

this week

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Brexit: GPs told not to overprescribe

GPs should resist requests from patients to issue longer repeat prescriptions in the run up to Brexit and should liaise closely with pharmacists if they are concerned about drug shortages, experts have advised.

The Department of Health and Social Care for England has told GPs not to stockpile drugs or overprescribe and has insisted that contingency plans will ensure continuity of supply even if the UK leaves the European Union on 29 March without a deal.

But with no deal still a distinct possibility, GPs are reporting that some patients are concerned about the supply of their drugs. Krishna Kasaraneni, executive member of the BMA's General Practitioners Committee, said, "Some patients are asking for greater quantities of their medicines. One example is thyroxine for three months rather than the standard one monthly supply. It's putting GPs in a difficult position as they have responsibility for individual patients as well as the collective needs of all their patients."

The National Pharmacy Association, the body for independent pharmacies, said Brexit was not the "root cause" of shortages but was "exacerbating the situation," leaving pharmacists struggling to source some drugs such as naproxen and nifedipine. "Brexit is bringing to a head

issues that should have been grappled with years ago," a spokesman said.

Medical defence organisations told *The BMJ* that GPs should follow the advice not to overprescribe and to maintain a close dialogue with pharmacists. Rob Hendry, medical director at the Medical Protection Society, said, "Our main message to the GPs would be to follow the guidance to prescribe as normal. But it would be a good opportunity to engage with pharmacies because should there be a problem, or should a patient complain, it would be useful if they could demonstrate steps they've taken to address that."

Andrew Green, the GPC's prescribing policy lead, said, "Even in normal times the supply chain does not have great reserves, and if early prescriptions are provided shortages will be created where none need exist."

A Department of Health spokesman said, "Patients should not stockpile medicines, and GPs do not need to write longer NHS prescriptions. We are confident that, if everyone does what they should, the supply of medicines should be uninterrupted in the event of a no deal EU exit."

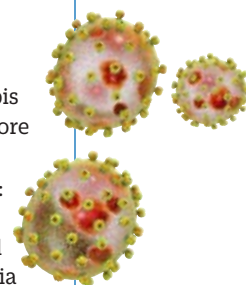
Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l762

GPs report that patients are pressing to be prescribed greater quantities of medicine, fearing a no deal withdrawal from the EU on 29 March

LATEST ONLINE

- Oxygen after surgery: review questions WHO advice that high levels reduce infection
- Euro MPs back wider use of medical cannabis amid call for more research
- Lassa outbreak: WHO warns of unusually rapid spread in Nigeria



SEVEN DAYS IN



GUY BELL/SHUTTERSTOCK

School pupils gather in Westminster Square, London, during their strike action over climate change on 15 February

Doctors demand UK becomes carbon neutral

Health professionals from a range of specialties have called on UK parliamentarians to legislate urgently for the UK to be carbon neutral by 2030.

In an open letter published in *The BMJ* and the *Lancet* on 21 February, the group called for laws to allow the UK to reduce its carbon emissions to net zero levels over the next decade. The signatories, led by Robin Stott, co-chair of the Climate and Health Council, warned of a new level of crisis, with “increasingly forceful statements” from the Intergovernmental Panel on Climate Change.

“The UK must take the lead, set an international example, and become carbon net zero by 2030,” the letter said. “We simply don’t have time to procrastinate. Policies need to be introduced now that will reduce the use of fossil fuels, clean up our air, and support active and healthy lifestyle choices.”

The letter’s 27 signatories included Ian Gilmore, former president of the Royal College of Physicians, Fiona Godlee, editor in chief of *The BMJ*, and Robin Russell-Jones, scientific adviser to the All-Party Parliamentary Group on Air Pollution.

Visit bmj.com to view the letter in full

Harriet Pike, Cambridge [Cite this as: BMJ 2019;364:l763](https://doi.org/10.1136/bmj.2019.364:l763)

Assisted dying

Doctor-patient relationship “would change”

The campaign alliance Care Not Killing found that 48% of more than 2000 survey respondents agreed with the statement, “If GPs are given the power to help patients commit suicide it will fundamentally change the relationship between a doctor and patient, since GPs are currently under a duty to protect and preserve lives.” Just under a quarter (23%) disagreed with the statement, and 29% were not sure. In the poll, carried out by ComRes, 51% of respondents thought that some people might feel pressured into accepting help to take their own life “so as not to be a burden on others,” while 25% disagreed.

Clinical negligence

Women harmed by mesh “should sue surgeons”

A health minister urged women who have experienced complications from mesh treatment to sue their surgeons for clinical negligence. In an adjournment debate about medical devices Jackie Doyle-Price said that she did not want to pre-empt the Cumberlege review, which is due to report later this year, but said, “It is becoming

clear that mesh was deployed far too insensibly: far too many women were given this treatment, often at comparatively young ages, given that this was going to stay in their body for a long time.”

Menopause

Acupuncture may ease symptoms

A brief course of acupuncture may help to ease symptoms of the menopause, concluded a study of 70 women, half of whom had five weeks of acupuncture. The treatment may help to reduce hot flushes, mood swings, sleep disturbances, and skin and hair problems, researchers reported in *BMJ Open*. They acknowledged that a placebo effect could not be ruled out but concluded that acupuncture offered a “realistic option” for women who cannot use hormone replacement therapy or do not want to.

United States

FDA looks to curb vaping in US teens

The US Food and Drug Administration’s plans to use regulation to turn older smokers into “vapers” by facilitating approval

of non-combustible nicotine delivery systems is under threat by the “mounting public health crisis” of youth vaping, said the FDA chief, Scott Gottlieb (below). About 4.9 million teenagers had used some type of tobacco product in the previous 30 days, up from 3.6 million in 2017, data showed, with a 2018 spike “likely due to the recent popularity of certain types of e-cigarettes, such as Juul,” Gottlieb said.

J&J will reveal drug price in TV advertisements

Johnson and Johnson will give pricing information for its most prescribed drug, the anticoagulant rivaroxaban (Xarelto), in direct-to-consumer US TV advertisements starting next month, the company has announced. They will display the list price—around \$500 (£390) a month—and the

“potential patient out-of-pocket costs,” the company said.

The plan is similar to a Trump administration proposal to demand drug makers declare their list prices in advertising, and it is widely seen as an attempt to forestall compulsory government measures.

Diabetes

Insulin users can use flash device before driving

Drivers who treat their diabetes with insulin can now choose to use flash and continuous glucose monitoring devices (below) to take readings before they drive or during breaks, said the Driver and Vehicle Licensing Agency. Until now drivers have had to check their glucose levels with a finger prick blood reading, no more than two hours before driving and then again after every two hours.



Complaints

People regret not raising concerns about care

People are being asked to speak up about their care experiences (www.cqc.org.uk/sye), after a CQC survey of 2000 patients showed that 58% regretted not raising concerns. Reasons for not acting included not knowing who to complain to (33%) and fears of being thought a troublemaker (33%). Of those who did raise a concern, 66% said it helped improve the service.



MEDICINE

Sexual health

Condoms in schools “do not encourage sex”

Distributing condoms in secondary schools did not increase sexual activity and reduced sexually transmitted infections, a literature review by the UN Population Fund found. Authors of the paper, published in the *Journal of Adolescent Health*, said their findings supported condom availability programmes in schools. They said that more evaluations were needed on whether school programmes were linked to reductions in HIV and unintended pregnancy.

