

# comment

“It’s not just about treating all doctors fairly but giving them support to thrive” **IQBAL SINGH**

“We can’t afford a high proportion of people to lose fitness and health” **SCARLETT McNALLY**

**PLUS** Helen Salisbury on social determinants of health

**TAKING STOCK** Rammya Mathew

## A golden opportunity to improve asthma care

It’s more than 10 years since the publication of the National Review of Asthma Deaths, which revealed that most deaths from asthma in the UK were preventable. In the years since, many of the problems identified in asthma care have persisted, and the annual death toll has continued to rise.

One of the key risk factors for deaths from asthma is the overuse of reliever inhalers and the underuse of preventer inhalers. When undertaking asthma reviews it’s common to hear patients say that the short acting  $\beta_2$  agonist (SABA) reliever inhaler feels effective, because of its immediate effects—but this in turn can lead to poor compliance with preventer inhalers and an overall worsening of a patient’s asthma.

NICE recently released new guidance that seeks to finally put an end to the overuse of SABAs. Clinicians are encouraged to start combination inhalers early on and to use maintenance and reliever treatment regimens rather than creating a counterproductive dependence on SABAs. This could be the watershed moment we’ve all been waiting for in asthma care, but it needs to be accompanied by proactive plans for change and investment to better integrate asthma care and upskill primary care teams in asthma management.

The initial challenge will be to create the time and capacity to ensure that management plans are updated for people with asthma, in line with new guidance. This will require proactive review of patients, especially those who are overusing SABAs. We also need to make sure that clinical staff with delegated responsibility for conducting asthma reviews are confident in assessing asthma control—and are aware that overuse of SABAs is itself a sign of poor control.

It’s important to acknowledge that asthma expertise isn’t available in all practices, and competencies in

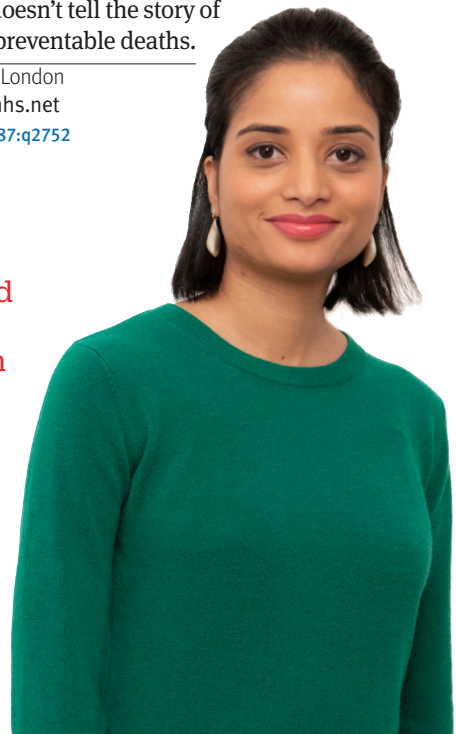
asthma management can be variable. Research by Asthma + Lung UK showed that seven in 10 people weren’t receiving basic aspects of asthma care. As we’ve done for other long term conditions, we have an opportunity to train identified clinicians so that they can offer this expertise at the level of a primary care network or neighbourhood, with easy access to specialist advice in this setting, so that patients with poor asthma control aren’t just kept on the same regimen but go on to have their treatment optimised.

In recent years we’ve finally seen improved access to objective diagnostic tests for asthma. But with the introduction of this new NICE guidance, and the formation of neighbourhood teams, we have a golden opportunity to tangibly improve asthma care so that the next decade doesn’t tell the story of thousands more preventable deaths.

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This could be the watershed moment we’ve all been waiting for



## Two years on from Singh and Forde's review, the GMC is making progress

Efforts to improve equality in medicine still face many challenges

It is two years since the Singh and Forde review of the GMC was published. The report's recommendations focused on ensuring regulation is fair, compassionate, supportive, and local first.

