

this week

DANDRUFF page 3 • **BAWA-GARBA APPEAL** page 4 • **NHS'S TOP ACHIEVEMENTS** page 5



NEIL MOCKFORD/GETTY IMAGES

Private sector told to improve safety

Almost a third of private hospitals in England require improvements to the way they deliver care, and safety is the biggest area of concern, the Care Quality Commission (CQC) has found.

In a report summarising its inspections of 206 independent hospitals, the regulator said that most were providing good quality care, with 62% rated as “good” and 8% “outstanding.” But it expressed concern at the wide variation, with almost a third rated as “requires improvement.”

Safety was the CQC’s greatest concern, as 41% of hospitals were rated as “requires improvement” in this area and 1% were “inadequate.” It also raised concerns over leadership, rating 30% as “requires improvement” and 3% “inadequate.”

The CQC said that problems were often driven by a lack of safety checks and poor risk monitoring. It said that failure of effective governance was brought into sharp focus in the case of the breast surgeon Ian Paterson who worked at Spire Healthcare hospitals and was jailed for 15 years last May for wounding with intent.

Ted Baker, CQC’s chief inspector of hospitals, said, “Too often, safety was viewed as the responsibility of individual clinicians, rather than a

corporate responsibility supported by formal governance processes. Where we found failings, we have been clear that improvements must be made.”

In some cases, the CQC said hospitals were not effectively monitoring consultant clinicians who were not direct employees. It warned that checks to ensure they were working within agreed scopes of practice were not always taking place, creating a risk that poor practice goes unchallenged.

The sector was rated highly for caring for patients, with 89% of providers rated as “good” and 11% “outstanding.”

Derek Alderson, president of the Royal College of Surgeons, said that the private sector should adopt similar processes to the NHS by publishing data on unexpected deaths, “never” events, serious injuries to patients, and clinical outcomes.

He said, “The Paterson case demonstrated that there is no room for complacency, and further actions should be taken to minimise harm to patients in both the NHS and private sector. We must continue to promote a culture, in all types of healthcare, where patient safety concerns are not brushed aside.”

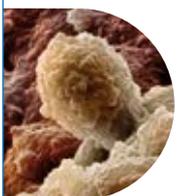
Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2018;361:k1571

Inspections of private hospitals, such as Cromwell in London (above) showed a third needed to improve, said chief inspector Ted Baker (above far left). Derek Alderson said the private sector should adopt NHS processes

LATEST ONLINE

- Hospital doctors face unfair disciplinary procedures, says defence organisation
- Randomised controlled trials may have many unrecognised potential biases
- UK to invest £75m in new research to improve prostate cancer care



SEVEN DAYS IN



MEN MEDIA

BMA criticises decision to deport GP trainee

The BMA has criticised the government for threatening to deport a GP trainee who qualified in the UK. Chaand Nagpaul, BMA council chair, said the decision to deport Luke Ong, who is from Singapore, because of a visa delay was “incomprehensible.”

“This situation, in which a doctor—who has committed the past 10 years of his life to studying, training, and serving in the NHS—faces deportation over what appears to be an honest oversight, beggars belief at a time when the government is prepared to spend millions recruiting GPs from abroad,” he said.

In a petition on change.org, which has more than 37 000 signatories, Ong said that last September he was five months away from completing his GP training when his application for indefinite leave to remain was refused for being 18 days late. He successfully appealed against the Home Office’s decision, but it has now appealed. “I have given the best years of my life to the NHS, toiling relentlessly, paying my taxes, and contributing to wider society. Sadly, all this counts for nothing,” he wrote.

A Home Office spokeswoman said, “Dr Ong’s case is currently under appeal and it would be inappropriate to comment further while legal proceedings are ongoing.”

Abi Rimmer, *The BMJ* Cite this as: *BMJ* 2018;361:k1587

Cancer diagnosis

New “one stop shops” aim to save lives

GPs in 10 areas in England who suspect that patients may have cancer can refer them to a rapid diagnostic and assessment centre being piloted as part of NHS England’s drive to speed up cancer diagnoses. The centres aim to end the repeated referrals and tests that people with non-“alarm” symptoms often undergo. The centres are at North Middlesex University, University College London, Southend University, Queen’s, the Royal Free, St James’s University, Airedale General, the Royal Oldham, and Churchill hospitals plus University Hospital South Manchester.

Biobank

Full genomes of 50 000 UK residents will be sequenced

The Medical Research Council has made £30m available for sequencing the genome of the 50 000 people registered with UK Biobank, to establish the world’s most detailed whole genome database and accelerate research into disability and premature death. Rory Collins, UK Biobank principal investigator, said that sequenced data were a vital piece of the health jigsaw that scientists

had not expected so soon. “This massively extends the sorts of questions that scientists can ask and the speed at which they will get results,” he said.

Sure Start

Call for urgent review of children’s centres

Some 1000 centres set up by the Labour government from 1998 to deal with social inequalities and give children “the best start in life” have closed, the Sutton Trust said. The social mobility charity urged the government to complete the long promised review of the children’s centre programme “to confirm its national importance and overall purpose with national guidelines.” This, it said, could stop the piecemeal closures that were creating a postcode lottery of the centres, which bring together services for young children and their families.

Research news

Opioid scripts fall in legal marijuana states

US states that have permitted legal access to marijuana saw a significant 14.4% average reduction in opioid prescriptions from 2010 to 2015, a study in

JAMA Internal Medicine found.

The effect was pronounced in hydrocodone and morphine use. Prescribing of non-opioid pain medicines also fell after the passage of laws on the medical use (by 8.36%) and adult use (by 8.69%) of marijuana.

Public health

Soft drinks levy is “not enough” to tackle obesity

Parveen Kumar (below), chair of the BMA’s board of science, said the soft drinks levy, introduced on 6 April, was “long overdue” and would go “some way towards reducing the prevalence of obesity in the UK.” But more needed to be done, such as “tougher rules on junk food marketing aimed at children.”

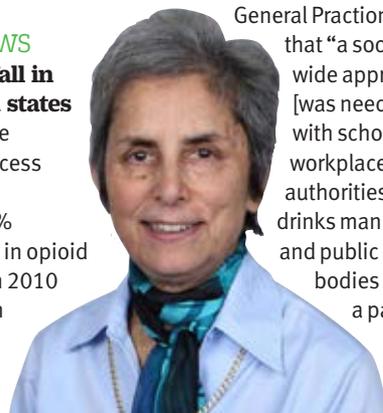
Helen Stokes-Lampard, chair of the Royal College of General Practitioners, said that “a society-wide approach [was needed] with schools, workplaces, local authorities, food and drinks manufacturers and public health bodies all playing a part.”

Stop prioritising cars, doctors urge policy makers

UK governments must stop prioritising the car if they are serious about tackling childhood obesity, clinicians insisted in the *British Journal of Sports Medicine*. Investment in road building far exceeds that for active travel—public transport, footpaths, and cycle lanes—“resulting in an environment that often feels too risky for walking or cycling,” they wrote. In a letter to UK transport ministers the authors cited significant savings to the NHS, reductions in pollution, and ingraining sustainable travel behaviours if active travel is prioritised.

Taxes on harmful products are found to be effective

Taxes on alcohol, tobacco, and soft drinks offer an effective strategy for reducing chronic disease among the poorest people who are disproportionately affected by unhealthy products, a review in the *Lancet* found. A second study showed that increasing taxation of unhealthy products was likely to bring greatest benefit to people on low incomes because they generally had the strongest response to price changes.



MEDICINE

Online consultations

Royal college issues guidance on GP providers

Whether an online provider of GP consultations has been inspected by a regulator such as the Care Quality Commission, has access to patient records and stores personal information securely, and the cost of the service are some questions that patients, general practices, and clinical commissioning groups should be asking when choosing an online provider, says guidance from the Royal College of General Practitioners. Martin Marshall, RCGP vice chair and author of the guidance, said, "Online consultations should be provided in addition to traditional services, not instead of them."