Sponsorship

College ends funding by formula milk companies

The Royal College of Paediatrics and Child Health announced it has stopped accepting funding from companies that make formula milk. It earned around £40 000 a year in event sponsorship and advertising. The policy change came amid growing pressure from doctors and campaigners, who said the arrangement was incompatible with the healthy promotion of breastfeeding. The college will still work with formula milk companies on specialist milks for babies unable to breastfeed and those with allergies and gastrointestinal conditions.



Legal decisions

Court reduces “wrongful birth” damages to £1.4m

The Court of Appeal overturned a High Court judgment awarding £9m to the mother of a boy born with severe haemophilia and autism after a GP wrongly told her that she did not carry the haemophilia gene. The High Court ruled in 2017 that Omodele Meadows was entitled to the costs of raising a child with both

conditions on the basis that, if she had known that she was a carrier, she would have had the fetus tested for haemophilia and terminated the pregnancy. But three appeal court judges concluded that the High Court judge had applied the wrong legal test. They reduced the damages to £1.4m, representing the cost of raising a child with severe haemophilia only.

Patient is imprisoned for GP’s attempted murder

A patient who used a crossbow to shoot a GP he blamed for his father’s death was sentenced to 20 years in prison for attempted murder. Mark Waterfall burst into Gary Griffith’s room at Sutherland House Medical Centre in Watford and announced, “You killed my father and I am going to kill you,” before pulling the trigger. The bolt entered Griffith’s abdomen, but the folds of the GP’s shirt prevented it from penetrating his colon. Waterfall’s father, Terence, 76, had died of lung cancer in hospital four days earlier. Griffith had referred him there urgently after he consulted him complaining of breathlessness. At St Albans Crown Court, Judge Stephen Warner said that Waterfall will serve two thirds of the sentence before he can apply to the parole board for possible release. He will remain on licence until 2044.

Cite this as: *BMJ* 2019;364:l760



FAMILY CARE

Every 10 additional primary care physicians per

100 000

population in the US was associated with a 51 day increase in life expectancy, after accounting for healthcare, demographic, socioeconomic, and behavioural factors

[*JAMA Internal Medicine*]



SIXTY SECONDS ON... WAITING TIMES



IT’S WINTER, SO WHERE’S THE SEASONAL MELTDOWN?

The traditional lament has fallen silent. There’s even been some positive mood music from NHS England, claiming in its weekly reports that the system is working well.

IS THAT EVEN POSSIBLE?

December 2018 wasn’t bad, to be fair: bed occupancy, emergency department waiting times, and ambulance handover delays were all better than in December 2017.

YOU’RE ABOUT TO SAY, “BUT . . .”

I am. But, since then, things have gone less well, and the long term trends do not show a system in recovery, despite the input of money. Data collated by the Royal College of Surgeons show a trend of fewer hospital treatments. In 2018 there were 3 532 453 hospital admissions for consultant led care, 68 899 (1.9%) fewer than in 2017.

GOOD NEWS, SURELY? ISN’T THE PLAN TO KEEP PATIENTS OUT OF HOSPITAL?

It is, but not just by making them wait. If community based care were reducing demand for admissions, that would be fine. But the waiting list has just topped four million for the first time since 2007. “Despite the number of patients on the waiting list increasing, there has been a steady decrease in hospital admissions for consultant led treatment over the past four years,” says college president Derek Alderson.

CAN THEY CATCH UP WHEN SPRING ARRIVES?

Not likely. There were a few months in 2018 when admissions were higher than the same month in 2017—April and July, for example—but they didn’t make up for earlier shortfalls. The RCS wants more beds to ease the pressures.

WOULD FEWER LONG STAYS SOLVE THINGS?

It would help, but don’t hold your breath. NHS Improvement called last spring for a 25% cut in patients who had been in

hospital for more than three weeks, but data obtained by *Health Service Journal* suggest only 25 of 131 acute trusts were on target to achieve this by the end of 2018.

Nigel Hawkes, London

Cite this as: *BMJ* 2019;364:l752

GP struck off for research dishonesty

A GP partner who conducted clinical trials for drug companies has been struck off the medical register for enrolling ineligible patients, dishonestly altering medical records, and attempting to divert payment meant for the contract research company into his private account.

Blackpool GP Jerome Kerrane worked as a principal investigator for Fylde Coast Clinical Research, a private company that shared the premises and computer system of his practice, Layton Medical Centre. The practice had been involved in medical research since the 1980s.

Uncovered details

Kerrane left the practice and the research company in 2015, and his replacement uncovered details of patients who had been enrolled in trials despite failing to meet recruitment criteria.

She reported her findings to the Medicines and Healthcare Products Regulatory Agency, which in turn referred the case to the GMC.

Kerrane did not attend the medical practitioners' tribunal in Manchester, which found that over eight years he had enrolled 14 ineligible patients in six Novartis trials studying treatments for COPD. He contested some charges and admitted others. He had wished to preserve his reputation at Novartis as a "good recruiter," he wrote. All the charges against him were found proved.

Kerrane, who qualified at Nottingham University in 1996, will be struck off after 28 days unless he appeals.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2019;364:l692

Philippines measles outbreak is deadliest yet

The Philippines has recorded 136 deaths, most of them children, from measles since the start of 2019, the country's health ministry has said. Fewer were killed by the virus in the entire World Health Organization European region in all of 2018.

From 1 January to 16 February 8433 measles cases were recorded in the Philippines, up from the nearly 2400 in the whole of 2017 and 18000 in 2018. Vaccination rates fell from a 2014 high of 88% to 73% in 2017, then plummeted to about 55% last year.

Lotta Sylwander, the country's Unicef representative, said the agency was "deeply concerned" about the outbreak, adding that about 2.5 million children under 5 are not vaccinated. "There has been a notable unwillingness of parents to vaccinate their children," she said.

The country's Epidemiology Bureau said that 79% of those killed by measles this year were not vaccinated.

Measles has now gained a firm foothold in the densely populated

capital, Manila, as well as four other regions, and risks spreading further, said the government, urging parents to take up free vaccinations. The Philippines is an exception in WHO's Western Pacific region, where vaccination rates have been climbing faster than elsewhere in the world.

Rise in Europe

But measles has also been on the rise in regions such as Europe where overall immunisations are up, because of uneven coverage that leaves pockets of increased susceptibility. The deadliest previous outbreak was in Thailand, which has generally good coverage, but where 22 people died last year in the predominantly Muslim southern region.

The number of cases worldwide rose 30% from 2016 to 2017, according to WHO. Globally, first dose vaccine coverage has stalled at 85% for several years, while second dose coverage is 67%. The coverage needed for herd immunity is 95%. Last month, WHO named vaccine hesitancy as one of its top 10 threats to global health for 2019.

There is a notable unwillingness of parents to vaccinate their children

Lotta Sylwander, Unicef



GP at Hand is given go ahead to expand

"It is wholly inappropriate to allow this service's expansion with no assurances over its safety and effectiveness"

Richard Vautrey, BMA

Babylon's GP at Hand service has been given the green light to expand outside its west London base to Birmingham after a U turn by NHS England.

It had previously been blocked from subcontracting its digital service from Hammersmith to the Midlands on clinical safety grounds, amid concerns about how patients would access screening services.

