Drug shortages are already affecting patient care, even before the potential effects of Brexit, doctors have warned.

Helgi Johannsson, a consultant anaesthetist and clinical director at Imperial College Healthcare NHS Trust, asked colleagues on Twitter to report how drug shortages were affecting them, after he reported that his hospital often experienced shortages of basic drugs such as diamorphine and metronidazole.

He received more than 600 responses to a snapshot poll, with almost nine in 10 respondents (87%) reporting they often had shortages. He said he was alarmed that more than a quarter of respondents (26%) said shortages were affecting patient care.

He told The BMJ, “I thought shortages would be commonplace, but I didn’t think as many would respond that it was affecting patient care. That’s really worrying when we’re having to give inferior care because we haven’t got the drug that gives the best care. It’s not that these are expensive drugs . . . It’s an issue of supply.”

Johannsson said that drug shortages were already “a massive issue nationwide” and that he fears the situation will worsen after Brexit. “There are several drugs we use in everyday practice that are running short or not there. And it’s certainly worse than it was about two to three years ago,” he said.

Dean Burns, an emergency and critical care physician, responded to Johannsson’s Twitter poll. He posted, “Lorazepam and diazemuls [are the] latest [shortages] for us. It occupies an incredible amount of pharmacists’ time dealing with shortages.”

GPs too are reporting shortages. Andrew Green, of the BMA’s General Practitioners Committee, said, “The implications of Brexit on supply not only of drugs but also of essential personnel and equipment were not stressed before the referendum and have not been adequately addressed even now.”

Last month the Department of Health for England wrote to drug companies asking them to ensure that their UK stockpiles of drugs were sufficient to cope with any potential delays at the border that may arise in the event a no deal Brexit.

A department spokesperson said, “The government is confident of reaching a deal with the EU that benefits patients and the NHS, but we are preparing for all situations and we are working closely with partners to ensure adequate stockpiles are in place for all medicines which may be affected in the event of a no deal Brexit.”

Gareth Iacobucci, The BMJ

Cite this as: BMJ 2018;362:k4040

Helgi Johannsson was shocked at how far his survey showed patient care was being impaired by drug shortages even before EU withdrawal

“Brexit will make drug shortages worse”

LATEST ONLINE

• Pay rise for doctors in Wales
• New California law requires doctors on probation for serious misconduct to inform patients
• Alcohol is blamed for one in 20 deaths as reduced consumption remains elusive
In-house pharmacists save GPs five hours a week

A clinical pharmacist based in a general practice frees up almost five hours of GP time a week by taking on prescribing work, a small study in Scotland has found. They also improve patient safety and staff morale, and reduce stress levels, according to surveys of GPs and practice staff.

In 2015 the Scottish government announced a £50m primary care fund, part of which was used to recruit up to 140 whole time clinical pharmacists to support the care of patients with long term conditions. Researchers looked at the effects of these pharmacists in 16 urban practices with a total of 69 GPs in the Inverclyde Health and Social Care Partnership in NHS Greater Glasgow and Clyde.

The clinical pharmacists took on special requests (for acute care prescriptions created by a GP without an appointment), immediate discharges (ensuring drugs were clinically reviewed and accurately reconciled), outpatient requests, and other drug matters. For two weeks before the study and for two equivalent periods during the study, GPs recorded the time they spent on these activities.

The findings, published in the British Journal of General Practice, showed that the clinical pharmacists reduced GP time spent on these four key prescribing activities by 51% (79 hours) a week, saving 4.9 hours a week per practice.

Ingrid Torjesen, London  Cite this as: BMJ 2018;362:k4019
**MEDICINE**

**Research news**

**Experts extol benefits of golf for all**

Playing golf may be good not only for mind and body but also for a long life, by reducing risk factors for heart disease and stroke, said a consensus statement by experts in the *British Journal of Sports Medicine*, which aims to widen participation in the sport. Golf can boost strength and balance and is associated with good mental health, the statement added. It called for initiatives to promote inclusivity to attract more people to the sport, including women and girls.

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**Fewer children buying cigarettes after display ban**

Removing displays of tobacco products from shops in 2015 seems to have cut the proportion of children buying cigarettes from shops by 57% to 40% of those who smoke, in an analysis of survey responses from 18,000 11-15 year olds. But two in three children had not been refused cigarettes when they last bought them—a figure unchanged from 2010 to 2016, the study in *Tobacco Control* found.

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**Cancer**

**Obesity to be “bigger threat for women than smoking”**

Obesity is set to overtake smoking as the biggest preventable cause of cancer among UK women within 25 years, Cancer Research UK said. By 2035, 10% of cancers in women (around 25,000 cases) could be caused by smoking and 9% by excess weight, but by 2043 excess weight could overtake smoking, said the report in the *British Journal of Cancer*. Cancer Research UK is launching a campaign to raise awareness that excess weight increases the risk of 13 types of cancer.

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**Medical students**

**Graduates face worsened access to medical school**

The closure and shrinkage of graduate entry medical degree courses is stopping candidates from diverse backgrounds entering the profession, students warned in a letter to the *Journal of the Royal Society of Medicine*. The proposal to move full GMC registration from the end of the first year of foundation training to graduation from medical school was partly to blame, they said, as the first foundation year counts towards the graduate medical degree, which the European parliament states must be five years.

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**Clinical negligence**

**GPs can expect to be sued once every 10 years**

In a 40 year career GPs can expect to be sued four times, but latest figures show that in only 17% of cases are doctors found to be negligent, the Medical Defence Union said. It called for “root and branch legal reform” to tackle the problem of soaring costs from clinical negligence claims.

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**Life expectancy**

**UK life expectancy did not improve in 2015 to 2017 and remained at 79.2 years for males and 82.9 years for females. It fell by 0.1 years for males and females in Scotland and Wales, and for males in Northern Ireland**

[Office for National Statistics]

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**SIXTY SECONDS ON…**

**P-HACKING**

**Sounds uncomfortable**

It’s proved so for Brian Wansink (below), a prominent food researcher who has resigned from Cornell University after six papers were retracted by *JAMA* and its specialty journals over suspicions of P-hacking.