Conviction

Doctor with hit list, arms, and ammunition is jailed

Martin Watt (below), a former NHS emergency consultant at Monklands Hospital in Airdrie, North Lanarkshire, was jailed for 12 years for possessing firearms with intent to endanger life. He had been sacked from his job in 2012 after disciplinary proceedings. Three years later police raided his home after a tip-off and found three submachine guns, two pistols, ammunition, and homemade gunpowder, along with an envelope labelled "bad guys," with names, addresses, and car registration numbers of former colleagues and NHS managers he blamed for his dismissal.



Blackpool, and other coastal areas, featured heavily in the worst 10 places in England for drug deaths

Drug misuse

Six in 10 drug death hotspots are coastal

Blackpool has had the highest death rate from heroin/morphine in England and Wales since 2010-12, with 14 deaths per 100 000 people in 2016, the Office for National Statistics found. This compares with a national average of 1.7 in England and 2.3 in Wales and is almost twice as high as the next highest area, Burnley, which had a rate of 7.6. The other seaside locations were Bournemouth, Portsmouth, Hastings, Thanet, and Swansea. Others in the top 10 were Reading, Hyndburn, and Neath Port Talbot.

Assisted dying

Hawaii grants right to die to terminally ill patients

Hawaii became the seventh US state to allow assisted dying as an option for terminally ill people, after a law was introduced on 6 April that allows doctors to prescribe life ending medication. Oregon was the first state to pass such legislation in 1997. Canada legalised medical aid in dying in 2016, and Victoria, Australia, legalised assisted dying in 2017. Guernsey's parliament will debate a bill later this year.

Cite this as: *BMJ* 2018;361:k1588

BACK PAIN

The NHS spends almost **£40m** a year on cortisone injections into facet joints despite NICE guidelines in 2009 and 2016 recommending against the **£540** procedure. Last year 70 608 such injections were given, up from 62 570 five years ago
[The Times]

SIXTY SECONDS ON... DANDRUFF



ISN'T THIS A BIT OF A FLAKY TOPIC FOR A MEDICAL JOURNAL?

Absolutely not. NHS England is on the warpath against unnecessary prescribing of over-the-counter products and it has dandruff firmly in its sights, along with 34 other minor ailments and self limiting conditions.

IS GENERATION SNOWFLAKE VISITING GPs FOR SELF MANAGEABLE THINGS?

I couldn't possibly say. But the upshot is that prescriptions for OTC products cost the NHS in England £569m last year. The plan is to save £100m a year, which could pay for more useful services such as community nurses, hip replacements, and cataract operations.

NOT TO BE BRUSHED OFF, THEN?

Indeed. Dandruff shampoos alone cost the NHS £4.5m a year.

IS DANDRUFF SPENDING HEAD AND SHOULDERS ABOVE THAT OF OTHER MINOR CONDITIONS?

Nice, but no it isn't. The highest spend, of £48m, goes on vitamin and minerals for which "there is insufficient high quality evidence to demonstrate [their] clinical effectiveness," says the guidance. Other costs that the government wants to shift to patients include those for constipation (£22.8m a year), indigestion and heartburn (£7.5m), mouth ulcers (£5.5m), and athlete's foot and other fungal infections (£3m).

WHO'S BEHIND THIS SCALPING?

The chief executive of NHS England, Simon Stevens, wants everyone across the NHS to "Think like a patient, act like a taxpayer." He has a point. A pack of 12 OTC anti-nausea pills costs £2.18, while the cost to the NHS would be over £3 if dispensing fees were included, and over £35 if seeing a GP and other admin costs were included.

DIDN'T DOCTORS BLOW UP A (SNOW) STORM ABOUT THIS?

Your memory serves you well. Objections from the Dispensing Doctors' Association, the BMA, and the Royal College of General Practitioners mean that GPs will be able to prescribe OTC items for longer term or more complex conditions and for patients whose ability to self manage "is compromised."

Zosia Kmiotowicz, *The BMJ*

Cite this as: *BMJ* 2018;361:k1557

BMA registers interest in Bawa-Garba's appeal



The Bawa-Garba case sparked an unprecedented outcry. Supporters raised more than £360 000 to fund an appeal

The BMA is applying to intervene as an interested party in the appeal by the paediatric trainee Hadiza Bawa-Garba against her erasure from the UK medical register.

The doctors' trade union has instructed Mary O'Rourke QC, who acted for the consultant paediatrician David Southall in 2010 when he won an appeal against a High Court decision that he should be struck off the register. O'Rourke has a strong record of defending doctors against the General Medical Council (GMC), Bawa-Garba's opponent in the appeal.

In November 2015 Bawa-Garba was convicted by a jury at Nottingham Crown Court of gross negligence manslaughter after the death of Jack Adcock,

aged 6. The GMC took her case to a medical practitioners tribunal, arguing that her conviction meant that she must be struck off.

But the tribunal took account of systemic failures at Leicester Royal Infirmary, where Jack had died, and decided to suspend her for 12 months instead. The GMC then appealed to the High Court, which struck her off the register.

Permission to appeal

The case sparked an unprecedented outcry from the medical profession, and supporters of Bawa-Garba raised more than £360 000 to fund an appeal. She was granted permission to appeal on 28 March.

Lord Justice Simon ruled that she had an arguable case

Traumatic brain injury "raises dementia risk"

People who have sustained a traumatic brain injury have a higher risk of developing dementia and Alzheimer's disease, a nationwide population cohort study suggests.

The study is one of the first to have a sufficient sample size and follow-up time to assess the effects of traumatic brain injury.

36 year study

It includes data on 2 794 852 people living in Denmark on 1 January 1995 who were aged at least 50 at some point in the follow-up period (1999-2013). Registries were used to identify people who had sustained a traumatic brain injury from 1977 to 2013 and those who had had dementia diagnosed.

Over the 36 year study period 132 093 people (4.7%) had

at least one traumatic brain injury, and 126 734 (4.5%) had dementia diagnosed during 1999-2013. Data analysis showed that people who had sustained at least one traumatic brain injury were 24% more likely to have dementia diagnosed than those without a traumatic brain injury (hazard ratio 1.24 (95% confidence interval 1.21 to 1.27)) and 16% more likely to have Alzheimer's disease diagnosed (1.16 (1.12 to 1.22)).

The risks for dementia rose with the number of traumatic brain injuries experienced, rising from 1.22 (1.19 to 1.25) with one injury to 2.83 (2.14 to 3.75) with five or more. Severity of injury was also linked to a higher dementia risk, and even a single mild injury (concussion) was linked to a 17% higher risk.

Risk factors

Dementia risk was highest in the first six months after the injury (4.06 (3.79 to 4.34)) and decreased with time. The younger the person at the time, the higher the hazard ratio for dementia when stratified over time.

The researchers of the study, published in *Lancet Psychiatry*, said this may be because several risk factors for dementia are common in older people. They wrote, "From a public health perspective, traumatic brain injury prevention programmes have an opportunity to reduce the burden of dementia worldwide."

Carol Brayne, from the University of Cambridge School of Clinical Medicine, said in a linked commentary, "Traumatic brain injuries have various origins, with road traffic

injuries and military exposures being important. The probability of survival after traumatic brain injury has changed radically in high income countries.

"Traumatic brain injury is a sufficient enough concern for international consortia to be formed to attempt to support better care across the world.

"It will be many years before the outcomes of the mildest traumatic brain injuries studied in younger adults will be known, as it will be decades before the age groups reach the age of highest dementia risk."

Ingrid Torjesen, London

[Cite this as: BMJ 2018;361:k1597](#)

People who had **SUSTAINED** at least one traumatic brain injury were **24%** more likely to have dementia diagnosed than those without a history of traumatic brain injury



for saying that the High Court, having rejected the GMC's argument that a gross negligence manslaughter conviction should lead to erasure in all but truly exceptional circumstances, went on to apply an equivalent test in allowing the GMC's appeal.

The GMC argued in the High Court that the tribunal had erred in impermissibly going behind the jury's findings in Bawa-Garba's case. It said that it was obliged to appeal against the tribunal's decision because the tribunal had not followed the rules for cases of conviction.

