when she couldn't take analgesic drugs and conventional medicine had no more to offer

Eighteen months ago I developed severe pelvic girdle pain when pregnant with my second child. I had this condition in my first pregnancy, when it was successfully managed with physiotherapy and manipulation. However, this time it was much more severe and did not respond to the same treatment.

I reduced physical activity, did daily core stability exercises, and wore a sacroiliac support belt, but my mobility deteriorated precipitously. Walking became so difficult I needed crutches and a wheelchair. Sitting and even lying for too long on either side was painful. I could not work and became practically housebound.

My physiotherapist felt she could do no more for me. In desperation I saw two other therapists, but with no relief. My obstetric team offered me an elective caesarean section as early as possible, but there was nothing more they could do.

Few safe options

This realisation was devastating. I felt abandoned and let down, and I was terrified about how I would cope with the rest of the pregnancy.

There are few safe options for pain relief in pregnancy: anti-inflammatory drugs are contraindicated and opioids can cause neonatal abstinence syndrome. I took paracetamol and codeine, desperately hoping that I would not need anything stronger.

> It was therapeutic to see an empathic professional who had the time to listen and who understood my pain. I felt cared for

Kumari Manickasamy, patient and general practitioner, London
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I looked at non-drug options for pain control. A TENS (transcutaneous electrical nerve stimulation) machine gave mild temporary relief.

Then I recalled seeing a physiotherapist for low back pain a few years ago, who had used acupuncture alongside manual therapy. I knew that acupuncture is widely used to treat many types of pain and has few adverse effects. After discussion with my physiotherapist, I booked a session at a local private physiotherapy clinic.

I was reassured that the practitioner was a trained physiotherapist who had experience of my condition. She said that in theory acupuncture could trigger premature labour but that little evidence supported this.

After examining me carefully, she gently inserted needles into tender points in the gluteal muscles and pelvic girdle. She also needled a point near my ankle that is supposed to trigger relaxation. After the tiny prick of the needles entering I felt a warm tingling sensation that was rather pleasant. The needles were left in for 15 minutes, during which she occasionally rotated them. The session lasted half an hour and cost £45. I was advised to limit driving afterwards and to rest if possible. On returning home I slept for two hours.

I saw her weekly until delivery. Overall I felt a small reduction in pain, but crucially I did not need to increase my analgesia throughout the rest of the pregnancy. I also found the treatments relaxing.

Perhaps, most importantly, I felt cared for. It was therapeutic to see an empathic professional on a regular basis who had the time to listen, who understood my pain, and who was trying to relieve it.

An offer of hope

At a time of great physical and mental suffering, when I had exhausted all avenues offered by conventional medicine, acupuncture offered me hope. I am fortunate that I was in a financial position to afford it.

Women with pelvic girdle pain have to strike a difficult balance between controlling their pain and risking harm to their child. In this situation, there seems to be a clear role for a safe and potentially effective treatment such as acupuncture to help both mother and baby.

Cite this as: *BMJ* 2018;360:k990