In October, the GMC published its annual update on the equality, diversity, and inclusion targets it set in 2021, which shows progress across a number of metrics.

There are sustained signs of improvement in terms of fitness to practise referrals by employers, in which ethnic minority doctors are disproportionately represented. The attainment gap in specialty training for international medical graduates (IMGs) is narrowing. And the organisation is ahead of schedule on targets around the representation of ethnic minority staff in its own workforce. Ethnic minority representation is 18.7% of the GMC's workforce, up from 14.3% in 2020.

But there's no denying that there are

challenges and there's a long way left to go. Although the 2024 annual update shows promising signs of progress in many key indicators, the ethnic representation on senior leadership positions within the GMC continues to be a challenge.

The GMC's recent update report highlights that while targeted interventions can yield results in the short term, systemic and cultural change is much harder to deliver.

### Local resolution

Much of this falls outside the regulator's remit. The GMC has sought to improve local resolution of concerns—employment liaison advisers are pushing employers to manage complaints internally so that it does not need to reach the GMC and spark an investigation, which can be really stressful.

The GMC's efforts, such as their work with responsible officers around the impartiality and fairness of referrals, are welcome. But ultimately much depends on the culture in



### Ultimately, much depends on the culture in the workplace

the workplace and what doctors from ethnic minorities see, hear, and experience every day. This requires wider commitment and action across healthcare.

It is not only a case of treating all doctors fairly, but also giving them the support to thrive. Our health service would collapse without overseas doctors, but too often they are left to sink or swim when they arrive in a new system and a new country. While programmes such as the GMC's Welcome to UK Practice are valuable, they must be part

## An illusion of control

Our surgery has been shaken recently by some unexpected diagnoses and sudden deaths that have reminded us of how poor doctors can be at predicting the future health of patients.

With some people you can see a downward trajectory, signalled a long time in advance—although even then they may surprise you, recovering from yet another acute admission or infectious exacerbation and carrying on for many more years. But there are others who were seemingly in the peak of health and fitness and are suddenly gone.

Most people understand the things they need to do to stay healthy. The messages patients get from their doctors haven't changed much in 50 years: don't smoke, exercise regularly, limit your alcohol intake, and maintain a healthy weight. Also, accept the vaccinations you're offered, check your blood pressure, and attend cancer screenings.

On top of these basics, many private health

screening and “wellness” companies are suggesting that people “take control of their health” by having additional tests to detect abnormalities before they become serious, although evidence for this being beneficial is limited.

The brutal fact is that our health is determined by many things we can't control. We don't choose our genetic inheritance and can't influence the material circumstances we grow up in. The availability of good food and safe places to play outside may determine a lifetime of

**We don't choose our genetic inheritance or the circumstances we grow up in**

healthy weight or obesity, and physical and emotional security in childhood has a huge impact on our future mental health.

So, perhaps we should stop focusing obsessively on what we need to do for our personal health, as we know that beyond the obvious basics, the rest is mainly luck and inheritance.

Of course, I'm not suggesting that we should halt the scientific research that may lead to medical advances and turn some of those devastating diagnoses into treatable conditions. Rather, to benefit the generations coming after us we should harness what we already know about the social





MARK THOMAS

of a wider welcoming and valuing package for recruits.

Greater support is required, not only for doctors in difficulty, but also when there is a need for remediation such as the one provided by the Centre for Remediation Support and Training at the Institute of Medicine, Bolton University, which helps to enable a safe return to clinical practice.

Without services like this, we are wasting a valuable resource and setting these doctors up to fail.

Iqbal Singh, professor and chair, Centre of Excellence Safety of Older People, University of Bolton  
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determinants of health, thinking about how we can improve the circumstances children are experiencing as they grow up today.

A report from the Joseph Rowntree Foundation last week showed that seven million UK households were going without essentials, and 5.4 million were living with food insecurity. More than 151 000 children are living in temporary accommodation. Ending child poverty would be the biggest step any government could take to improve the nation's health.