The BMA is applying to intervene on behalf of doctors in general to clarify the position of doctors who are convicted of a criminal offence in the future, not just those convicted of gross negligence manslaughter. Argument is likely to centre on the extent to which tribunals

are justified in going behind the jury's verdict to look at the surrounding facts for themselves.

The Professional Standards Authority, which oversees the GMC and eight other health and care regulators, is also considering intervening in the case. Its chief executive, Harry Cayton, told *The BMJ*, "We haven't made a decision, but we are meeting with a QC to decide whether or not to intervene." Along with the GMC the authority has a right to appeal against tribunal findings, which was preserved when the GMC won its own right to appeal in December 2015.

The authority has taken legal opinion on the Bawa-Garba case, which concluded, contrary to the GMC's view, that erasure was not the only option open to the tribunal.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2018;361:k1498



The BMA has instructed Mary O'Rourke QC (above) to intervene in the case of Hadiza Bawa-Garba (top)

FIVE MINUTES WITH ...

David Galloway

The president of the Royal College of Physicians and Surgeons of Glasgow on the Bawa-Garba case

"I think the profession has lost confidence in the GMC. Doctors on the ground, especially younger doctors, face an overstretched service with suboptimal staffing that presents patient safety concerns. This is against the background of this tragic case and they, inevitably, feel exposed.

"So, what does the GMC tell them? It says to escalate their concerns but not to walk away. Well fine, and in our guidance we're not suggesting that people walk away but we are offering them clear advice about what they can do, such as clearly documenting the situation after the event and contacting the college with concerns. It's all very well to say escalate but what does that actually mean?"

"In terms of written reflection, there is an impression this could work against someone if they were very self

critical. So people will not write reflections in the same detail that they were being encouraged to before this case. The GMC has said it would not use reflective comments in such a way, and that is helpful. The problem is that reflective documents could still be discoverable by a court of law. So, unfortunately, the GMC's comment doesn't offer the protection we hoped for—that these reflections would be private and for self learning only.

"Rightly or wrongly, the GMC is now seen as the regulator with the big stick. This is because it has said that one of its principal roles is to protect the public, and on occasion that will mean taking action against a doctor who is considered to be putting patients at risk.

"The GMC's statements have been more helpful than not, but whether that has been heard by the profession is a different matter. The perception of the GMC by doctors on the front line indicates it has a mountain to climb to regain some of that lost respect."

The RCPSG's guidance can be found at <https://rcpsg.ac.uk/news/2103-college-publishes-new-guidance-for-trainees>

Abi Rimmer, *The BMJ* Cite this as: *BMJ* 2018;361:k1573



"THE GMC HAS WORK TO DO IN TERMS OF HOW IT IS PERCEIVED"

What is the NHS's top achievement?

When the NHS launched on 5 July 1948 its mastermind Aneurin Bevan told the professionals at its heart "to use your skills and judgment without hindrance." At the time there were shortages of doctors and nurses, just as there are now. Nevertheless, the NHS has won an admiring global audience, and its endurance over 70 years of reform and challenge should be celebrated.

But what is the one thing that makes us most proud? Is it the elimination of polio in the UK, the world's first IVF baby, the success of smoking cessation clinics and cancer screening services, or the commitment to general practice at the heart of the world's most cost effective healthcare system? Or simply the fact of its survival, as a

service based on need and free at the point of delivery?

Performance targets?

Does NICE deserve the "greatest" accolade? Or should that go to performance targets that brought down waiting lists, or to scrutiny of GP prescriptions to reduce wastefulness, overtreatment, and variation? Or perhaps it is the "national" in the NHS that we should celebrate, as it allows researchers access to millions of patient records to answer the myriad questions that make medicine attractive to creative and scientific minds alike.

When *The BMJ* relaunched

in 2007 it asked readers to vote for the most important medical milestone since the journal was first published in 1840. Of 15 contenders (bmj.com/content/medical-milestones), sanitation won a poll that attracted more than 11 000 votes.

Now we would like you to turn your minds to the past 70 years and tell us, in no more than 100 words, what you think is the NHS's most important achievement. You have until 28 April to make your nominations. We will seek champions for the most popular before putting them to a vote. The results will

be announced in time for the NHS's 70th anniversary in July.

Zosia Kmiotowicz, *The BMJ*

Cite this as: *BMJ* 2018;361:k1562



HAVE YOUR SAY

Make your nomination by filling in the form at <http://bit.ly/2GAxtiT>

Obstetrician who altered stillbirth notes is struck off

A doctor in obstetrics and gynaecology who altered a patient's notes to deflect blame after a stillbirth has been struck off by a medical practitioners tribunal.

Amir Iqbal Malik's retrospective alterations, to make it seem that he had told midwives to restart monitoring the fetal heartbeat sooner than he had, might have gone unnoticed had not one of the midwives photocopied the original, the tribunal heard.

Malik was not accused of causing the death of the fetus or harm to the mother, a 23 year old who was admitted by ambulance to Pinderfields General Hospital, Wakefield, in December 2015. He admitted failing to correctly interpret cardiotocography (CTG); to realise that the CTG result was non-reassuring or difficult to interpret; to seek a senior doctor's opinion; and to ensure continuous monitoring.

The tribunal held that these failings did not amount to serious misconduct. But altering the notes was dishonest, had a potential effect on Mid Yorkshire Hospitals NHS Trust's investigation, and meant Malik's integrity could not be relied on, said the tribunal chair, Charles Thomas. Malik added the text "1/" before "2-3," trying to change his recommendation to monitor the CTG after two or three hours into a half hour delay.

Two midwives testified that Malik had not requested frequent or early monitoring but had, in the words of one, been "blasé" in response to their concerns.

Malik was excluded from the trust and given an exclusion letter he was duty

bound to show to potential employers. But he admitted he had worked on five occasions for Barnsley Hospital without mentioning the letter. Thomas told him, "This demonstrated a doctor who put his own interests above patient safety and integrity with his employers."

The tribunal accepted Malik had made "considerable efforts to remediate his failings in respect of interpretation of CTGs," said Thomas, but this "was insufficient to demonstrate an appropriate level of insight and remediation." Malik, who qualified in Pakistan in 1989, asked for a 12 month suspension, pointing to his otherwise unblemished career, positive references, and his family's reliance on his income. But the tribunal determined his dishonesty was "repeated, persistent, and carried out in order to protect his own interests." The erasure will take effect after 28 days unless Malik lodges an appeal.

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2018;361:k1539

NEWS ANALYSIS

Can public health strategies tackle rise in fatal violence?

London's spate of murders has highlighted knife crime, which may lead to attitude change, reports **Ingrid Torjesen**

"London remains one of the safest cities in the world," the Metropolitan Police assured *The BMJ* last week after a spate of violent attacks left most media outlets reporting the city's murder rate higher than in New York.

The Met has investigated 55 murders since January, including 15 in February and 22 in March, while in the same months New York recorded 11 and 21 murders, leading to the media hype. But as Simon Jenkins in the *Guardian* pointed out, "Comparing murder rates for periods of less than a year is dumb." The figures may be just a blip, as in the whole of 2017 London had 116 murders, whereas New York had 290, its lowest rate since the 1950s.

What is certain, however, is that London has a problem with knife crime, particularly among young men. Eighty of the murders in 2017 were stabbings, and on the evening of 5 April five teenagers were stabbed across the city in the space of 90 minutes.

Scottish model

The Met police commissioner, Cressida Dick, has implied that a public health approach is needed to tackle

knife related violence. "The public health approach is well evidenced in Scotland," she told the London Assembly in December.

After a UN report described Scotland as the most violent country in the developed world, its government first tried to tackle the problem through more enforcement, such as increased stop and search tactics, and longer jail sentences for carrying a knife, but this approach was not successful.

Most of the knife crime involved white teenage boys in territorial Glasgow gangs. Christine Goodall, director of the Scottish charity Medics Against Violence and honorary consultant in oral surgery at Glasgow University's dental school, explained: "They weren't doing it for profit, they weren't running drugs, it was recreational violence among teenage boys from deprived backgrounds."