**Which is?**

Playing around with data until you find a correlation that meets the statistical standard for significance, which is P less than 0.05.

**Remind me what P IS**

P measures the probability that any correlation has arisen by chance. If it’s less than 0.05 (one in 20) that’s taken as good enough to reject the chance explanation and regard the correlation as real.

**Can you give me an example?**

Wansink did an experiment in an Italian restaurant where half the customers paid half price for a buffet meal. He was convinced there would be a correlation between how much they paid and how much they enjoyed the food. But there wasn’t.

**A failed experiment, then?**

Not at all. He encouraged a graduate student to slice and dice the data until she found a significant result. Try breaking up the diners into groups, he suggested: “males, females, lunch goers, dinner goers, people sitting alone, people eating with groups of two, people eating in groups of more than two, and so on.”

**Did it work?**

Like a dream. In a year she had published four studies, all coauthored by Wansink. He called her “the grad student who never said no” and celebrated her in a blog post—a big mistake. He encouraged a graduate student to slice and dice the data until she found a significant result. Try breaking up the diners into groups, he suggested: “males, females, lunch goers, dinner goers, people sitting alone, people eating with groups of two, people eating in groups of more than two, and so on.”

**Is P-hacking common?**

It’s pervasive, according to a 2015 study that looked at reported P values in many disciplines. The clustering of P values just below 0.05 was the giveaway.

**What’s the answer?**

Eternal vigilance. Pre-registering trials with specific endpoints is a big help as it makes it harder to tinker with the data once gathered. But like death and taxes, P-hacking isn’t going away.

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Nigel Hawkes, London

Cite this as: BMJ 2018;362:k4039
Supporters of online consulting should listen to critics, says GP leader

Advocates and providers of online GP consulting must engage with criticism and be more receptive to “rigorous evaluation” of new technologies, the vice chair of the Royal College of General Practitioners has argued.

Martin Marshall (below), the college’s vice chair and a GP in east London, told a Westminster Forum debate on the future of general practice that there was “enormous potential” in online consulting, which he had employed on occasion. But he said it was crucial that the potential risks and benefits were properly evaluated and that people who raised concerns were not dismissed as Luddites.

Marshall said, “The advocates of online consulting need to be more willing to listen to critics than they have been so far. Critics are often dismissed as conservatives or dinosaurs, and sometimes the language is abusive and unpleasant. It seems to me that policy that’s driven by deaf enthusiasts and by commercial interests is not likely to be good policy.”

Marshall said online consulting services such as GP at Hand, which is available in London, offered potential benefits such as convenience for patients and career options for doctors who may be seeking portfolio careers. But he said the benefits needed to be assessed against potential risks, such as the possibility of diagnoses being missed if patients are not seen face to face, fragmentation of care, and health inequalities. Health secretary Matt Hancock was recently criticised for calling for GP at Hand to be rolled out across the country.

Evidence based

Marshall acknowledged that technology moves fast but urged policy makers—and providers of digital services—to commit to “rigorous scientific processes” to ensure that policy is evidence based.

He said, “We know online consulting has great benefits. We know it has great risks. We have no idea how that balance will play out, so we need to have evaluations. We need to expose the results to a peer review process; we shouldn’t be publishing them at big glossy seminars for the media first.

“I’m not asking for randomised controlled trials that give the answer after technology has moved on. I’m asking for pragmatic forms of evaluation.”

Marshall also warned against overclaiming what online consulting and artificial intelligence could achieve. “We have lots of experience of e-health technology in the NHS and the evidence is fairly clear that, by and large, they overpromise and underdeliver. If we integrate online consulting into the established model of a general practice, it’s much more likely to be effective.”

Gareth Iacobucci, The BMJ

Cite this as: BMJ 2018;362:k4035

CCGs win right to offer patients Avastin for wet AMD

A group of 12 clinical commissioning groups in the north of England has won a legal battle to offer patients off-label bevacizumab to treat wet age-related macular degeneration, which they say will save the NHS millions of pounds.

Drug companies Novartis and Bayer took legal action against the CCGs last November because they were offering bevacizumab (Roche’s Avastin), which is not licensed for treatment of wet AMD, alongside ranibizumab (Novartis’s Lucentis) and aflibercept (Bayer’s Eylea), which are approved by NICE for treating the condition.

The legal action was taken on four grounds: the supply of bevacizumab was unlawful; it undermined drug regulation; it undermined patients’ right to have a NICE approved drug; and the patient information sheet was misleading. However, the High Court’s Mrs Justice Whipple dismissed the application for judicial review on all grounds.

She said the companies’ arguments that the NHS could not consider bevacizumab unless Roche applied for an eye treatment licence was an “absurd proposition” that “would give unbounded power to the pharmaceutical companies to decide which medicines to make available for which purposes. That would be seriously detrimental to the wider public interest in maintaining a cost effective public health system.”

David Hambleton, a former consultant geriatrician and lead for the North East and North Cumbria CCG Forum, said that the group was delighted.

“Novartis and Bayer have argued long and hard for the more expensive drugs to be the only ones available, but, thankfully, the court has recognised that there is no medical basis to that argument.”

The High Court ruled that bevacizumab (below) can be used off label

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Gareth Iacobucci, The BMJ

Cite this as: BMJ 2018;362:k4035
NHS making good progress on sustainability, report shows

In the past decade the health and social care system in England has reduced its carbon footprint by 18.5% at the same time as clinical activity has grown by 27.5%, according to a report from the Sustainable Development Unit for NHS England and Public Health England.

Carbon emissions have fallen from 33.3 m to 27.1 m tonnes since 2007—a cut equivalent to the annual emissions from a country the size of Cyprus. The rate of reduction has speeded up in the past two years but is still behind the trajectory to reach the Climate Change Act 2020 target of 34%.

The NHS’s total water footprint fell by 21%—from 2.83 bn m$^3$ in 2010 to 2.23 bn m$^3$ in 2017. The footprint includes direct use of water and that used in the manufacture and supply of goods and services.