However, Hammersmith and Fulham Clinical Commissioning Group, which holds the service's NHS contract, was told by NHS England on 12 February that a solution had been found. NHS England would not give any details as to how the concerns had been resolved, but it is to work with the London CCG, Birmingham and Solihull CCG, national screening services, and GP at Hand to firm up the details and set a start date.

The decision paves the way for Babylon to expand beyond Birmingham to other areas it is known to be interested in, such as Manchester, Leeds, and Southampton. That it has the backing of the health secretary for England, Matt Hancock, is also likely to aid its cause.

Subcontracted clinics

The proposed service will operate in the same way as the London clinics subcontracted by the GP at Hand practice. Birmingham patients will be able to see a GP at a local clinic or receive consultations through a smartphone app—but they will be registered with the Hammersmith practice, and the NHS money attached to them will flow there.

Richard Vautrey, chair of the BMA's General Practitioners Committee,





REX/SHUTTERSTOCK

Discussing the European data for 2018, WHO epidemiologist Zsuzsanna Jakab said, “The picture for 2018 makes it clear that the current pace of progress in raising immunisation rates will be insufficient to stop measles circulation. While data indicate exceptionally high immunisation coverage at regional level, they also reflect a record number affected and killed by the disease. This means that gaps at local level still offer an open door to the virus.”

The biggest gap in Europe is in Ukraine, which leads the world in

measles cases, with 53 218 in 2018, or 121 per 100 000 people. War has severely disrupted its vaccination programmes. The country registered 3142 cases in the past week. But the average patient is older than in the Philippines, and there have been fewer deaths: 16 since January.

In the US, a measles outbreak in Washington state seems to have stabilised, with 53 cases found, but there are 101 cases in 10 states overall.

Owen Dyer, Montreal, Canada

[Cite this as: BMJ 2019;364:l739](#)

UNICEF said about **2.5 million**
of the country's children under 5 are not vaccinated

said it was “premature” to allow the expansion before publication of the Ipsos MORI evaluation of the service. Due next month, this will provide a full assessment of the service’s effects on the wider NHS and examine whether it has contributed to inequality and assess outcomes among patients.

“It is wholly inappropriate to allow this service’s expansion with no assurances over its safety and effectiveness,” said Vautrey. “We are incredibly disappointed with this decision, which flies in the face of place based care delivered by practices embedded in local communities.”

The GP contract deal announced last month made a commitment that every patient in England would have access to online and video consultations from 2021. But for practices to achieve this, Vautrey said that they must be properly supported, with more investment in IT and infrastructure to be able to operate

on a “level playing field” with private companies such as Babylon.

Since its launch in November 2017 GP at Hand’s critics have accused it of cherry-picking young, healthy patients and destabilising existing GP services. Earlier this month *The BMJ* revealed the host CCG planned to cut outside hours GP appointments elsewhere because of funding pressures, with GP at Hand identified as “the key driver.”

Digital first primary care

A Babylon spokesperson said, “The NHS long term plan and GP contract framework set the vision for digital first primary care, and we look forward to making this a reality. We will continue to work closely with NHS commissioners, regulators, and local providers on the safe and effective delivery of all our services.”

Gareth Iacobucci, *The BMJ*

[Cite this as: BMJ 2019;364:l748](#)

FIVE MINUTES WITH . . .

Sohail Munshi

Manchester Local Care Organisation’s chief medical officer on how GPs helped design primary care networks

“In Manchester we’re probably a bit ahead of the descriptions of primary care networks than appears in the long term plan. We have 12 integrated neighbourhood teams and, like other areas, they each cover about 50 000 patients. But we’ve also integrated social care formally into that relationship.

“We already had a partnership agreement between the city council, the GP federation, the mental health trust, and three major hospitals. The partnership also has a memorandum of understanding with the voluntary, community, and social enterprise sectors, allowing us to work better with communities and accelerate social prescribing.

Health and social care spend

“The local care organisation helped us create a service called High Impact Primary Care. We risk stratified the city’s population and found that the top 2% of the population in terms of risk accounted for about 50% of the health and social care spend. We’ve taken a multidisciplinary approach with a GP, a social worker, and a mental health worker whose full time job is to look after these people in a proactive way, not to wait for them to go to the emergency department but to contact them and offer care plans and intensive resources.

“After nearly a year, not only is it returning a financial investment but, more importantly, it’s dealing with the most vulnerable people and giving them care closer to home. It’s shown us that a lot of people with complex multimorbidity get much better outcomes when you tackle their social factors with other factors. We’re only doing that in three of our 12 neighbourhoods, but the idea is we’ll scale it up to all 12 over the next 18 months.

“There were difficult moments along the way. But I’ve observed a feeling among GPs that stuff is being dumped on them without extra resources. So being in control of the rate and the design of the process is the best way to engage. People who try to do this without prior engagement of primary care will probably fail. But there’s no reason why you can’t replicate it if you do the groundwork.”

Gareth Iacobucci, *The BMJ* [Cite this as: BMJ 2019;364:l754](#)



IT’S DEALING WITH VULNERABLE PEOPLE AND GIVING THEM CARE CLOSER TO HOME

Assisted dying and the RCP poll: what do BMJ readers think?

Recent articles on assisted dying, and the current poll by the Royal College of Physicians, which closes on 1 March, have generated much interest on bmj.com, finds **Richard Hurley**

A few weeks ago Sandy Buchman, a Canadian palliative care doctor, documented how he decided to provide euthanasia to his patients (*BMJ* 2019;364:l412), provoking a slew of responses on bmj.com.

Among several critical reactions was that from Williard Johnston, a family physician and assistant professor in Vancouver, who worried about “already intense social pressure” to widen the Canadian regime’s eligibility criteria “to include euthanasia of children, healthy disabled, cognitively impaired [through advance directives], and mentally ill [people].”

The Canadian Medical Association’s neutrality was the topic of a commentary by its vice president Jeff Blackmer (*BMJ* 2019;364:l415). But Johnston had a warning for other countries: “Few Canadian doctors foresaw that ‘going neutral’ would guarantee the arrival of euthanasia . . . Learn from our mistakes.”

Rose coloured glasses

A group of palliative care experts in Canada, including Leonie Herx at Queen’s University in Ontario, told Buchman and Blackmer to “take off the rose coloured glasses.” Although federal law provides for doctors not to take part, the experts write, some provinces require conscientious objectors to refer patients to other doctors for medical assistance in dying.

Meanwhile, the retired British psychiatrist Colin Brewer asked whether the



We do not have a healthy enough attitude to disability to give non-disabled people access to a “right to kill us” law David Gillon

UK’s palliative care doctors were really as unanimously opposed to assisted dying as they seem, unlike in other jurisdictions. “Either no other British palliative care consultants agree with the views of [most of the public], or several consultants do agree but are too frightened to say so. I suspect the latter.”

Claud Regnard, honorary consultant in palliative care medicine, and other UK specialists responded to Brewer: “We have been too respectful and considerate of the views of others, but that is neither cowardice nor a fear of remarkable individuals such as Cicely Saunders. Indeed, a decade after she died [in 2005] the Association for Palliative Medicine polled its members and 92% were against legalising assisted suicide.”