The gangs were mapped and attempts made to engage with their members through a gangs exit programme. The teenagers were encouraged into diversionary activities, to get back into education or training or to find a job, and helped to secure a house move if needed. Medics Against Violence went into schools and spoke



"A doctor who put his interests above patient safety and integrity with his employers"

Don't spend too little on mental health, commissioners are warned

Commissioners have been told to increase mental health spending or face sanctions from NHS England, in a letter from its national mental health director, Claire Murdoch.

The letter, dated 9 April, follows up the *Refreshing NHS Plans for 2018-19* guidance issued in February, which emphasised that CCGs must meet the Mental Health Investment Standard (MHIS). This states that the 2018-19 investment in mental health must rise at a faster rate

than their overall funding increase.

NHS England describes this as a "landmark moment" for mental health services and for the government's commitment to putting mental and physical health on a level footing.

In her letter Murdoch said, "Currently, the overwhelming majority of CCGs—85%—meet the MHIS, but nearly nine in 10 is not enough."

Even though Murdoch thanked CCGs for planning for this requirement, she added, "I also want to emphasise to you



TOBY MELVILLE/REUTERS

about the consequences of violence, and older pupils were trained to talk to younger pupils. “The programme was successful in getting about half of the young people out of gang situations,” Goodall said.

Changing social norms

Although the Glasgow model could not just be dropped into London, the principles of treating knife crime like an epidemic or disease should apply, as they have also been in New York, Boston, and Chicago, said Sarah Jones, Labour chair of the all party parliamentary group on knife crime.

“You go in and you treat the problem at source,” she said. “So you do really intensive work with these young people and try to get them out of the situation they are in. You inoculate

the rest of the population through education and trying to change social norms: the role of young people and what they should be doing and what should be expected of them.”

In London, knife crime tends to involve young black men and is drug related, Jones said, but there are comparisons with Scotland in terms of poverty, inequality, and lack of support for teenagers who have been in care.

And knife crime is also not just a London issue. It is rising in all regions, Jones added. Criminal gangs are taking teenagers to small towns and rural and coastal areas to sell drugs in enterprises known as “county lines.”

The government has the opportunity to make knife crime a public health issue in its strategy for tackling violent crime, which is due

VIOLENT CRIME FIGURES

Knife crime in England and Wales in the year to September 2017 was 21% higher than in the previous year, rising to 37 443 offences recorded by the police. Gun crime was up 20% (to 6694 offences). This rise could be due to better recording, but the Office for National Statistics commented: “It is our judgment that there have also been genuine increases.”

The homicide rate per 100 000 people in the UK (0.9) is the same as that in Germany, lower than in Denmark (1.0), Finland (1.6), France (1.6), and the US (4.9), but higher than in Norway (0.6) and Spain (0.7), show UN figures that used data from 2013, 2014, and 2015.

to be published imminently. Taking a public health approach to tackling teenage pregnancy, and setting a target to halve it, was successful.

The borough of Lambeth has already taken action. Last month it decided to adopt a public health approach with the publication of a “Tackling violence against young people” strategy.

Ingrid Torjesen, London

Cite this as: *BMJ* 2018;361:k1578

“You treat the problem at source. You work intensively with these young people”
Sarah Jones MP

that regardless of pressures, meeting the MHIS is not an optional extra, but something we are deeply committed to and expect every CCG to achieve.”

Failure to meet the standard by March 2019 will have consequences, she said, such as CCGs having to explain themselves to Murdoch or other senior NHS England officials.

Further follow-up will be pursued through the national performance and delivery group, the letter added, as well as regional “deep dive meetings”



Claire Murdoch says NHS England is deeply committed to the investment standard

chaired by Murdoch and reporting regularly to NHS England’s chief executive, Simon Stevens.

Sean Duggan, chief executive of the mental health network of the NHS Confederation, which represents NHS organisations, said he welcomed the advisory note. “We appreciate decisions around funding are never easy for commissioners, but it is crucial that, as promised, mental health services are given parity to physical health services,” he said.

NHS Clinical Commissioners, the body that represents CCGs, has already welcomed the “clear steer” from NHS England on the importance of funding mental health services appropriately. Phil Moore, chair of its mental health commissioners network, said, “We have heard from some members that they have faced pressure to spend money on stabilising the acute sector rather than investing in mental healthcare. CCGs have worked hard to deliver spend for mental health services and have already made excellent progress.”

Adrian O’Dowd, London

Cite this as: *BMJ* 2018;361:k1569

The **OVERWHELMING** majority of CCGs, **85%**, meet the MHIS, but nearly nine in 10 is not enough





THE BIG PICTURE

Whales, toxins, and a way of life

The ancient tradition of Faroe Island men, such as Bárður Isaksen (left), taking to small boats to hunt pilot whales by hand, turning the sea red with blood, is a revolting spectacle to many outsiders and attracts global protests. Once landed, the whale meat is divided and wheeled away by islanders, recalling a time when hunting was so important to these barren islands that it was a crime not to report a pod of whales. The meat is consumed even today, as the self governing Danish islands, halfway between Norway and Iceland, are an expensive place to live.

Mike Day, a Scottish former lawyer, spent five years making the film *The Islands and the Whales*—from which these stills are taken—getting to know the notoriously camera shy locals so that they would allow him to record their way of life. The film features Pál Weihe, a doctor whose quest, through a 30 year longitudinal study, is to educate the islanders about the dangers of consuming whale meat. It is contaminated with heavy metal pollutants, including mercury from around the world, and his study has shown how it has impaired islanders' cognitive function, reduced IQs, and increased the risk of Parkinson's disease.

Weihe told *The BMJ*, "For centuries, the pilot whale has been precious to the Faroes when access to other food was limited. For the last century, humans have carelessly polluted the oceans with contaminants such as mercury and persistent organic pollutants. Our research has shown that when pregnant women consume polluted whale meat it has a negative effect on the child's developing central nervous system and on the immune system.

"Our message to the world is that the children of the Faroes pay a price for this pollution. That should be a reminder to the international community to stop the harmful emissions."

The Island and the Whales is showing around the UK until 4 June

Ingrid Torjesen, London

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© BMJ CONFIDENTIAL, Pál Weihe, p 42

Strengthening research in the NHS

The potential is there, we just need to unlock it

NHS research is outstanding. A recent review concluded that “the UK punches above its weight internationally,”¹ supported by NHS England, the National Institute for Health Research (NIHR), the emerging UK Research and Innovation, medical research charities such as the Wellcome Trust, our university partners, and industry. What is less well known is that research active NHS organisations have better patient outcomes² and doctors find that research brings variety to their role, challenges them, and increases morale.³ Finally, investment in research has been found to provide a substantial long term return.⁴

So win, win? Well, not actually.

Although research in the NHS has been going from strength to strength, increasing year on year,⁵ challenges remain to ensure patients have access to the best treatments and innovations and to keep the UK a world research leader. We still need to strive for greater efficiency and, crucially, avoid duplication in the system.⁶

Making it better

This is what NHS England is aiming to achieve with its “12 actions to support and apply research in the NHS” (box). Proposed at the end of last year, and now being finalised after a period of consultation, this initiative identifies “glitches” in the system and considers how they can be ironed out.⁶

One example is the frustration around excess treatment costs associated with research—“the difference between the cost of standard treatment and the cost of treatment within the research study.”⁶ Present approaches to these costs vary and confusion persists. Sorting out payment for excess costs slows down research and adds complexity, which is a disincentive for researchers.³

Greater simplicity and transparency, would be widely welcomed, especially the proposal to manage costs in a standardised manner through local clinical research networks (LCRNs). LCRNs and research and development departments are often not given the support they deserve, but they have a leading role in making research more efficient and cost effective.

With a single nationwide health provider, the UK is in a great position to conduct population wide research and implement research findings on a national scale, but it could use data better and improve how different IT systems work with each other to support research and population health management.

Patient partners

NHS England and the NIHR are increasingly engaging patients throughout every part of the research pathway, including in setting priorities for funding, through schemes such as the James Lind Alliance⁷; it is encouraging to see this commitment continue in the 12 priorities. Research activity is increasing,⁵ but capacity, capability, and adoption of innovation must continue to improve. Research currently takes up to 17 years to be translated into patient care.⁸ We need NHS clinicians working in partnership with academia and industry to speed up this process.