In 2016-17 NHS providers generated nearly 590 000 tonnes of waste, the report says, of which 85% was not sent directly to landfill. Some is used to produce energy and 23% is recycled. The report says, however, that further action is needed to reduce waste and in particular the use of plastics.

Air pollution
The report also gives a first assessment of NHS impact on air pollution. It estimates that there were 9.5 bn road miles of NHS related travel in 2017, creating 7285 tonnes of nitrogen oxide and 333 tonnes of particulates (specifically PM$_{2.5}$). The largest source of air pollution comes from patient and staff travel.

The report says staff should be supported in making healthier travel choices. It points to the examples of Central Manchester University Hospitals NHS Foundation Trust, which increased its cycling infrastructure.

The report comes as draft guidance from NICE calls on NHS organisations to replace high polluting vehicles with electric or hybrid makes. It says commissioned services should identify how they will reduce emissions from their vehicle fleets.

Efficient use of drugs and less overprescribing can have many benefits—cutting carbon emissions, reducing the water footprint, and saving money, says the report. It points out that metered dose inhalers represent 3.2% of the health and social care carbon footprint because of the high global warming potential of the propellants used. It says lower emission and safe alternatives are available.

Medical equipment is the largest area of carbon emissions and the fourth largest water impact area. The report says it is important to work in partnership with suppliers to minimise the creation of waste. One example of good practice is the British Red Cross in Nottinghamshire, which saved the NHS more than £1.7m by reusing community equipment.

Saving money
Jane Dacre, president of the Royal College of Physicians, said good progress had been made in many areas of sustainability. “We hope that progress continues at a faster rate. The good practice examples show that reducing waste can also save money that can be ploughed back into patient care.”

Laurie Laybourn-Langton, of the UK Health Alliance on Climate Change, said, “The NHS leads the world in implementing sustainable practices, reaping the health and economic benefits in the process.”

Jacqui Wise, London
Cite this as: BMJ 2018;362:k4032

The BMJ
Cite this as: BMJ 2018;362:k3974

Doctors turn to Google Translate to talk to patients

Doctors are using Google Translate to overcome language barriers in consultations with patients, a research team at the London School of Hygiene and Tropical Medicine has found.

The researchers learnt about doctors’ use of online translation tools while studying attitudes to vaccination among Polish and Romanian communities in England.

Sadie Bell, a research fellow in public health evaluation at LSHTM, described the finding when presenting the results at Public Health England’s annual conference, in Coventry on 11 September. “Healthcare workers discussed challenges during consultations with communication,” she said. “A large number reported relying on using online communication tools—so, Google Translate—rather than going to more formal modes of communication, using telephone or face to face interpreters.”

She said that the reliance on online services was partly driven by difficulties in using services provided by the NHS. “The perception around telephone and face to face interpreters was that they could be expensive and time consuming and that there are going to be issues with the messages getting lost in translation,” she said.

“It was considered quite hard for some of them to get the right translator, particularly for people who needed Romanian translators.”

Speaking to The BMJ, Bell said that challenges arose in both verbal and written communication. “Healthcare workers reported using online translation tools, such as Google Translate, as a medium for verbal communication or to help with the translation of written vaccination histories,” she said. Online tools were considered more accessible than other options, “particularly during time pressured appointments.”

As part of the research the team collected verbatim quotes of healthcare workers’ comments. “Very often I use Google Translate,” said one of the doctors interviewed. “People have said, ‘Oh, it’s not the direct translation,’ but it’s better than me struggling and the person not having a clue what I’m talking about.”

Tom Woburn, The BMJ
Cite this as: BMJ 2018;362:k3974

WATER footprint of the NHS in England fell by 21% over the past seven years

The total
Survey of doctors highlights blame culture in the NHS

A major survey of UK doctors reveals a bleak picture of the workplace. Many believe they work in a dangerous and toxic environment with a blame culture that jeopardises patient safety and discourages learning and reflection.

The survey of 7887 doctors—including GPs, junior doctors, and consultants—was carried out as part of a BMA project, Caring, Supportive, Collaborative, aimed at finding solutions to the challenges faced by the NHS.

Most doctors (78%) said NHS resources are inadequate and this significantly affects the quality and safety of patient services, which have worsened, including waiting times for patients and staffing levels. Around three quarters said they believed national targets and directives are prioritised over the quality of care.

The survey found that 95% of doctors said they are occasionally or often fearful of making a medical error in their daily workplace and the level of fear has increased over the past five years. Nine in 10 doctors said one of the main reasons for making errors is pressure or lack of capacity in the workplace.

**Practise defensively**
Just over half (55%) worry that they will be unfairly blamed for errors that result from systemic failings and pressures and, as a result, 49% said they practise defensively. The report said that the recent case of Hadiza Bawa-Garba reinforced perceptions among doctors that they will be held accountable for wider systemic failings.

Three quarters of doctors said they are cautious about recording reflections for fear it could be used against them, with junior doctors expressing particular concern. The survey found that 49% said they do not have the time to learn and develop professionally.

A significant proportion of the surveyed doctors think bullying, harassment, or undermining is a problem in their workplace, with 29% saying it was sometimes a problem and 10% that it was often a problem. Black and Asian doctors were more than twice as likely as white doctors to say that there is often a problem with bullying, harassment, or undermining (18% versus 7%).

Moreover, only 55% of black and Asian doctors felt respected or culturally included in their workplace, with many saying they experienced racism in everything from job progression to training and interaction with patients.

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Judges tell GMC to use more restraint in tribunal appeals

“**This case addressed an important point of principle, as well as vindicating our member**”
Caroline Fryar, Medical Defence Union

Three Court of Appeal judges have overturned a High Court judge’s ruling that a doctor acted dishonestly and have urged the GMC to show restraint in appealing against findings of fact in regulatory cases.