The focus on prevention that we've been promised in the NHS shouldn't just be about asking patients to take control of their own health through lifestyle changes: it should also work on intervening at the earliest stages to ensure that today's children have an opportunity to grow up healthy and happy.

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## Better health will ease strain on care

**H**ospital beds are full. Over 12% of inpatients no longer meet the criteria to be there. This has knock-on effects for emergency departments and leads to cancellation of elective operations.

The costs of social care are unaffordable for many and are rising massively. Adult social care accounts for half of some local councils' revenue budgets, so many are making drastic cuts in the things that keep people healthy—swimming pools, play parks, walkable streets.

Being physically active reduces the need for social care. Yet our default healthcare model creates patient passivity. Many staff are aware of initiatives such as All our Health and End PJ Paralysis, which focus on keeping patients active, but struggle to apply them.

I believe that we're stuck for two reasons. First, staff are overworked and scared of patients falling: there were 247 000 falls in England's hospitals in 2022, and it can feel safer in the short term to keep people in bed. Second, the media, the public, and popular culture expect older people to rest and middle aged people to be sedentary.

But losing fitness is not inevitable with ageing, and fitness levels of someone 10 years younger can be achieved by starting to be active. Healthcare staff need to be clearer that health messages apply to everyone and that it's safer to do some exercise than to be sedentary. A quarter of England's adults have multiple health conditions, and resources at #WeAreUndefeatable and Versus Arthritis show how they can improve their health.

I live in an area where 25% of the population will

soon be over 75. We can't afford for such a high proportion of the population to lose fitness and health. There are simple ways people can maintain a healthier lifestyle, such as using the stairs more frequently, keeping active by going out shopping, joining community initiatives, and helping family and neighbours. Keeping active and connecting with others is vital for health.

In healthcare, discussions on workforce and pathways need to change. Doctors and senior clinicians should lead in individualising messages about living a healthier life. This requires follow-up from the rest of their team, including non-clinical and support staff, who should be empowered to help by having simple training in holistic health and motivational interviewing.

So, let's end the year with some positivity. The Centre for Perioperative Care has a new workforce strategy explaining how to fit holistic health back into healthcare, as well as web pages on seven interventions that reduce the risk of complications after an operation—some by as much as 50%.

Macmillan Cancer Support has resources on preparing for cancer treatment, including exercise, nutrition, and psychological support. As a cancer patient myself I know that using weights means you have lovely big veins for chemotherapy, so for people undergoing treatment who are able to, I'd advise trying to do some strength training.

Let's use our most senior clinicians to lead, with the whole workforce behind them so that healthcare truly improves health holistically for every patient. It only takes a few patients to show what's possible.

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**Our default healthcare model creates patient passivity**



# Sudan is facing a humanitarian crisis, but the IRC is helping to restore hope

**A**s the country director for the International Rescue Committee in Sudan, I have witnessed the devastating impact of a conflict that has torn our nation apart for more than 18 months. The situation has spiralled into a humanitarian catastrophe that has destroyed the fabric of society—with women and girls bearing the most brutal consequences.

For millions of Sudanese people, the past year and a half has meant leaving our homes; being separated from family and community; and facing unimaginable difficulties in accessing essentials such as food, clean water, healthcare, fuel, and electricity.

Amid this humanitarian deterioration, women and girls are suffering particularly devastating consequences. Conflict and displacement have exposed them to an alarming increase in gender based violence, and reports of intimate partner violence, sexual exploitation, and abuse are widespread.

The economic collapse of the country has stripped women of opportunities to earn a living, pushing many into desperate circumstances that heighten their

vulnerability to exploitation, trafficking, and marginalisation. As hospitals and health centres have been forced to close, and healthcare staff forced to flee areas of fighting, women have been left struggling to access lifesaving reproductive care.