I have been a BMA member for 25 years and I have never been asked for my view Roshan Agarwal, oncologist

Aberdeenshire, took issue with some of the detail. “Far from ‘digging deep,’” he wrote, BMA research into end of life care “made clear from the outset that assisted dying would only be examined in the limited context of its ‘possible impact on the doctor-patient relationship’ . . . speculations were not explored in depth nor scrutinised with evidence from overseas.”

Disabled people

Jane Campbell’s blog on *BMJ Opinion* explaining some disabled people’s fear of legal assisted dying prompted further debate. Randy Tyson wrote, “There’s a very simple solution for you: don’t request it. But your position is one which tries to take that choice from everyone else.” In reply, David Gillon described some of the hate that disabled people experience: “This country does not have a healthy enough attitude to disability to give non-disabled people access to a ‘right to kill us’ law.”

The terms of the current RCP poll attracted comment, with Kenneth Wong, consultant cardiologist in Lancashire, calling the 60% threshold for continuing to oppose a law change “highly undemocratic.” On Twitter some commentators were dismayed that the college seemed not to have set a closing date for the poll. It now states it is 1 March.

New articles on bmj.com and *BMJ Opinion* continue to inform the debate. The ethicist Daniel Sokol says that “assisted dying is compatible with the Hippocratic Oath.”

Richard Hurley, *The BMJ*

Cite this as: *BMJ* 2019;364:l787

Not one NHS patient has benefited from cannabis law change, say campaigners



Mike Barnes, Jon Liebling, Hannah Deacon, and Greg de Hoedt are all campaigning for easier access to medicinal cannabis

Very few UK patients have gained access to previously illegal cannabis based medicinal products since doctors were given permission to prescribe them last November, and patients are complaining.

"The situation is appalling. Not one patient has benefited from a cannabis prescription on the NHS," Mike Barnes, honorary professor of neurological rehabilitation at Newcastle University, told *The BMJ*. "The legislation has had no impact on the health of people who remain criminalised due to the lack of education of the medical community and overcautious guidelines produced by the Royal College of Physicians and the British Paediatric Neurology Association [BPNA]."

Links to the guidelines were given in a letter to doctors from the Department of Health and NHS England last October. Campaigners say they, and doctors' and NHS managers' fear of and lack of training in prescribing cannabis products, are major barriers.

Guidance criticised

Since 1 November doctors have been able to prescribe unlicensed products containing tetrahydrocannabinol (box). But the BPNA's guidelines recommend against prescribing any product containing this cannabinoid.

In an open letter the parents of 39 children with intractable epilepsy recently called for the association

to review its guidance. "You appear to be ignoring the advice of Dame Sally Davies [England's chief medical officer], who recommended it should be made available . . . Where is the duty of care?"

The campaign End Our Pain has sought access to the drugs for 17 children with intractable epilepsy. Doctors have refused all of them prescriptions, its director, Peter Carroll, said. Last year End Our Pain publicised the case of Alfie Dingley, a boy with intractable epilepsy whose case was instrumental in changing the law. His frequent seizures were fully controlled, and steroid use stopped, when he was in the Netherlands and able to take full cannabis plant preparations. Media attention led to Alfie being the first person in the UK to receive such products under an extraordinary licence before the law changed.

Barnes said that, in addition to Alfie, he knew of only five other patients who had been prescribed unlicensed products containing THC, including Billy Caldwell, another child with severe epilepsy whose publicity spurred the legal change. But all five have obtained the products through private prescriptions, he said.

NHS England is monitoring cannabis based prescriptions and expects data by the end of next month, Steve Brine, public health and primary care minister, recently said in reply to a parliamentary question.

Hannah Deacon, Alfie's mother and an End Our Pain ambassador, said, "The law change is a catastrophic failure. Families were over the moon with hope that their children would have access to medical cannabis." Doctors are too afraid, she said. "One family's doctor told them he'd be sacked if he wrote a prescription."

Campaigning group the United Patients Alliance estimates that a million UK people take illicit cannabis to help with their conditions. But street cannabis is an unknown quantity in

The law change is a catastrophic failure

Hannah Deacon

terms of content, strength, and contaminants. Jon Liebling, its political director, said he knew of

"only two doctors willing and able to write prescriptions." He added, "Specialists should understand that any decision not to prescribe is a decision to leave the patient in the hands of the criminal market."

Doctors reticent

Greg de Hoedt, who has Crohn's disease, coordinates a UK network of some 70 "cannabis social clubs," each with around 200 patients. He said he knew of no members who had succeeded in getting an NHS doctor to prescribe cannabis based products. "I don't know where to turn, as someone who can't afford private prescriptions," he said. "My [NHS] consultant doesn't want the rigmarole. Patients are being treated as if we're stupid."

Richard Hurley, *The BMJ*

Cite this as: *BMJ* 2019;364:l753

MEDICAL CANNABIS IN THE UK

- **Cannabidiol (CBD)** is one of the most prevalent of more than 100 cannabinoids in cannabis but has never been subject to legal restrictions in the UK. It is considered safe and non-addictive and is the cannabinoid being most studied for its therapeutic properties. It is marketed as Epidiolex

by GW Pharmaceuticals and is licensed in the US and awaiting licensing in Europe.

- **Sativex**, which contains CBD and tetrahydrocannabinol (THC), the cannabinoid that produces the "high," is licensed in the UK for treating spasticity in MS.
- **Since 1 November 2018** doctors in the UK can

legally prescribe unlicensed products containing THC.

- **Products** that contain both CBD and THC may be prepared from cannabis plant material. They include products such as Bedrocan, Bedrobinol, Bediol, and Bedrolite, which are all made by Bedrocan in the Netherlands.

- **Molly Meacher**, chair of the All-Party Parliamentary Group for Drug Policy Reform, has said that full plant products containing THC as well as CBD were being sidelined in the UK because of the industry's and doctors' vested interests in promoting single cannabinoid products.



THE BIG PICTURE

Art for health's sake

A charity that has been brightening hospital walls with calming, thought provoking, or cheerful art for six decades is celebrating its anniversary with 60 weekly blogs from artists, art critics, patients, and carers.

Paintings in Hospital has been loaning art to healthcare spaces for 60 years, including the Toy Box Tales exhibition (right) and *Garden² (no.7)* by Marc Quinn (below). The first is a collaboration with #ToyLikeMe, which creates toys adapted to resemble disabled children. The Quinn work is part of *Rooted in the Landscape*, a new exhibition that will tour hospitals in southwest England this year. It also features works by Keith Vaughan and the Turner Prize nominee Janice Kerbel.

The 60 Years, 60 Voices project aims to highlight the contribution the charity has made to the nation's physical, mental, and social health since it was founded in 1959. The blogs, featuring personal stories from a diverse community of supporters, starting with founder Sheridan Russell, can be read on its website and on social media (#60Voices).

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2019;364:l783





BETH MOSELEY PHOTOGRAPHY AND ELOISE ROSS PHOTOGRAPH

The inaugural Doug Altman Scholarship

A scholarship to foster future leaders in evidence based medicine

Doug Altman (1948–2018) was *The BMJ*'s chief statistician for more than 20 years. His work on improving the execution and reporting of research made him a world leader in evidence based medicine and a distinguished role model.

His editorial, "The scandal of poor medical research," written in 1994 is essential reading for those new to evidence based medicine.¹ Its call for "less research, better research, and research done for the right reasons" remains relevant today. His passion for teaching and mentoring makes him a source of inspiration for early career researchers.