A medical practitioners tribunal ruled in February 2017 that Hemmay Raychaudhuri, a locum paediatric registrar, had not been dishonest and that his fitness to practise was not impaired. It gave him a formal written warning. The GMC appealed, and a High Court judge substituted a finding that Raychaudhuri had been dishonest.

Backed by the Medical Defence Union, Raychaudhuri appealed against that decision, and the Court of Appeal has ruled that the tribunal was right to find no dishonesty. Lord Justice Bean expressed “regret” that the appeal had been brought, adding, “It should require a very strong case for a court to overturn a finding of the medical practitioners tribunal that a doctor has not acted dishonestly.”

The ruling is another loss for the GMC, a few weeks after the Court of Appeal ruled that a tribunal had been right not to strike off trainee paediatrician Hadiza Bawa-Garba.

Raychaudhuri had been working at the Royal Berkshire Hospital, Reading, in 2014, when a 5 month old baby with Dandy-Walker syndrome was brought to the emergency department.

**Memory aid**
Before he had seen the patient he used a letter from the baby’s GP and medical records to begin the initial assessment form. He was called away and later explained he had intended to use the form as a prompt, confirming or amending the entries after his examination.

The tribunal found that, in a later telephone
It said that there needs to be a clear acknowledgment that errors may result from the environment in which a doctor works rather than being the fault of an individual. System pressures and the underlying factors causing them, including lack of resources, staffing, and poor infrastructure, must be tackled, it added.

And steps need to be taken to ensure all grades of doctors are confident in raising safety concerns, and written reflections in all education and training documents should be legally protected.

BMA chairman Chaand Nagpaul said, “It is vital the government and policy makers heed the views of all doctors who provide care; they are in the best place to know the problems the NHS faces on a daily, hourly basis. They know the scale of impoverishment in the NHS is staggering. They are working in a culture which has improved little since the publication of the Francis and Berwick reports following the tragedies in Mid-Staffordshire five years ago.”

Jacqui Wise, London
Cite this as: BMJ 2018;362:k4001

Three quarters of doctors said they are cautious about recording their reflections

conversation with the on-call consultant, Raychaudhuri had made misleading statements but had not been dishonest. But the High Court ruled that this decision had been “wrong” and that the registrar’s fitness to practise was impaired.

At the Court of Appeal Lord Justice Sales (left) said the tribunal’s assessment was that Raychaudhuri had intended to examine the baby and that, although his actions were wrong, he had been open and honest and his evasive answers to the consultant “were not part of a truly dishonest effort to cover up what he had done.”

“Anxious consideration”
Lord Justice Bean said the tribunal had given “anxious consideration” as to whether Raychaudhuri’s conduct could be considered dishonest. Its witnesses, he said, “were well placed to make an evaluative judgment of the nuances of how the individuals had interacted and that judgment should have been accorded great weight, not only by the court but by the GMC in deciding whether to bring an appeal at all.”

Caroline Fryar, of the Medical Defence Union, said, “This case addressed an important point of principle, as well as vindicating our member, and we are pleased the appeal was successful.”

A GMC spokesperson said, “We will reflect on the judges’ full comments, as we do in all cases.”

After an outcry by doctors over the GMC’s appeal in the Bawa-Garba case, the regulator is to lose its right to appeal against tribunal findings. But it intends to use its powers in the meantime.

Clare Oyer, The BMJ
Cite this as: BMJ 2018;362:k3970

FIVE MINUTES WITH . . .

Clare Gerada

Now is the time to develop a new charter for general practice, says the doctor caring for sick colleagues

“For the past decade I’ve been looking after sick doctors. We’ve had about 5000 doctors through the Practitioner Health Programme and 1500 of those have been GPs.

‘Of the GPs presenting to us, about a quarter are within their first five years of training. We have a workforce that, in any measure, is burnt out, and doctors in general practice are leaving because they can’t cope with the pressure. Providing a mental health and treatment service means that we can start to tackle some of their problems—but we have to focus on the underlying causes.

“One of the major factors is the rise of complaints. Anyone who has received a complaint knows how devastating it is. The process of handling complaints leads to depression, change of behaviour in the doctor, and sometimes to suicide. We must put in place a new code of conduct so that, if you get a complaint as a health professional, you know what is going to happen. At the moment it’s hit and miss, depending on your employer.

“Another area that’s causing a great deal of distress is the lack of space to reflect. Even 10 years ago I would have had time with my partners to sit and talk. Now you’re barely able to go to the lavatory. We have to create some space within the doctor’s working week so they’re able to digest the emotional impact of their work.

“When general practice was last in this state—about 1970—our leaders created a new charter which defined what GPs should do, how they should do it, and all sorts of other matters. We’ve got the Five Year Forward View but I don’t think that covers us in general practice.

“I think we have to start looking at our contract. It’s far too rigid; it dictates how many patients we see in our consulting room, which means we can’t give longer appointments. I think we need a new charter created by all GPs together that would hopefully sustain us for 40 or 50 years.”

Clare Gerada is the medical director of the NHS Practitioner Health Programme

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2018;362:k4021
Could Brexit harm the NHS?

Forecasts of a smaller UK economy and fewer staff from EU countries present challenges for the health service after 29 March 2019, argues Anand Menon. But Graham Gudgin is unconvinced by what he believes are biased estimates promoted by a government pushing for a soft exit. Overleaf, Jeremy Taylor sets out patients’ four main withdrawal fears and Niamh Griffin reports on the concerns of doctors practising along the Irish border.

No one knows what Brexit will mean for the UK and for several reasons. We don’t know what Brexit will look like—will our relations with the EU be like those of Canada, Norway, Switzerland, or none of the above? And no one—not even, apparently, the government—knows how we will adapt as a country to leaving the EU. What is the plan for health, for education, or for immigration?

The EU has limited direct competence over health policy. Consequently, the effect of Brexit on the NHS will mostly be indirect. Nevertheless, there are at least two good reasons to think

Brexit could affect the NHS, firstly through its impact on the UK economy. A smaller economy would result in reduced public expenditure, although the NHS might continue to be protected. A second way is through potential immigration controls affecting the inflow, and perhaps retention, of EU nationals working in the NHS. The Treasury, Bank of England, London School of Economics, and others have estimated the potential
that, in the short to medium term, Brexit’s effect on the NHS will be negative.