One problem that arises repeatedly is lack of protected time for clinicians to do research, with clinical duties encroaching on any protected time they do have. In a snapshot survey of members this winter, the Royal College of Physicians (RCP) found that 56% (395) of respondents doing research didn't have any protected time, and, of those who did, 35% often and 27% sometimes didn't get to use it for research because of clinical demands.⁹ The RCP has previously reported that 64% of doctors want to

NHS England's 12 principles for improving research

Simplifying NHS processes

- Manage excess treatment costs better
- Eliminate delays in confirming multisite trials

Articulating research priorities better

- Set out research priorities for national NHS programmes
- Increase research focus and capability on value and cost
- Set out local NHS research and innovation priorities of the academic health science networks and STPs

Enhancing the data infrastructure

- Increase GP presence in Clinical Practice Research Datalink
- Back local systems as they create interoperable local care records that are research ready

Supporting advanced research into leading edge technologies

- Develop the genomic medicine service
- Develop the application of artificial intelligence in pathology and radiology at scale

Improving and simplifying our adoption ecosystem

- Use NHS England's specialised commissioning and commercial medicines clout, combined with NICE appraisals, to drive faster uptake of affordable, high impact innovation
- Back academic health science networks to become the main local NHS delivery vehicle for spreading innovations
- Review and simplify the number of different national innovation projects and programmes



do more research but face barriers such as time and funding.³ These challenges must be addressed.

We can and should support skills

development, streamline processes, and target funding to unlock this potential in the workforce. This will have the added benefit of supporting recruitment and retention as well as improving morale. It is never too early or late, with the right flexibility and support, to begin research. Support is particularly important in regions with low research intensity—often the same areas where recruitment is hardest.⁵

As part of the RCP's 500th anniversary we are running a year long project called Our Future Health, examining the dilemmas faced by doctors in clinical practice, including what it means for research within the NHS.¹⁰ We continue encouraging doctors to gain research skills that ultimately improve patient care, but we need the NHS to give clinicians the time for these skills to be used.

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Hunger strike renews detention centre concerns

Government policy threatens the physical health, mental health, and human rights of detainees

On 21 February 2018, 120 women and men detained in Yarl's Wood immigration removal centre in Bedfordshire started a month's hunger strike to protest against the conditions of their detention. Their demands included access to adequate healthcare (including mental healthcare) and an end to the policy of indefinite detention.¹ Their actions provide a timely reminder of the medical community's serious concerns about the implications of detaining migrants.

The UK has one of the most extensive immigration detention systems in Europe, and is the only country within the EU to have opted out of a 28 day limit on detention, allowing people to be held indefinitely. Although about 80% of those detained are held for less than two months, some are held for years.² This uncertainty means life in detention is lived in limbo, in a state of constant anxiety about the future.

The government detains people whose applications to be in Britain have been refused or are being processed. In 2016, 46% of those detained were asylum seekers, and of the 28 661 people entering detention, only 13 556 were removed from the UK, with most being released.² The chief inspector of prisons has described conditions inside detention centres as "prison-like."³

Systemic failings

The policy of indefinitely detaining asylum seekers and other migrants for "administrative purposes" has come under persistent scrutiny because of its harmful

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A BMA report concluded the only way to protect health in immigration centres was to end the policy of detention

effects on the mental and physical health of detainees.⁴⁻⁶ A 2016 report by the charity Medical Justice concluded that a high number of deaths had occurred within detention centres between 2000 and 2015 because the Home Office and NHS England had not tackled systemic failings in healthcare provision.⁷

Independent clinical reviewers analysed 38 deaths and concluded that several were avoidable, including 13 resulting from self inflicted injury and two from tuberculosis. Two people were not taken to hospital appointments that may have averted their deaths. One man missed four neurology appointments before his death from epilepsy in 2014.

The report also highlighted inadequate screening and medical care on arrival at detention facilities. Particular concerns included failure to screen for notifiable diseases and to identify the complex needs of people with mental health problems, the lack of effective safeguards to prevent vulnerable people being detained, substandard healthcare facilities within the centres, and failure

to obtain or pass on clinical records.

Detention itself is deleterious to mental health^{8,9} and its adverse effects persist after release.¹⁰ Anxiety, depression, post-traumatic stress disorder, self harm, and suicidal ideation are all more common

among detained immigrants than in other asylum seekers.¹¹ Asylum seekers and other vulnerable detained people, such as survivors of torture, have high

rates of pre-existing mental health problems and can find the experience retraumatising. Pre-migration trauma does not account for differences in mental health between those inside and outside detention,⁸ suggesting that detention itself contributes to mental health problems. This conclusion was shared by the authors of a detailed review commissioned as part of a government sponsored inquiry into the immigration of vulnerable people.¹²

The detrimental effects of detention are unsurprising given the allegations of endemic physical, verbal, and sexual abuse.¹³ During the protest, reports emerged that the Home Office had sent a letter to strikers suggesting that refusing food and water could accelerate their deportation, drawing sharp criticism from some MPs.¹⁴

No improvement

In September 2014, commissioning responsibility for healthcare in detention centres was transferred to the NHS. However, despite this there has been little or no improvement in conditions, and the hunger strikers have risked their health in an attempt to have their basic human rights respected. The continuing problems were highlighted in a BMA report published in December 2017, *Locked Up, Locked Out: Health and Human Rights in Immigration Detention*,² which concluded that the only way to protect health in immigration detention centres was to end the policy of detention altogether.

In line with the BMA's recommendations, the medical profession must continue to support detainees and to speak out against a system that is both harmful to health and fails to acknowledge and respect the human rights of some of the most vulnerable people in the UK.

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NHS at 70: loved, valued, and too costly

How is it possible to sustain the institution and retain its core principles?

As the NHS celebrates its 70th birthday this year while engulfed in a sense of crisis, it's easy to wonder how much longer it can go on. The NHS is more than an organisation. It is a set of principles about how we value health, at both an individual and a societal level. It is the value we attach to dealing fairly with the risk and uncertainty of ill health. And it is an expression of one of the fundamental roles of the state: to protect its citizens.

The NHS today, in many respects, is in much better shape than in its younger days. More care is provided, in better ways, to more people. Care is also more evidence based, less paternalistic, and less institutionalised. The proportion of national wealth spent on the NHS has doubled.¹ Staff numbers outstrip increases in the population served. Perhaps most importantly, the NHS retains huge public support.

Rationing decisions

The NHS's creation was a rejection of what were, and remain, unfair ways of rationing healthcare through ability to pay. Rationing is inevitable in a world of finite resources and rising demand, but has the NHS found acceptable ways of matching resources to demand?

Establishing NICE was a milestone in implementing a systematic and transparent approach to rationing, but it tackles only a small proportion of the decisions that need to be made. A major, and often overlooked, rationing decision is political choice. This sets the financial envelope within which all other rationing decisions are confined. In the past 70 years spending on the NHS has increased around 10-fold

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Rationing is inevitable in a world of finite resources and increasing demand for health services

in real terms.⁴ Much of this is funded by a growing economy, coupled with political decisions, mainly to spend less in other sectors. With a doubling to over 7% of GDP devoted to the NHS, plus the amount spent on private healthcare, the UK is in the middle of the pack when comparing health spending with other European countries. On other metrics, such as spending per head and the numbers of beds, doctors, and nurses, the NHS fares less well by comparison.

Despite the overall spending rise, the NHS struggles to meet demand, even though many organisations overspend their budgets. So, what comes next? How much should we spend? When is enough enough?

Increasing NHS funding more quickly than GDP is unsustainable. Indeed, how do we improve the way funders and the public exercise their spending preferences? Is there a better method than general elections to reconnect the public with the hard economic consequences implicit in decisions about health spending?