To commemorate his contribution and leadership to medical research, the EBMLive conference—a collaboration between Oxford's Centre for Evidence Based Medicine and *The BMJ*—is launching the inaugural Doug Altman Scholarship. The scholarship encourages and supports future



An opportunity for early career researchers seeking to improve the quality of research and its use in clinical practice

leaders in evidence based medicine by offering a valuable opportunity to early career researchers seeking to improve the quality of research and its use in clinical practice.

Those who will shape the future of evidence based medicine need places to meet, learn, exchange ideas, be inspired, and help to inspire others. They also need a seat at the table, to hear today's leaders, to contribute to developments in medical research, and to learn how to lead.

In 2017, the evidence based medicine community, through EBMLive, launched the "evidence based medicine manifesto,"² a road map towards more trustworthy evidence that pledges to "encourage the next generation of leaders in evidence based medicine."³ This scholarship is one way to support this commitment. It aims to reinforce the importance of mentorship, which was at the heart of Doug's work and is still at the heart of the evidence based medicine movement.⁴

Shared enthusiasm

Several leaders in evidence based medicine emerged in the 1990s. Their shared enthusiasm for improving the development, appraisal, quality, and dissemination of medical research led to internationally influential initiatives such as the Cochrane Collaboration and the EQUATOR network.^{5,6} Since then, lives have been saved through the clinical application of synthesised and appraised evidence from randomised trials and systematic reviews.⁷

Why do we need new leaders? Like most disciplines, evidence based medicine must refresh, develop, and rethink its direction as the evidence ecosystem, clinical medicine, and the world change. Challenges such as reporting bias,¹⁰ poor regulation,¹¹ undeclared conflicts of interest¹² and an overemphasis on surrogate endpoints¹³ and statistical

significance¹⁴ are unresolved. Developing effective solutions will require leadership, mentorship, and teamwork far into the future.

Swiftly evolving landscape

Evidence based medicine needs creative leaders who are open about the limitations of research and demand full transparency in the reporting of the benefits and harms of treatments. They will need to navigate the swiftly evolving landscape of medical research, and remain sceptical to new, untested interventions. They will need to overcome major perverse incentives such as the culture of "publish or perish" in academic institutions and other systemic barriers that inhibit or fail to foster emerging leaders in medical research.

Altman spoke about the need to attract expertise from all disciplines to help improve the design, conduct, and reporting of research. He and the late Dave Sackett, another world leader in evidence based medicine, both emphasised the importance of collaborative opportunities and mentoring to their own careers,^{16,17} and diligently extended these benefits to others. EBMLive is one such opportunity.

We encourage students, junior doctors, early career researchers, and patients from anywhere in the world to apply for the 2019 Doug Altman Scholarship. We welcome applicants from diverse backgrounds including academia, industry, publishing, government, healthcare, and advocacy to share their ideas on how to make evidence relevant and replicable for everyone. Doug Altman has left a legacy that will change the way we do research. This scholarship, in his honour, signifies our commitment to continue his extraordinary work.

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THE 2019 DOUG ALTMAN SCHOLARSHIP

The scholarship, funded by the McCall MacBain Foundation, will waive EBMLive delegate fees for 10 applicants, and the top submission will be awarded the full Doug Altman Scholarship. It will cover:

- travel to and from Oxford for the duration of EBMLive
 - three nights' accommodation in one of Oxford's colleges
 - attendance at the conference dinner
- During the conference, the Doug Altman scholar and the nine shortlisted submissions will:
- present their ideas and participate in dedicated "future leaders" session
 - contribute during debates
 - learn from leaders in evidence based medicine
 - develop networks
 - build a community of early career researchers

Further details and how to apply can be found at <https://ebmlive.org/doug-altman/>

Georgia C Richards, doctoral researcher, Centre for Evidence Based Medicine, Nuffield Department of Primary Care Health Sciences, University of Oxford georgia.richards@phc.ox.ac.uk

Helen Macdonald, head of education, *The BMJ*

Peter J Gill, assistant professor of paediatrics and honorary fellow, Division of Pediatric Medicine, Department of Pediatrics, The Hospital for Sick Children, Toronto

Publicising trial results before peer review

Clinicians should remain sceptical until peer reviewed findings are published in full

On 23 November 2018, Novo Nordisk issued a 500 word press release reporting that PIONEER 6, the cardiovascular outcome trial of oral semaglutide, an analogue of glucagon-like peptide 1 (GLP-1)¹ showed a “significant reduction in cardiovascular death and all-cause mortality.” These claims are unverifiable with the limited information available.

The release suggests an unequivocal and important benefit of oral semaglutide compared with placebo. Excitement ensued in the press and in the stock market, with the company’s stock rising in the following days. Although full results will be available “during 2019,”¹ even the minimal available information suggests these will lead to more nuanced conclusions than those reported.

Missing details

Importantly, the study was designed as a non-inferiority trial. The top line results indicate that semaglutide was non-inferior, but not superior, to placebo for the prespecified primary endpoint: a composite outcome of cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke. Statements about a reduction in cardiovascular death, then, come from parsing the components of this composite outcome. This may be misleading as the study was designed and powered to evaluate the composite outcome, not necessarily the individual components. Although the reported 51% reduction in the relative risk of cardiovascular death is striking, the absolute number of events in both groups is critical to understanding the clinical

Peer reviewed results, not press releases, should guide our treatment decisions

value of the effect. Context is also essential to understand adverse events; the press release states only that adverse events for oral semaglutide were “consistent with the established safety profile observed in previous PIONEER clinical trials.”¹

Not the first

This press release is just one of many similar examples. In 2015, results of the SPRINT trial were reported in the media before peer reviewed publication after a press release by the NIH sponsor.² Initial reports indicated that intensive blood pressure management resulted in lower all cause mortality than targeting the usual goal of a systolic blood pressure of 140 mm Hg.³ But once the peer reviewed study was published enthusiasm for intensive management waned as details emerged about associated harms such as syncope, hypotension, and renal failure.⁴

Beyond these case studies^{5,6} data are lacking to quantify the scope of this problem. Research is required to find out how often press releases are issued before peer reviewed publication; how often these press releases emphasise a secondary endpoint or subgroup analysis⁷; what effect this early release of limited data has on prescribing patterns; and whether companies consistently receive a bump in their stock price after release. Answers to these questions will help form appropriate regulatory, policy, and educational approaches to address this problem.

Some have suggested that journals could

decline to publish studies if results were publicised before peer review. However, a blanket policy limiting the dissemination of knowledge gained from patients’ altruistic participation risks creating more problems than it solves.

A broader response is required because study results are increasingly in the public domain before peer review. Presentations of study results at conferences used to be seen only by those attending; social media have broadened that audience substantially. Furthermore, preprint articles are by definition in the public domain before peer review.⁸

Efforts to educate clinicians to remain sceptical until peer reviewed results are available will be critical. The US Department of Health and Human Services “final rule” that requires submission of trial results, typically within one year after completion of the clinical trial, may be an important tool.¹⁰ Trial results (including baseline characteristics, efficacy, and safety endpoints) will be publicly available at www.clinicaltrials.gov.¹⁰ Although these trial data do not prevent a press release before peer review, they do provide interested readers with granular information about both the benefits and the harms.