**Smaller economy means less money**

The first is Brexit’s wider economic implications. Based on an analysis of the likely effect of, among other things, barriers to trade and falling migration, government forecasts and most independent economists suggest that the domestic economy will be around 5% smaller than it otherwise would have been if the UK and EU sign a free-trade agreement, which remains the government’s preferred option.

Remember that gross domestic product (GDP) would need to be just 0.8% smaller than it otherwise would have been to wipe out any gain from no longer paying into the EU budget for Budget Responsibility suggested that by the early 2020s public finances would be £1.15bn a year worse off as a result of Brexit. Even assuming that, once out of the EU, the government decided to spend the whole of the UK net budgetary contribution to the EU on health.

This is a heroic assumption, given the competing demands of those—including farmers, academics, and less prosperous regions—who already receive EU funding—this would amount to just £8bn.

All the signs are, therefore, that the government will have fewer resources after Brexit. And this in a context in which the Institute for Fiscal Studies, an independent think tank, reported that cost pressures on the health service will grow and NHS spending will have to rise by 3.3% annually simply to maintain today’s level of service.

So the financial picture is potentially grim. That regarding NHS staff is equally so. Before the 2016 referendum, the number of UK nationals was falling as a share of the NHS workforce, with that of EU nationals rising. Around 2500 EU nationals (net) joined the NHS in the quarter before the referendum. Between March and December 2017 the figure was just over 200.

**Vacancies are at record levels**

All this comes at a time when vacancies in NHS England are at record levels (surpassing 30 000 for the first time in June 2017), and NHS trusts lack sufficient visa quotas for non-EU nationals. EU nationals, moreover, make up a disproportionate number of frontline staff: they represent 5.5% of total staff but 9.5% of doctors, 9% of consultants, and 7% of nurses. Should current trends continue, we are likely to experience a shortage of doctors and nurses.

Brexit, therefore, will pose a substantial challenge for the NHS. This might, of course, prove a catalyst for necessary reform. The training of more British frontline staff, for instance, seems a sensible response to staff shortages. Moreover, economic forecasts are just that. They are not certainties. But making trade harder with our nearest and largest trading partner is unlikely to increase our economic performance in the short to medium term. And the fiscal environment is, even now, hardly encouraging. There were many good reasons for being dissatisfied with EU membership. Wanting a better staffed and funded NHS, however, was not among them.

**Treasury predictions, released during the the referendum campaign, have proved embarrassingly wrong**

Our economic modelling predicts that per capita GDP may be temporarily smaller in the early 2020s compared with a non-Brexit outcome, by around 1.5%, but will quickly recover. Our estimates are less optimistic than those of Economists for Free Trade, which uses a different modelling approach, but we both view the long term effect of Brexit as positive. Tax revenues may also be smaller in inflation adjusted terms, but there are no negative effects.

Moreover, higher inflation is reducing the UK’s public debt to GDP ratio, allowing scope for higher spending if the government wishes.

**Reality on staffing has been benign**

Huge publicity has also been given to potential problems with EU staffing in the NHS, but the reality has again been benign. NHS headcount data for England up to January 2018 show that the number of EU national staff has risen by 7000 (12%) since the beginning of 2016.

Post-Brexit migration controls may mean the NHS sees a switch in staff from EU to non-EU nationals but a long term fall is unlikely.

Rather than worrying about Brexit, to protect the NHS’s medical workforce the UK should relax its ludicrous restrictions on medical training places and cease poaching staff from poorer countries.

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**BMJ COMMENT** Jeremy Taylor

**Patients’ four main fears**

The possibility of the UK leaving the EU without a deal is looming. What are the implications for health? For patients, there are four key questions.

1. **Will I still get access to my drugs?**
   
   We take the supply of drugs for granted. But the pills in our pharmacies are there thanks to integrated supply chains, frictionless borders, and seamless regulations. What happens if there is more friction? What if it results in extra costs and delays to the production, quality control, and transport of drugs? What if my medicine is impounded by customs or stuck in a lorry queue? If this sounds fantastical remember companies have been asked to stockpile drugs.

2. **Will there be enough doctors to look after my family?**
   
   Our health and care system relies on workers from abroad to plug gaps in skills and numbers. Many are from EU countries, but migration from Europe has slowed and future flows are uncertain. Reducing freedom of movement was a big part of the rationale for Brexit. We could recruit and train more health and care workers and attract staff from outside the EU. But will the numbers add up?

3. **Will the NHS still pay for my treatment in the EU?**
   
   The reciprocal health agreement, symbolised by the European Health Insurance Card, makes it possible to travel with the assurance that there will be no unaffordable bill for treatment should the traveller fall ill in Europe. It also means that predictable treatment need, such as kidney dialysis, does not prevent travel in Europe. But the future of these arrangements is not assured.

4. **Will I still benefit from new treatments?**
   
   Health research is a global endeavour, and the UK is involved in many international collaborations. EU scientists work in our universities, hospitals, and research institutes. And we are part of Europe-wide networks for developing and supporting treatments. What happens to all of this?

None of these questions has a definitive answer. In each case the answer is: “We can’t be sure.” That is not good enough. The government’s preferred negotiating stance—the “Chequers deal”—is meant to tackle at least some of these concerns, but of course the government may not get its way. Furthermore, health matters are not a separate negotiating theme, so what happens to health depends on what is agreed on other matters, such as trade. And, as we know, the Chequers deal does not command universal support even within the governing party. Regardless of how they voted in June 2016, patients deserve an unequivocal “yes” in response to all four questions. The more of us who insist on this, the greater chance—we have to hope—that we can avoid leaving the EU in ways that damage our nation’s health. This is not about politics but implementation.