In an economic sense, as with other industries, we'd expect the NHS to become more efficient in the way it converts its inputs (money) into outputs (activity) and outcomes (health). The



Ten questions on the future of the NHS

- 1 What should be the NHS's scope, and how do we decide this?
- 2 What outcomes/quality can we expect from a free at the point of care publicly funded service, and how might it improve?
- 3 How do we know if the NHS is adequately funded, and what metric should be used?
- 4 If publicly funded does it also have to be publicly provided?
- 5 How good is NHS policy making?
- 6 What drives productivity, how do we embed those traits?
- 7 What might we learn from evolution of clinical specialties?
- 8 Will data, big and small, affect our health and the way we care for sick people?
- 9 What are the best investments for society, which will result in the greatest benefits to health?
- 10 What funding models are best for a healthy, just society?

NHS, like other health services, suffers from William Baumol's "cost disease": where a labour intensive business finds it hard to improve its productivity.^{5,6} But its productivity improved at a rate of just under 1% a year from 1995—and more recently the NHS improved more quickly than the rest of the economy.⁷

Indeed, it has made some significant gains, such as reductions in length of hospital stay and switching to generic drugs.⁸ These gains partially offset the need to increase funding further. But we need to understand better the underlying drivers of such improvements and how they might be stimulated to maximise future gains in productivity. Other factors, such as patient experience and integrated care, are important but harder to define in terms of economic productivity.

Universal coverage

All UN member are committed to achieving universal health coverage by 2030. It already exists in the UK, thanks to the NHS, which is observed keenly by the rest of the world as a natural experiment. The experiment does show, however, that achieving universal health coverage is only the beginning of the debate.

In the NHS's 70th year, the debate is at a critical point about the service's very essence and its sustainability. Over the coming months we'll examine its achievements and prospects, focusing on 10 questions (see box). The NHS inspires passionate opinions. We urge you to join the debate.

In all of this, we argue that one founding principle is inviolable: all people should have access to health services that is based on need and free at the point of delivery. As we open up *The BMJ's* pages for an intense, urgent, and necessary debate, this is the one principle on which we will not move.

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Your views on the assisted dying debate

Scores of correspondents responded to a series of *BMJ* articles, as **Birte Twisselmann** reports

The strongest argument against assisted dying, among the 91 responses from readers to our recent cluster of articles (bmj.com/content/assisted-dying), was that under no circumstances should doctors intentionally kill patients. Eunice Minford, consultant surgeon in Northern Ireland, quoted the retired judge Elizabeth Butler-Sloss: “The law... rests on the principle that we do not involve ourselves in deliberately bringing about the deaths of others. Once we start making exceptions based on arbitrary criteria such as terminal illness, the frontier becomes just a line in the sand, easily crossed and hard to defend.”

Assisted suicide might also be open to abuse, some readers thought. Barry Cullen, retired GP from Fareham, Hampshire, asked, “Would there be the same level of support for physician assisted suicide if it were introduced as a cheaper alternative to palliative care in an NHS already starved of resources?” But other readers assured that there was no evidence for a “slippery slope.”

Doctors' involvement

Some readers perceived that, though some doctors might be willing to adopt the practice, others might not—in analogy to the 1967 abortion law change. Richard Rawlins, retired orthopaedic surgeon from Devon, however, suggested that doctors need not be involved in assisted dying: “The final practitioner might be a nurse, a retired doctor who is no longer registered with the GMC, a lawyer, a priest, or a member of a new profession developed for the purpose. This is not hypocrisy—there can be a clear distinction in the responsibilities.”

The BMA's opposition to assisted dying was clarified by Anthea Mowatt, representative body chair, as being supported by research findings from 2016: “In line with



ASSISTED DYING
Why is the profession so out of step with the public?

our formal policy making process, our members voted to uphold the association's opposition to physician assisted dying and specifically rejected moving to a position of neutrality.” Her conclusion: “The standard of palliative care is clearly inconsistent throughout England, and the priority... must be to provide the best quality care to patients as they reach the end of their lives, regardless of where they live or their medical condition.”

But this was not enough to satisfy those calling on the BMA to adopt a neutral position, including Raymond Tallis, emeritus professor of geriatric medicine at the University of Manchester, who found Mowatt's response inadequate and lamented the BMA being “on the wrong side of history.” He wrote, “The Californian Medical Association was neutral on assisted dying when the law was passed in 2015. It was this stance that enabled the association to engage with lawmakers and help shape legislation.”

“We must champion a narrative that gives all of the issues the attention they are due”

The need for better palliative care was a recurring theme in responses. Bobbie Farsides, professor of clinical and biomedical ethics at the University of Sussex, had said in her commentary that palliative care and assisted dying were not mutually exclusive. Michael Stone, who describes himself as “retired, non-clinical,” agreed with Farsides when she wrote: “I still challenge the belief that a wish to die at a particular time and in a particular way can be ‘cared away,’ however great the skill of the professionals and resources committed to end of life care.”

Patient autonomy

Many correspondents mentioned patient autonomy. And, like Jacky Davis in her personal view, many said that doctors should be polled.

Of all 91 responses, 80 were from UK readers, half of them doctors. About half supported assisted dying, with the rest pretty evenly divided into those opposing a change in the law and those undecided.

“Currently, I am not decidedly for or against physician assisted suicide,” wrote Aoife Abbey, a year 5 specialty trainee in intensive care medicine in the West Midlands. “A ‘good’ doctor's practice does not just follow politics and policy... We must champion a narrative that gives all of the issues the attention they are due. We are all service users. We are all relatives. We are all patients.”

The only conclusion is that assisted dying remains deeply contentious for all, as *The BMJ's* features and debates editor, Richard Hurley, wrote in an opinion piece. “Reaction to recent articles has been immense, and we're keen to continue to provide a platform for all relevant views on assisted dying, for, against, or neither—so let us know your thoughts.” Please do.

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Dietary disclosures

Should nutrition researchers declare their own diet as conflicts of interests, asks **Tim Schwab**

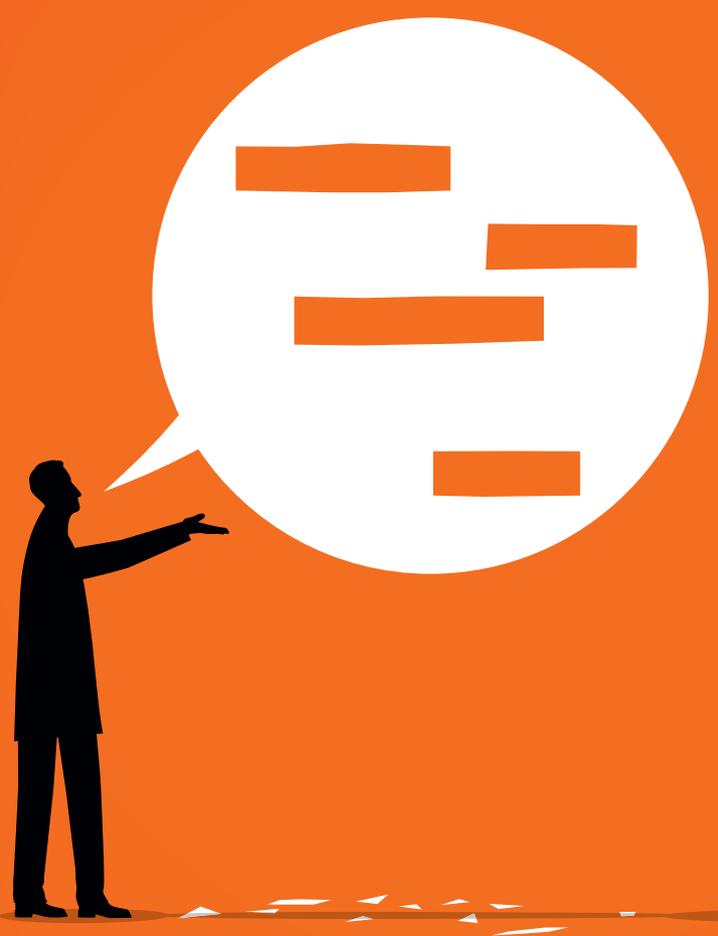
A provocative article in *JAMA* last December argued that when nutrition researchers disclose conflicts of interest they should include “non-financial” conflicts, such as their dietary preferences and advocacy work. Non-financial, or intellectual, interests in general might include holding particular religious or cultural beliefs or political opinions. Favouring a hypothesis, working in a particular theoretical framework, or even previous research findings could also constitute such an ideological interest.