Oral semaglutide may be an important addition to the diabetes treatment armamentarium. However, peer reviewed results, not press releases, should guide our treatment decisions.

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Michael Fralick, physician, Eliot Phillipson Clinician Scientist Training Program, Department of Medicine, University of Toronto
mike.fralick@mail.utoronto.ca

Chana A Sacks, physician, Division of General Internal Medicine, Department of Medicine, Massachusetts General Hospital and Harvard Medical School, Boston



SOCIAL CARE

Bankrupt: how will councils care for vulnerable people?

Northamptonshire has a plan to stave off insolvency but health and social care leaders fear its cuts will slash already weak support for those in need.

Richard Vize reports how local authorities across England are being driven to offering the legal minimum of services

As the NHS in England begins implementing its plan for spending its additional £20bn over the next 10 years, a growing number of local authorities facing financial crisis are slashing adult social care budgets.

The long term impact on health services will be profound, affecting everything from hospital discharge to falls prevention and rehabilitation. According to the Association of Directors of Adult Social Services, councils in England are removing £700m from adult spending this financial year, 4.7% of that budget.

East Sussex County Council is planning to strip its services back to a “core offer,” which includes reducing services for vulnerable children and adults. Worcestershire County Council is looking to shed around 200 staff—which will have a serious impact on child and adult social care which accounts for almost 70% of its budget. Other councils facing serious financial pressures include Cornwall, Lincolnshire, Somerset, Surrey, and Torbay.

Northamptonshire County Council—whose problems have been exacerbated by mismanagement—is in the deepest trouble. Last autumn, it adopted a financial stabilisation plan: targets include saving £700 000 by reducing long term care placements from hospital and £1.8m from



We don't have enough supported living solutions

Anna Earnshaw,
Northamptonshire
County Council

“new ways of delivering care and independence.”

Local health service leaders are concerned about the impact of the cuts on the wider health and care system; many important but non-statutory services are being badly hit, such as support for welfare rights advice and a home repair service for elderly and vulnerable people.

Misspent money

The county has, however, been running services that are both expensive and often inappropriate, so it should be possible to redirect money. There has been misspending on people with learning disabilities, for example. Anna Earnshaw, adult social services managing director at Northamptonshire County Council, says: “Half of all our customers are under 65 and many of them are learning disabled.

“The stabilisation plan recognises that what we’re doing at the moment is costing us a lot of money, especially in residential care, because we don’t have enough supported living solutions.”

Poor commissioning of services means Northamptonshire is spending an average of around £70 000 a year to keep a person with learning disabilities in residential care, £20 000 more than the average of surrounding councils. Many of these service users would be better cared for in supported living accommodation at a cost of £25 000—a saving of £45 000 per person per year.

The council is also spending too much on people leaving hospital. “About 60% of our demand for services comes from the hospitals,” says Earnshaw. “The referrals we get are twice the regional average—the norm is about 30%.”

So the local NHS and council are investing in intermediate care to discharge people more quickly and to stop them having to go into long term care. Domiciliary care bills are being racked up by allocating excessive care packages to people leaving hospital, a problem exacerbated by some being assessed for their needs while still in the unfamiliar hospital surroundings rather than being “discharged to assess.”



Northamptonshire County Council: local authorities are cutting millions from care budgets

“If we can do more to get the right level of care from the beginning then we release more capacity for homecare,” Earnshaw says. “The winter plans we have put in place are all about not doing any assessment in hospital—either move them home or to an interim bed to assess.”

Shortages of care

Nicki Slawson is clinical lead for Seatons Solicitors, which represents many people caught by the funding shortages across health and social care in Northamptonshire. People in need of both mental and physical health support have had to “wait until they get into a crisis,” she says. “They are firefighting the whole time on the frontline. Staff are dealing with it crisis by crisis.”

Slawson, a trained nurse, sees the problems caused by a shortage of intermediate care: “People are often not given the opportunity to go into rehabilitation or go home, so they are ending up in care homes when probably they shouldn’t be.”

She cites cases of people who have had modest social services support and are then admitted to hospital. After treatment they are moved to a “discharge to assess” bed, intended to allow them to have their needs assessed in their own home. After waiting three or four weeks for social services—or sometimes the NHS—to carry out the assessment they have lost their ability to live independently “so they end up in permanent care. It really bugs me.”

One woman was kept in hospital for six months and then discharged to an assessment bed; but no one gave her back her walking frame, Slawson says, so by the time she was assessed she had lost her mobility. Age UK, which has around 14 000 clients in Northamptonshire, also highlights the lack of intermediate care as “one of the big problems that acute hospitals are wrestling with.”

“Intermediate care is a problem for all health systems, everywhere: getting the right support for people at the right time,” says the charity’s chief executive in the county, Christopher Duff.

“The real answer is to provide ongoing support for people in their homes,” Duff adds, yet difficulties



in accessing domiciliary care are also having a significant effect. “We see it often. If domiciliary care isn’t there then patients are readmitted to hospital. There is another fall, or drugs regimes aren’t adhered to, or they sink further into loneliness and poor mental health, and they become even less independent.”

Joint assessment issues

Slawson believes that “more than dozens” of people have ended up selling their homes to pay for a care home place unnecessarily—either because they should have had a support package to keep them in their own home or because their primary condition is medical so they should have qualified for NHS support but were wrongly treated as having a social care requirement that then has to be funded.

“Although it would be brilliant if health and social care worked together it just doesn’t happen because both sides are trying to protect their budgets,” Slawson says.

She cites the case of people who had severe cognitive impairment, no verbal communication, double incontinence, needed constant skin maintenance, and have to have food and drugs administered through a tube in the stomach, “so a really high level of need, which should not be treated and funded as social care. That is healthcare.” Such rulings are being appealed.

Earnshaw acknowledges problems around joint assessments of health and social care needs: “It is a national challenge. One of you gets the cost. We need joint assessments that reasonably split the costs. We are in a good place already with learning disability and mental health clients, and we probably need to do it more around older people.”

Mark Major, chief executive of Northamptonshire Carers—and chair of Northamptonshire Carers’ Partnership, which involves charities, the county council, and NHS providers—says support for carers continues to be good. Cuts have had significant impact elsewhere, however, such as for deaf and visual impairment support and advice services, and it is taking longer to access care.

“The county council has backlogs of unallocated cases and backlogs around safeguarding,” Major says. In February 2018, the council admitted its adult services were on the “edge of being unsafe,” with 2000 unassigned cases. The number has since fallen.

Next big risk

The next big complication facing Northamptonshire’s social services is the decision to abolish the council and all its districts, and divide the county into two unitary authorities—providing all local government services—in 2020.

Earnshaw says: “We have to have safe landing from day one, so no one falls through the gaps. We may need to keep some teams—particularly safeguarding and quality—at a county level in the first instance so we don’t disrupt them.”

Her key advice for other councils facing a budget crisis is: “Don’t cut back too far on your capacity. If there are too few staff, it exacerbates problems by taking too long to put care in place and scale it back when it is no longer needed.

“If you don’t have the capacity to do that then every assessment becomes a crisis and patients are far more likely to end up in long term care or hospital.”