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**CROSSBORDER CARE**

**The big questions on the Brexit border**

GPs, hospital staff, and medical educators are operating in an information vacuum, they say, as they try to work out what withdrawal will mean for the patients and doctors who live and work where Northern Ireland meets the republic. *Niamh Griffin* reports

A GP in Northern Ireland turns to a map in his surgery to explain how Brexit could impact on his patients. To reach his practice they travel in and out of the neighbouring Republic of Ireland—easily done now, but no one is sure what next year holds.

Next 29 March the UK leaves the EU and, with just six months to go, doctors working in Northern Ireland and along the border say they are not sure what this means for their work or patients. Endless discussions about hard versus soft Brexit have an increased urgency when a land border with the EU is, sometimes literally, on your doorstep.

The border meanders from east to west across the island of Ireland, dividing towns, streets, and even diving into the River Foyle. A drive along it is soundtracked by the ping of mobile phones as the connection moves between two systems. The satellite navigation system gives directions in kilometres while driving past signs marked in miles. Locals carry both euros and sterling, and some petrol stations offer currency exchange. In Strabane town, Ulster Bank offers two ATMs—one for euros and one for sterling.

In the midst of this, cardiologists in Belfast send children to Dublin through the All-Island network, and oncologists in the republic’s Donegal send patients across the border to Altnagelvin, Derry, for radiology imaging. Patients on waiting lists on both sides benefit from EU rules allowing them to receive treatment in a foreign, private hospital that may be minutes from home.

Doctors want to know what to tell their patients; people worry about the practicalities of navigating this porous border. In April, an all-Ireland study found 208 border crossings. To put that in perspective, there are just 137 crossings along the whole eastern flank of the EU.
GPs on the edge
Kevin Allen is a GP at the Rathkeeland House Surgery in Crossmaglen, County Armagh. This border town is the most southerly in Northern Ireland. He draws along the border on a map, showing how a trip to neighbouring Forkhill—just 1.5 miles away—means crossing the border three times. “Some crossborder patients who have the right to use NHS services if they work and pay taxes in Northern Ireland may lose this after Brexit,” he says.

“We have one ROI patient who injured his hand; he’s had plastic surgery at Daisy Hill Hospital, in nearby Newry in NI, and now we’re treating him. We don’t know what the future holds for him—we don’t know if we will be able to continue treating him.”

Allen and other doctors point out that the lack of a Northern Ireland health minister, after the devolved government collapsed in January 2017, is adding to the problems.

Another of Allen’s worries is the out-of-hours arrangement between the Rathkeeland and doctors just seven miles away across the border in Castlederg, County Monaghan. He says: “Patients who ring here after 6pm can be sent to Castlederg for emergency treatment. It can be an hour’s wait compared with seven here, it is used regularly by the patients, they’re used to it.”

These are NHS patients and they get their prescriptions filled on that basis back in Northern Ireland, but Allen says it’s unclear if that can continue.

Following the border to the north west on the republic’s side, there are GPs working in County Donegal facing similar concerns. On a typical day, 15 of Rory Stewart’s 40 patients in Dunfanaghy town are residents of Northern Ireland.

He says: “Dunfanaghy is a tourist town, so maybe 50% of the residents are from Northern Ireland and here on holidays. There is an equivalency agreement between the republic’s Health Service Executive and the NHS—they can use their European Health Insurance Card (EHIC) and see a GP here.”

The EHIC gives EU citizens reduced cost or sometimes free care abroad for emergencies. “Will that remain in place?” wonders Stewart. “I can’t see this being discussed. So far, no one really knows. I foresee that being the biggest change.”

Lifesaving cardiac care
Stewart says the crossborder cardiac initiative that allows patients from Donegal to be treated 50 miles away in Altnagelvin Hospital in Derry is a literal lifesaver. The alternative is Galway, more than 120 miles away.

“Donegal is geographically isolated, stuck in the corner of Ireland,” he explains. “If you have a heart attack here, they transfer you straight to Derry by ambulance. Previously, they put you in a helicopter and got you to Galway. It’s infinitely superior to go to Derry because when you have a heart attack time equals muscle. If you’re waiting to go to Galway, you seldom meet the time targets.”

Doctors fear that returning to a hard Irish border that used to require a customs guardhouse (left) will negatively affect patients on both sides

Derry consultant cardiologist Albert McNeill explains that this agreement allows Altnagelvin to offer primary percutaneous coronary intervention (pPCI) treatment to heart attack patients from Donegal, which is too far from a republic hospital for patients to receive it within the golden time of two hours.

“We do approximately 70 patients every year for Donegal,” says McNeill. “It took a bit of time to set this up, we had to appoint a consultant—he was appointed to Letterkenny University Hospital in Donegal and works between there and us.

“It means our team is bigger; it has increased our numbers. Primary pPCI needs to be done at a high volume. But the main advantage is for people in Donegal. It’s been a success; it works well for the patients and the staff.” But Stewart warns that the initiative “relies heavily on crossborder funding and local agreements from both hospitals.”

Cancer collaboration
He also sends patients across the border to Northern Ireland for dialysis in the County Fermanagh town of Enniskillen, and says his practice relies heavily on Altnagelvin for radiology imaging.

The radiotherapy unit provides treatment, including combination radiotherapy and chemotherapy for curative and palliative purposes. Thanks to joint funding, the treatment is available to anyone on the island.

Breda Friel had the early part of her breast cancer treatment in Galway. Then
she was able to swap that four hour commute from her Donegal home for a 15 minute drive across the border to Altnagelvin for the final part of her treatment last year.

Friel says: “I live on the border, so it was massive to have that choice. I’ve two small kids so if I had to have it in Galway it was going to be six weeks down there. In Altnagelvin it was only three weeks, different protocols. It doesn’t feel like a border; we live so close we go shopping in Derry. If they close it, it would be a massive change.”

**All‐island programmes**

Another crossborder success that it is hoped will survive Brexit is the All‐Island Congenital Heart Disease Network, an agreement to send children for cardiac treatment from Belfast to Dublin.