“Scientists are likely to defend their work, their own discoveries, and the theories that they proposed or espoused,” wrote authors John Ioannidis and John Trepanowski of the Stanford Prevention Research Center in California.

“Nutrition scientists are faced with an additional challenge,” they wrote. “Every day they must make numerous choices about what to eat while not allowing those choices to affect their research. Most of them also have been exposed to various dietary norms from their family, culture, or religion.” They offer five examples of dietary views that could present conflicts: “strict veganism, Atkins diet, gluten-free diet, high animal protein diet, [and] specific brands of supplements.”

Their call for greater openness in nutrition science draws new attention to a perennial debate in medical research and practice over whether non-financial interests should be disclosed and scrutinised for potential bias in the same way as financial interests—for example, owning shares in the company that makes the drug you are researching or prescribing. But some researchers say that disclosure of non-financial interests could create more opacity rather than transparency.

Marion Nestle, a nutrition scientist at New York University, argues that hypothesis driven science depends on having a point of view, which is invariably informed by values and culture, including things like diet.



The whole truth: why non-financial biases matter

For transparency’s sake, people involved in public debate and policy making should reveal their conflicts of interest. Financial disclosures have long been the norm. But can we manage the intrinsic and woolly biases of advocacy, ideology, and reputation the same way? Read our debate on p 16.

First we consider a call for nutrition researchers to spill the beans on their own diet. And we leave till last, on p 18, the influence of religious faith in discussing topics such as assisted dying.

“All scientists have intellectual biases. They’re integral. They’re inherent. People couldn’t do science without them,” Nestle tells *The BMJ*. “Industry funding skews science in ways that ideological interests simply don’t.”

Several meta-analyses comparing industry and non-industry funded studies show that financial conflicts of interests can bias science, including in nutrition research. But no such robust evidence of bias exists around dietary preferences, a point Ioannidis acknowledges.

But Ioannidis, a professor of medicine renowned for highlighting new problems in science, says that strongly held dietary beliefs are, nevertheless, pervasive among nutrition researchers and should be disclosed as conflicts of interest.

“The majority have strong choices, probably,” Ioannidis tells *The BMJ*. “Many papers take very strong positions that probably go way beyond the data.”

In Ioannidis’s view, if scientists strongly adhere to specific diets—or engage in “advocacy and activism” around diets—they have conflicts of interest.

Although scientists in any discipline may form an “allegiance bias” to favoured theories or ideas, nutrition researchers may be particularly vulnerable, the *JAMA* article says. Not least because every day researchers have to make choices about what to eat without allowing those choices to affect their research.

Value based beliefs

Loma Linda University in California often publishes research about vegetarianism, and the school is operated by the Seventh-day Adventist Church, which advocates vegetarianism. Should researchers working there disclose their diets? What about their faith based advocacy?

A spokesperson for the university told *The BMJ* that the church’s dietary views are not dogmatically tied to vegetarianism: “We are always open to rethink our health principles positions based on new evidence.”

Eric Feigl-Ding, a nutrition researcher at Harvard University, says it is precisely because a researcher’s dietary preferences can be “highly cultural” or religious that science should push back against disclosure. Asking scientists to divulge information that might reflect on their “social and cultural upbringing,” Feigl-Ding says, is a “slippery slope” towards infringing privacy and potential prejudices.

Ioannidis suggests other scientific topics, such as mindfulness meditation, tai chi, or

One difficulty is defining non-financial conflicts. Are all diets conflicts of interest or only some? In research about the vegan diet, should only vegan researchers disclose?

circumcision, may also be subject to “cultural or religious value judgments” by researchers, which could represent disclosable interests.

Some authors are already disclosing. In a 2015 systematic review examining the association between transmission of herpes virus and a Jewish circumcision ritual involving orogenital contact, the authors disclosed their circumcision status and religious views.

Dennis Bier, editor of the *American Journal of Clinical Nutrition*, has co-written with Ioannidis a paper about non-financial



conflicts in which he disclosed several industry ties but no non-financial interests. Nevertheless, Bier says that non-financial interests may be more “prevalent or problematic” than financial interests in nutrition research—but also harder to manage.

“It’s really hard to come up with a generic approach,” Bier tells *The BMJ*. His journal has no plans to ask for dietary disclosures.

One difficulty is defining non-financial conflicts. Are all diets conflicts of interest or only some? In research about the vegan diet, should only vegan researchers disclose?

Another complication is asking scientists to view, and volunteer, their beliefs, ideologies, or diets as conflicts of interest that could introduce bias.

Some scientific journals and institutions have moved their conflict of interest policies to include non-financial interests, but in broad terms. The International Committee of Medical Journal Editors (ICMJE), for example, asks for non-financial “relationships or activities . . . that readers could perceive to have influenced” their work.

For research papers *The BMJ* asks prospective authors to follow the ICMJE, to

declare “Non-financial associations that may be relevant or seen as relevant to the submitted manuscript.” For other articles, it asks about unpaid work and relationships, saying, “We would also want to know about strongly held beliefs where they are relevant to the task in hand.”

Distraction from financial conflicts

Ioannidis’s call comes at a time when there is also heightened attention to financial conflicts in nutrition research, such as Coca-Cola’s influence in obesity research.

Efforts to scrutinise dietary preferences and other non-financial interests as conflicts can be a “red herring,” which draws attention away from financial conflicts, says Lisa Bero, an expert on the integrity of evidence at the University of Sydney. In an opinion piece in *PLoS Biology* in 2016 she criticised the “laundry list” approach to disclosures in which “anything and everything becomes labeled” as a conflict.

“It leads more to a satire or ridiculing of the whole concept of conflicts of interest,” Bero tells *The BMJ*.

Some of the leading voices calling for scrutiny of non-financial interests have been industry scientists. In the late 1990s, an industry scientist opined in *The BMJ*, “Perhaps science might seem more human and more believable if we all agreed that conflicts of interest are everywhere.”

A commentary in the *International Journal of Obesity* in 2010 discussed what the authors termed “white hat bias,” when researchers misrepresent findings to conform to their own “righteous” perceptions, such as “indignation toward certain aspects of industry.” White hats were often worn by the heroes of Western films. The authors of the paper disclosed extensive financial ties to the food industry.

Efforts to put non-financial conflicts on a par with financial interests may already be benefiting industry. A 2016 *BMJ* article explored how the US Food and Drug Administration had policed advisory panel members for “intellectual conflicts of interests” in a one sided fashion, excluding panellists who had criticised the drug industry but allowing financially conflicted scientists to remain on advisory panels.

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Competing interests: I previously researched conflicts of interest as an employee of the public interest group Food and Water Watch

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yes

People are driven at least as much by non-financial motives. These exert a powerful influence on human behaviour

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Non-financial conflicts of interest in medical research and practice, which include those of a political, ideological, individual, or religious nature, are often overlooked, denied, and even defined out of existence. The focus is directed instead towards financial interests, such as drug industry sponsorship of research, or payments to doctors.

But dismissing non-financial conflicts of interest is naive, empirically unfounded, and dangerous. It is also unnecessary because non-financial conflicts can be managed with nuance and sensitivity.

Research shows, and common sense dictates, that people are driven at least as much by non-financial motives as they are by financial gain. These motives, which include the desire to protect ourselves or our family from harm, to reinforce our deeply held beliefs and values, to reciprocate gifts or favours, to attain status, and to avoid social disapproval, unquestionably exert a powerful influence on human behaviour. As argued by Cappola and Fitzgerald in relation to academia, “the prospect of fame may be even more seductive than fortune.”

For example, the decisions of well remunerated doctors to participate in drug industry advisory boards or accept the role of “key opinion leader” are far more likely to be driven by other motives than by financial gain. Indeed, the financial incentives associated with advisory board membership—for example, \$1000 or a free flight—seem to pale in comparison with the social and psychological importance of being invited to contribute to clinically relevant research, “improve” patient care, and gain status and respect in the medical community.

Effects on policy and practice

Although non-financial conflicts have been much less studied than financial interests, emerging evidence indicates that they can affect biomedical research and policy. For example, evidence shows that non-financial interests may “call into question the impartiality of [systematic] reviews” and

negatively affect the equitable allocation of health resources in grant funding procedures.