Richard Vize, freelance journalist, London
richard.vize@publicpolicymedia.com

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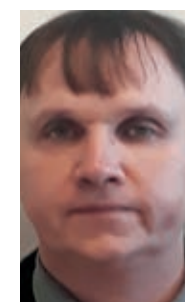
The real answer is to provide ongoing support for people in their homes

Christopher Duff,
Age UK



Frontline staff are firefighting the whole time

Nicki Slawson,
Seatons Solicitors



There are backlogs of cases

Mark Major,
chief executive,
Northamptonshire
Carers

How medical leaders win friends and influence people

Doctors' representatives are finding value in dropping an adversarial approach to win others round to their way of thinking. **Tom Moberly** explores the rise of this soft power

Does soft power work for trade unions?

"I'm not sure I would use the word 'soft'; instead it is about being very clear about what you feel needs to change and cutting through the posturing and what can be a treacle of game playing," says Chaand Nagpaul (below), chair of BMA Council.

"It is about creating an alignment of purpose with politicians. We argue for doctors to be able to do their jobs properly and to be given the appropriate rewards for doing so. This clearly has a direct impact on politicians because their electoral success will be enhanced by better patient care.

"When I became chair of the BMA GPs' committee, the then health secretary Jeremy Hunt had imposed contractual changes that were seriously damaging the profession in terms

of taking funding away, working harder, and quite punitive performance management. Within six months, 90% of those changes were reversed because I was direct and demonstrated clear evidence about the impact it was having on patients and it was in the government's interest to ensure that GPs were supported. And punitive changes would backfire on government itself.

"But this more constructive approach cannot occur on its own—it is complementary to the 'anger' outside. Politicians are influenced by political noise, by the perception of patients and the public, and therefore it is right that the BMA as a trade union should be publicising the realities faced by doctors.

"Many politicians understand that it is natural and in keeping with the territory of a trade union to be publicly having disagreements with the government. You can combine this with the direct dialogue that occurs with ministers behind closed doors."



They thought because you weren't jumping up and down on their behalf that meant you didn't care about them

Jane Dacre, former RCP president

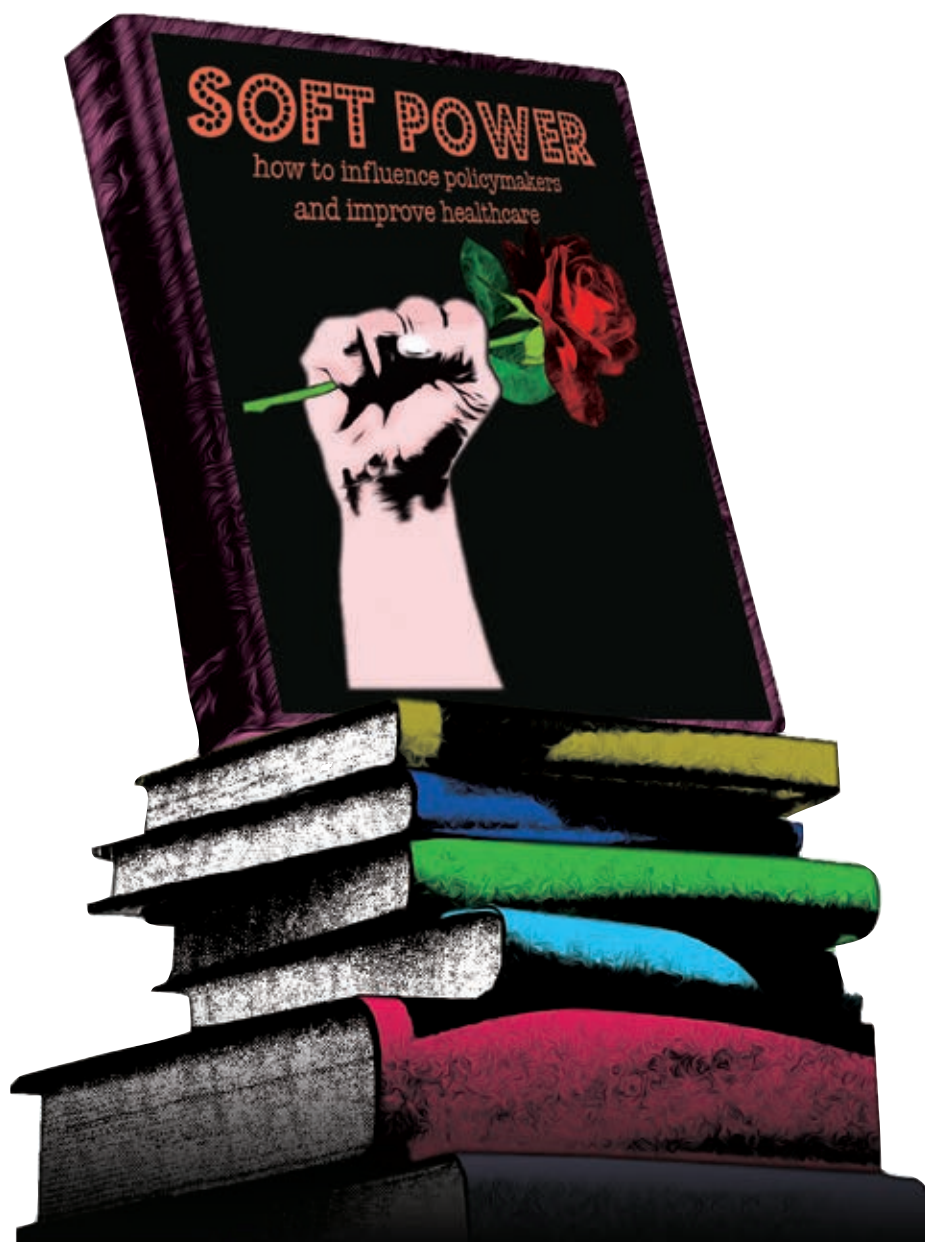
"It was the junior doctors' strike that really brought it home to me," says Jane Dacre, former president of the Royal College of Physicians, of the moment she recognised that an adversarial approach to engaging with policy makers doesn't always work.

"The mood out there was really angry and really anti-government, particularly the secretary of state. And the more that people expressed those views, the more

his natural reaction was to not engage with them," she says.

As a result of her experience, Dacre changed the way she and the college engaged with policy makers. "I observed that colleagues who are very vocal and say exactly what they think—and absolutely reflect the views of the membership and fellowship, often the more strident views—just did not get invited to discuss things," she says.

"That sort of adversarial approach didn't appear to get to the outcome that you wanted."



Soft power

The approach the college sought to take instead, under Dacre's direction, is often called "soft power."

The term was originally coined by the political scientist Joseph Nye in 1990 and used in relation to international relations. It has since been used in a broader sense of achieving influence in the absence of commanding power. Collins dictionary defines it as the "ability to achieve your goals without force, especially by diplomacy, persuasion, etc."

Dacre credits the change in the college's approach with helping to deliver several positive changes in the NHS. "I feel pretty confident that more money, more medical student numbers [and], lifting of visa caps were all things that we got through collaboration and soft influencing," she says.

"To do your best by the members and fellows you need to be at the table to be part of the discussion to find the solution."

Alan Milburn says that, during his time as health secretary from 1999 to 2003, adversarial approaches were rarely successful. "I found personally that what worked in terms of influence was a considered conversation rather than an outright confrontation," he says.