Sharon Morrow, the network’s director, says it is thinking of all the possible threats to the arrangement from Brexit. “Contingency planning for a range of eventualities is under way. We want to ensure there is minimum disruption to health services and that essential services are maintained on a crossborder, all island, and Ireland‐UK basis,” she says. “Priorities include ensuring continuity in the supply of drugs and medical devices, ensuring access to services, staffing in our health services, and continuation of existing crossborder health cooperation and public health arrangements.”

The Europe‐wide Cross Border Health Directive is perhaps the most well known of these arrangements. This allows patients on long waiting lists to pay for treatment privately in another EU jurisdiction and apply for a refund from their local health organisation—in this case the republic’s HSE or the NHS. Public waiting lists on both sides of the border for orthopaedic surgery in particular can be months long.

Alison Rogers, a GP in Armagh, says continuation of this programme is a concern. “It appears like a programme for well off patients but people scrounge together the money, I’ve come across it regularly—they would go to Dublin and then reclaim the cost,” she says. “In our practice, some of the patients have had hips, knees, and other procedures done. I imagine that will go.”

Despite the uncertainty, new funding has been announced, including €88m (£78m) for crossborder programmes in dermatology, urology, and vascular interventions.

**Information vacuum**

While doctors struggle to work out the impact of Brexit on their patients, the broader outlook in Northern Ireland is no clearer, according to observers.

Mark Dayan, policy analyst at the Nuffield Trust, says a key concern is uncertainty around drug supplies. He warns: “There is a risk of prices going up. The supply side could be affected by problems with manufacturing and extra checks at the border. We don’t know yet where the checks will be for drugs coming into Northern Ireland—there is a lot of debate about the placement of the border.”

In common with other NHS trusts, he says, hospitals and administrators in Northern Ireland are working in a vacuum of financial information. “Estimates vary between about £14bn for a soft Brexit up to £80bn for a hard Brexit. For Northern Ireland that would mean tens or even hundreds of millions less in funding.

Dayan also notes that Northern Ireland has the highest number of GPs who qualified in the EU out of any country in the UK, making that sector particularly vulnerable to changes to labour laws. “One in 10 doctors in Northern Ireland qualified in the EU, and that is even higher for GPs. What happens if they decide to relocate? They could be in an insecure position. If there is a weak pound then it’s not attractive for them.” Earlier this month, the Royal College of Physicians said that the government’s lack of clarity over how the UK’s immigration system will work after Brexit could leave the NHS spending up to half a billion pounds per year on international recruitment.

“It’s a bad situation,” concludes Dayan, “but it’s not necessarily all bad. There are potentially areas where Brexit could free people up to do things that might be better than the status quo.” One is the Working Time Directive, he says, unpopular with some of the medical royal colleges who would like to see some exceptions made after Brexit.

“But,” adds Dayan, “You don’t need a hard Brexit to get that sort of freedom, and I would say it is probably outweighed by other areas of concern.”

**Medical training pitfalls**

The only medical training centre in Northern Ireland is also acutely aware of possible Brexit pitfalls, according to Mark Lawler, dean of education at the Faculty of Medicine at Queen’s University Belfast. He says, “We have a mix of international and local students; we want to nurture our doctors here but nowhere in the UK is self sufficient for doctors. There are big problems ahead in terms of human capital—that is a fundamental matter.”

At the moment, EU students can study at Queen’s for the same cost as local students. “The fee structure could change,” Lawler says, “that would change how we recruit students. We want to recruit the best and be competitive.”

Lawler also raises concerns about the future for research grants and fellowships. “The university’s ability to attract the best is linked to funding. Current EU Council grants are guaranteed, but what happens after that? A clinical researcher would have a five year grant, but what happens then?”

This uncertainty is echoed across the board, with doctors and other clinicians saying they are unable to plan, unable to say how changes will impact on them and their patients.

Perhaps Margaret Chambers best sums up the medical community’s resigned attitude. A GP for more than 30 years in the border town of Keady in County Armagh, she says: “We have no information—we’ve been left on our own. We don’t even have a health minister. But we will adapt; whatever Brexit brings we will adapt for the patients’ sake. People will still get sick, they will still need treatment. We can live with a border if necessary; we’ve done so in the past.”

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EDITORIAL

Beyond QOF

Will the framework evolve further than the carrot and stick approach?

NHS England’s review of the Quality and Outcomes Framework (QOF) in England, a pay-for-performance scheme for general practice, sets out its vision for the future and proposals for how to get there.1 Introduced in 2004, QOF is one of the largest of such schemes globally, but much has changed in the meantime.

General practice is the bedrock of the NHS, but epidemiological and financial pressures facing the NHS are driving changes in its role.2 Funding for general practice has grown at only half the rate of that for hospitals, and GP numbers are falling even though the UK is already under-doctored relative to comparable healthcare systems.3 GPs in the UK reported the highest stress levels in an international survey.4 NHS general practice is seen globally as a lead among primary healthcare systems, and nationally as a jewel in the NHS crown, and despite these difficulties it has one of the highest (84%) satisfaction ratings of any public service. But patient surveys show falling performance5—further evidence, if it were needed, of a service struggling to cope.

Proposed solutions

The General Practice Forward View outlines ambitious plans to tackle these problems, including through additional funding and recruitment of overseas doctors.6 Whether it succeeds remains to be seen. Meanwhile, against this backdrop, what happens with QOF is all important since it is core to general practice’s role, workload, funding, and ways of working.

The review aims to respond to the need for change and future proofing while maintaining some stability at this challenging time for general practice. The proposed review of indicators, and their measurement, to better align with the evidence and professional values has obvious merits, as does the proposal to reduce the risk of polypharmacy with QOF’s disease based approach. As the overseer of QOF indicators, the National Institute for Health and Care Excellence (NICE) has a key role in ensuring rigour and an evidence based approach in this process.

Evidence shows that performance can fall when indicators are retired,6 so the overall effect of changes to indicators also needs consideration to ensure funding is not destabilised nor quality of care compromised. The introduction of a quality improvement domain could add a new dimension to QOF provided that the activities (proposed examples include medicines safety, end-of-life care, and local priorities) are not overly bureaucratic and meet the design requirements of pay for performance.