Even without formal research, it is not difficult to find examples of the far reaching effect of non-financial interests. Take, for example, the influence that Christian beliefs regarding the moral status of the embryo have had on stem cell research, particularly in the United States, through prohibiting the public funding of embryonic stem cell research and human somatic cell nuclear transfer.

Identify, assess, manage

The dismissal of non-financial conflicts of interest often stems from the notion that they are too complex and ubiquitous to be effectively managed. However, non-financial conflicts can be identified, assessed, and managed using similar strategies to those for financial interests—including, for example, disclosure and recusal. For instance, it is reasonable to expect a member of a committee deciding whether to approve the subsidisation of a new drug to declare if he or she or a relative has a medical condition that may benefit from the drug being considered.

Clearly, the disclosure of non-financial interests, some of which may be highly personal, must be handled with discretion to avoid needlessly intruding into people’s privacy or placing them at risk of discrimination. However, mechanisms are often put in place to balance the tension between disclosure and privacy, such as controls over documentation and public access to declarations of certain conflicts, and these could be applied more broadly.

It is equally important that people with non-financial conflicts of interest are not automatically excluded from key roles such as participation in advisory committees. For example, it is concerning that US Food and Drug Administration regulation of “intellectual interests” may allow people with important financial conflicts of interest to participate while excluding people who may have safety concerns.

In medicine, as in life more generally, money is not the only determinant of behaviour. Values, beliefs, and social relationships matter just as much, and we cannot afford to deny the effect of these forces on decision making and health policy.

HEAD TO HEAD

Should we try to manage non-financial interests?

Ideological biases influence medical research and practice and should be disclosed and managed, say **Miriam Wiersma and colleagues**. But many of these interests are widespread and inherent to life, **Marc Rodwin** argues, and cannot be avoided or eliminated

no

Regulating these potential sources of bias using a conflict of interest framework would burden professionals and institutions for little benefit

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Some doctors and academics argue that intellectual interests and points of view are conflicts of interest because they can bias medical researchers or practitioners. Some propose trying to regulate the intellectual conflicts, while others would reduce or cease oversight of financial conflicts. However, consider that the law—which is where the notion of conflicts of interests first emerged—does not define conflicts of interest simply as anything that creates bias, nor does it regulate non-financial biases as conflicts of interest.

And for good reason. Treating intellectual conflicts as conflicts of interest would unmoor the concept from its original meaning, making it merely another phrase for bias. Although intellectual interests can cause bias, this does not mean that they constitute conflicts of interest and can be regulated as such.

Legal construct

Legally, there are two broad types of conflicts of interest: conflicts between an individual's obligations and financial interests and conflicts resulting from an individual's conflicting duties, roles, or divided loyalties—sometimes referred to as conflicts of commitments. For example, a physician might treat patients and conduct clinical trials. However, having your patient participate in your research creates conflict of interest because the goals of research are different from those of caring for patients.

Consider the interests in the box. These interests are quite different. The law defines only the last five interests as potential sources of conflict. Redefining “conflicts of interest” to include any potential intellectual interests that conflict would make the concept a less practical tool. There is no effective way to eliminate most intellectual conflicts, which are widespread and an inherent part of life. Regulating these potential sources of bias using a conflict of interest framework would burden professionals and institutions for little benefit. But financial conflicts of interest generally can be avoided or eliminated.

Certainly, a predilection for a hypothesis and intellectual commitments can influence a person's work and interpretations. Yet

TPOLOGY OF INTERESTS

- 1 Intellectual commitments (eg, working within a theoretical framework, school of thought, or having proposed a hypothesis)
 - 2 Interest in a positive outcome to a study that will support your previous findings
 - 3 Interest in maintaining professional reputation
 - 4 Interest in career advancement
 - 5 Interest in finding potential practical applications of research
 - 6 Interest in maintaining good relations with future research funders
- Legal conflicts of interest
- 7 Income or gifts from a commercial interest that will profit if you make professional decisions that favour its interests
 - 8 Income from consulting related to your research
 - 9 Intellectual property in fruits of research
 - 10 Financial interest in a firm sponsoring your research
 - 11 Equity interest in firms that commercialises your research

these tendencies are revealed in people's publications, and routine scientific debate effectively counters intellectual bias. In contrast, a researcher's financial interests are often unknown. And studies show that financial conflicts influence results, especially industry supported studies that evaluate the industry's products. Furthermore, having researchers with diverse intellectual perspectives enriches scientific inquiry.

Although desire for recognition can affect a researcher's conduct in undesirable ways, these interests cannot be eliminated. In contrast, financial conflicts are an unnecessary source of bias, and eliminating them protects the integrity of research.

Society has long regulated the financial conflicts of interest of public servants, judges, lawyers, and financial professionals, but it has not regulated their intellectual conflicts, for good reasons. The fact that other activities can compromise medical research and practice does not mean that we should cease to regulate financial conflicts of interest. There may be reasons to address these other sources of bias, but we should not do so using a conflict of interest framework.

Competing interests: See bmj.com.

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HIDDEN BIASES

Why religious belief should be declared

Faith can profoundly affect views on matters such as abortion and assisted dying, and full disclosure is essential when taking part in public debate to provide full context, say **Richard Smith** and **Jane Blazeby**

“If in doubt, declare a competing interest” is standard teaching in ethics. Hiding a competing interest hints at dishonesty, raising doubts about the integrity of what has been written or said. It thus seems elementary that you should declare a religious competing interest because faith and other non-financial competing interests often have a profound effect on people’s views. Yet people with deep religious beliefs and other non-financial competing interests often do not make such a declaration, perhaps believing it to be a private matter or because of the tendency to focus on financial conflicts of interest.

Religious conflicts of interest are important in healthcare. One example is the wide variation in the availability of NHS abortions during the ’70s and ’80s, which was often driven by the religious beliefs of medical leaders.² In the West Midlands, for example, women often had to pay for or forgo abortions because of the religious beliefs of the professor of obstetrics and gynaecology in Birmingham. Such a variation in the availability of treatments for heart attack or fractured bones would not have been tolerated, but it was tolerated for years in the case of abortion.

Abortion still evokes strong passions, but for many countries the main battleground where religion is important today is assisted suicide.³ Many of those prominent in the

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debate have strong religious beliefs. Most religious authorities are against assisted suicide, so it is essential that people participating in the public debate declare their religious beliefs. This is partly because their beliefs will influence their views but also because their religion may require them to take a particular view.

Of course, not all religious people will follow the strictures of their religion: Patrick Kennedy, a US Catholic politician, supported abortion despite a bishop asking, “How can you claim to be a Catholic and also support abortion?” and arguing that he should be denied holy communion.⁴

A conflict of interest is a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest.⁵ Conflicts of interest influence people’s views.^{5,6} And statements disclosing competing interests influence how other people evaluate their articles or speeches.⁷

Arguments against disclosure

Such disclosures are important because they allow arguments to be considered in their full context. Indeed, a figure such as George Carey, the former Archbishop of Canterbury, changing his views from opposing to supporting assisted suicide in certain circumstances can profoundly influence the debate.⁸

Arguments against declaring religious interests might include that they are irrelevant, all that

matters are a person’s arguments, and that disclosure might mislead because the person might not agree with the view taken by his or her religion. But religious (and other non-financial) competing interests clearly are relevant in many debates, and the point that all that matters are people’s arguments potentially applies to all competing interests, and long ago this ceased to be acceptable in medical journals. The fact that people’s beliefs may conflict with those of their religion may add strength to their argument, suggesting deep thought rather than passive acceptance. Another argument against declaration might be that religion is a “personal matter,” but that argument could also be used for financial conflicts of interest and is not acceptable.

If you are dressed in purple, perhaps wearing a mitre, and sign yourself as a bishop you do not need to declare your religion as a competing interest—it’s plain for all to see. But if you have a religious faith that is not apparent and you are participating in a debate on an issue affected by religious belief, such as abortion or assisted suicide, then you should declare that competing interest even if your views conflict with those of your religion.

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