Those who take an adversarial approach may not even get the opportunity to influence politicians, points out Nick Black, professor of health services research at the London School of Hygiene and Tropical Medicine. "Colleagues who go straight for the jugular and criticise a particular politician for coming up with a ludicrous policy get the response you can imagine from that politician," he says.

"You're certainly not going to be invited to come and give your views."

Solutions and evidence

A better approach, Milburn argues, is to offer solutions. "If you're a health minister, the last thing that you need is someone walking into your office with yet another set of problems, because you already have an in-tray full of those," he says.

"And certainly the people that I found the most frustrating to deal with as health secretary were people who brought me yet more problems rather than those who could suggest solutions."

An approach focused on solutions is about being helpful to achieve a

common purpose, Dacre argues. "Rather than saying, 'Don't do it,' say, 'Have you thought of this?' or 'Why didn't you do it like this?' or 'If you do it like this you're more likely to get buy-in from our members and fellows.'"

"We're on the same side, really, in trying to get the health service improved, and the way to make progress is by just explaining that rather than being adversarial."

Carrie MacEwen, chair of the Academy of Medical Royal Colleges, believes that evidence is key to any approach to influencing policy makers. She points out that doctors are able to provide politicians with evidence of both what is happening and what the effect of any proposed solution would be.

"That's quite powerful: going in and saying, not only do we have experience on the front line but we've got evidence to support that this will work," she says.

Telling tales

Although evidence can be helpful in influencing politicians, it rarely clinches things, argues Simon Wessely, professor of psychological medicine at King's College London and former president of the Royal College of Psychiatrists. "Most government decisions are not made on pure scientific or doctors' advice," he says.

He gives the example of an discussion with a minister on alcohol policy. "He listened to our presentation. At the end he said, 'Well, very good. Thank you for that. I understand the points you are making. You've been very helpful.'"

"And then he said, 'But, you know what, I think the lads deserve a drink.' And, you know, that's his job. He weighed up the options and thought, actually, we do subsidise alcohol—people have tough jobs, all that kind of stuff. That's what a minister can do, and that's what they should do."

Sube Banerjee, who led the development of the Department of Health's national dementia strategy, says it is important to create a narrative around the change you are discussing. Telling a story about the issue can be a good way, he says, to allow policy makers and others to shift their point of view, and also to see what the next steps need to be.

"You build a story that's coherent and simple," he says. "You believe the story and you're telling yourself the story. Then other people start believing it, and they start telling that story to other people."

LEARNING TO INFLUENCE



Sube Banerjee, who led the development of the national dementia strategy, says that influencing skills end up being learnt through experience. "I think mostly we make it up as we go along without knowing what we're doing," he says. "I am not sure if we'd have done it any worse if I had known what I was doing; it's more that I'd have had the frameworks to understand what I was doing"



Jane Dacre, former RCP president, believes that understanding how to influence others has to be gained in a practical way. "It needs to be role modelled, understood, discussed," she says. "It needs to be more overt. And some of that is by mentorship and by training. Just having a course on 'Let's learn how to influence' is not necessarily going to make the kind of difference that you want"



"Like everything that is important, no one ever tells you how to do it, although they are always on hand to let you know when you have done it badly," Simon Wessely, former president of the Royal College of Psychiatrists, wrote in a blog post in March 2017

GETTING CORONATION STREET, THE ARCHERS, AND CALL THE MIDWIFE ON SIDE



Ron Daniels (above), chief executive of the Sepsis Trust, believes that clinicians wanting to change healthcare services shouldn't think that they have to stick to using formal approaches to royal colleges and NHS organisations.

"What I've learnt over the years is that there are opportunities to achieve similar—or in fact greater—change collaboratively with such agencies by

stepping slightly outside them and advocating from a public facing perspective," he says.

The charity seeks to use media stories to help public awareness of sepsis. It decided to pursue this approach after reports showed that, even though sepsis care was improving,

patients often died because they presented too late to healthcare services. "If you package together a piece of news with a new case study, then the media sit up and take notice when that is put in the context of the number of cases of sepsis in our country," he says.



"The media like stories about children"

The charity is sometimes criticised for using too many case studies of children and young attractive women, but Daniels says this reflects the reality of what the media want. "The media like stories about children growing up without a mum, or children who might have grown up without a mum were it not for quick action," he says. "They're less interested in the biggest cohort of sepsis cases, which is patients over 75."

Daniels believes that the charity has "made sepsis a mainstream news item" through its media work. "Most recently we've been working with the soap operas to further extend

the reach of sepsis into the public psyche," he says. "*Coronation Street*, *The Archers*, and *Call the Midwife* chose to run programmes on sepsis and came to us for advice."

From the outset, the charity has taken a public facing approach to its work, Daniels says, because of the importance of raising awareness to improving outcomes. "We have champions out there writing letters to their parliamentarians and publishing in their local newspapers," he says.

"We've engaged the public as ambassadors and we've got them to go out speaking about it, which I think the traditional route wouldn't involve."

And they believe that story to be their story. They take it on. They start running with it.

"Those stories propagate and actually not only change people's minds but also frame what the actions will look like. Because a good story tells you something about what you need to do—not just that there's a problem but what the solutions might be—and that's what people start selling."

Behind closed doors

Despite the potential of a soft power approach, the fact that it relies on discussions behind closed doors and avoids public confrontations can lead to irritation and dissatisfaction. For members of representative organisations who are not privy to these discussions, this frustration may be magnified by the fact that gains made through soft power are often not announced or publicised.

Dacre says that it is important "not to gloat" when you get what you want through soft influencing approaches. "Our approach is to say, 'It's great that this has happened and we've been asking for it because it's a really good thing to

If you're a health minister, the last thing that you need is someone walking into your office with yet another set of problems

Alan Milburn, former health secretary

do," and not say 'We won and you lost,'" she says.

This approach, particularly a lack of confrontation in the public arena, presents challenges for membership organisations, Dacre admits. "Some of the members and fellows didn't get that," she says. "They thought because you weren't jumping up and down on their behalf that meant you didn't care about them."

Clare Gerada, who was chair of the Royal College of GPs from 2010 to 2013, says that another challenge of explaining the impact of soft power is that influence is often achieved by stopping things happening. "When I was chair, people often asked, 'What does the RCGP do?', she says. "The RCGP stops bad things happening by being at the right meeting at the right time with the right people and giving the right coherent argument."

But the effect of this work is largely invisible to members, and so they remain unaware of these interventions by the college, she says. "The problem is you never see it. It doesn't make headlines because the headlines aren't, 'College stops something happening that might not have happened in the first place.' But that's what you do.

"This is about the machinery of the colleges and the membership organisations, and it's difficult for people to understand. But that is the soft power."

A "soft power" approach also, Dacre acknowledges, means walking a fine line between having influence and being influenced. "You sometimes have to say, 'Okay, enough,'" she says. "You sometimes have to go public with it. Because there's a risk. The risk is that you get too close and you're actually being manipulated."

Dacre believes that a greater understanding of how doctors can influence policy makers would be a great benefit to the profession. "I have travelled around nearly every trust in the country, and you pick up enormous frustration about not being able to get things done, usually because of lack of resources," she says.

"Less thought is given to how to get things done, less of a view that, 'If we work with our organisations towards a common goal, this is what we will be able to achieve together.'"

Tom Moberly, UK editor, *The BMJ*, London
tmoberly@bmj.com

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