More radical are the proposed incentives for primary care networks rather than individual practices. There is precedence for this—Scotland has retired QOF indicators in favour of network level quality improvement initiatives. But although network incentives are seemingly a natural progression, attribution and performance management could be problematic when accountability is shared; furthermore, practices in England are more numerous and diverse than in Scotland. Such incentives should be phased, piloted, and evaluated before wider rollout.

A cautious approach is also advisable in how general practice is used to help deliver pressing health policy goals, such as reducing hospital admissions.7 Past attempts to use QOF in this way failed, and developing integrated care models is complex, takes time, and doesn’t guarantee lower costs or fewer hospital admissions.8 Changes to QOF should support general practice in prevention, improving population health, delivering quality improvement, and building on the important contribution QOF has made to embedding structured management of long term conditions and secondary prevention in general practice. This plays to the strengths of general practice. Any changes should have professional support and credibility.

Continuity of care

Finally, continuity of care gets scant mention in the review. It may not lend itself to incentives but is valued by patients and has multiple benefits, including lowering mortality.9 It should not be compromised in the scaling up of general practice.

Like many pay-for-performance schemes, QOF’s effect on patient outcomes has been modest.10,11 It has substantially altered how care in general practice is organised and delivered but, longer term, strategies for high quality primary care will need to evolve beyond QOF.12

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[Image 448x30 to 596x560]
The babies splash around happily, the mothers are joyful; here is the positive side of bringing up a child with a Zika related disability.

In 2015 the plight of pregnant women who had been infected by the Zika virus, leaving their babies with microcephaly, was reported worldwide. Joana Passos, a marketing executive living in Salvador, Brazil, was one of them. She says that having Gabriela, 2, was the best thing that happened to her. “Gabriela loves to play with her older sister. She smiles a lot.”

Passos accepts her life has changed irrevocably: Gabriela has appointments with doctors and therapists every day. “She has the busiest schedule in the family,” she laughs. But the change is not simply due to having a child with disabilities. Passos has founded an advocacy and support group called Abraço a Microcefalia (Embrace Microcephaly) with her friend Mila Mendonça, whose son Gabriel is also affected. The group offers social support and helps ensure that more than 200 children receive rehabilitation from physiotherapists and occupational therapists, as well as these swimming sessions.

Last week Passos and Mendonça were in London at the Royal Society of Tropical Medicine and Hygiene to highlight their work and share their experiences. Passos remembers how at the height of the epidemic researchers, who were not always empathetic, descended on often vulnerable families. “They need to realise this is a child, not a guinea pig for research,” she says.

Last year the women became involved in a project led by Hannah Kuper, a researcher in global disability at the London School of Hygiene and Tropical Medicine, who was helping to develop a parent support programme in Brazil. So far, Kuper has found that there seems to be less stigma associated with Zika related disability than with other disabilities and less carers’ depression. Despite the findings, Passos says the need for support is ever present. “The epidemic has not finished: for us, it is just starting.”

Jacqui Thornton, London

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Clinically assisted nutrition and hydration

Landmark judgment returns decision making to clinical teams and families

The recent Supreme Court judgment given by Lady Black removed the requirement to obtain legal sanction for every decision to withdraw clinically assisted nutrition and hydration from people who lack capacity through “prolonged disorders of consciousness” (PDOC). This represents the culmination of a paradigm shift over the past six years, moving from a focus on a patient’s diagnosis and level of awareness to a focus on the patient’s best interests. It returns clinical decision making to the clinical team, including families. It removes the exceptionalism that has grown around this decision.

The judgment confirms that there is “no requirement in domestic law for an application to the court” and that “the combined effect of the MCA [Mental Capacity Act] 2005, the Mental Capacity Act Code, and the professional guidance, particularly that emanating from the GMC” provides a sound, protective regulatory framework.

No distinguishing features

Black also expressed “difficulty in accepting that there are readily apparent and watertight categories of patient, with PDOC patients clearly differentiated from, say, patients with a degenerative neurological condition or critically ill patients, in such a way as to justify judicial involvement being required for PDOC patients but not for others.”

Clinical teams can thus be reassured that there are no clinical, legal, or moral features that distinguish decisions made for patients with PDOC from those made in the best interests of patients with other conditions. Furthermore, there are no features that distinguish decisions about hydration from all other similar decisions that may lead to the death of a patient, such as stopping ventilation or not treating severe infection. The process should be identical in all situations.

Black highlighted that any exceptional and separate process for one group of patients may inadvertently harm patients through delaying decisions or in some cases inappropriate treatment continuing by default.

Since the judgment in 1993 allowing Hillsborough victim Tony Bland to die through withdrawal of all treatment, including food and water, no more than 200 other cases have been taken to court. In each of those 24 years, at least 1500 people have entered a prolonged disorder of consciousness after acute brain damage. Most people would not want treatment continued if they were in this state, so many people are likely to have received treatment they would not have wanted.

Clinical teams can now take back control of decisions about hydration and nutrition, adhering to existing law and guidance, and using the best interests process from the time a person loses capacity. They should not be required to use a new exceptional guidance for this group of patients, as is being considered. This could simply prolong the failure of the health service to manage these patients in accordance with the Mental Capacity Act 2005.

Clinical teams in all settings must comply with the Mental Capacity Act 2005. But the act is poorly applied, clinical services often fail to identify people lacking capacity and have lacked the confidence and expertise to use the law appropriately in this group of people; they have been deskilled.

Better training

Instead of developing a new clinical process, we should develop much better education and training. Initially, this could be specific to people receiving life sustaining treatments.

Clinical teams must include families in decision making from the outset. The central feature of the new model is a requirement to establish what the patient would have wanted. Only close family and friends can do this, supported by incidental documentation—for example, in emails and on social media.

Black’s judgment will benefit everyone: patients, who will now have their wishes established and respected; families, who will now be central to the decision making process; the courts, who will be spared routine involvement and can focus on difficult cases; and clinicians, who will no longer be put off from making decisions by involvement of the law.

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