Since April 2023, my team and I have worked to scale up our emergency response to help meet people's basic needs despite increasingly difficult conditions. We are committed to continuing our efforts to prevent and respond to gender based violence, provide access to women's health services, and promote women's economic empowerment.

One of my colleagues, displaced twice inside Sudan, is delivering lifesaving reproductive care to women in a camp for internally displaced populations. She works tirelessly to provide essential healthcare to pregnant women throughout the ante and postnatal periods, and also runs information sessions on family planning and hygiene.

Despite the challenges she faces personally, the violence and disease that women and girls are exposed to drive her commitment to helping them reclaim their dignity.

The situation is dire not only within



NOORY TAHHA/IRC

**Zakia Yaqoup, a midwife with IRC, provides antenatal care in Gedaref, an internally displaced persons camp in Sudan**

Sudan's borders. Millions of Sudanese people have fled to neighbouring countries, such as Chad, South Sudan, Uganda, and Ethiopia, where refugee camps are overcrowded and under-resourced—posing increased health risks, especially for women and girls. The IRC is scaling up its efforts in these countries to provide new arrivals with access to essential services. In South Sudan, for example, IRC have run Women's Protection and Empowerment programmes, where women and adolescent girls who have fled Sudan receive vocational training in skills such as sewing, knitting, and crocheting. These programmes help create economic opportunities and offer much needed psychosocial support.

The services we provide are not just about survival—they are about restoring people's hope and dignity. Your support can be transformative.

Eatizaz Yousif, country director in Sudan, International Rescue Committee

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# Appropriate management of heart failure in older people with frailty

Guideline directed medical therapy using several drug classes may do more harm than good as they are based on trials that have excluded people over a given age, say **Henry Woodford and colleagues**

**T**he management of heart failure is evolving. Recent clinical trials have widened the range of effective treatments.

Simultaneously, recognition is growing of the importance of frailty in populations with an increasing proportion of older people.<sup>1</sup> Heart failure, old age, and frailty are intertwined. The prevalence of frailty increases with age.<sup>2</sup> The average age at diagnosis of heart failure is around 77 years in developed countries,<sup>3,4</sup> and mortality rises with age, reaching almost 40% in the first year after diagnosis among those over 85.<sup>4</sup> Frailty is present in up to 45% of people with heart failure,<sup>5</sup> and people with existing frailty are more likely to develop heart failure.<sup>6</sup>

In 2022-23 around 5300 people a month were admitted to hospitals in England and Wales because of a heart failure exacerbation, with an average age around 78.<sup>7</sup>

However, uncertainty remains about management of heart failure in patients with frailty. Some clinicians champion the wider use of evidence based therapies; others urge a more cautious approach. Who is right?

**Frailty is present in up to 45% of people with heart failure, and people with existing frailty are more likely to develop heart failure**

## Problems with clinical guidelines

The medical management of heart failure has improved substantially. Trials demonstrating benefits from concomitant use of several drug classes have been translated into guidelines to standardise management and promote best practice.<sup>8-11</sup>

Typically, people who have heart failure with reduced ejection fraction (HFrEF) are recommended a combination of four or five drugs—a beta blocker, an angiotensin converting enzyme inhibitor or combined angiotensin receptor neprilysin inhibitor, a mineralocorticoid receptor antagonist, and a sodium-glucose co-transporter 2 (SGLT-2) inhibitor—plus a loop diuretic for symptom relief. For people with heart failure with preserved ejection fraction (Hfpef) guidelines recommend an SGLT-2 inhibitor alone, alongside a loop diuretic if needed.

However, the guidelines are based on clinical trials in carefully selected people (table 1).<sup>16</sup> The evidence on treatment in people with moderate or severe frailty is limited, and current guidelines offer sparse advice for this group (table 2). This is because criteria in protocols often include an age cut-off or exclude people with certain diagnoses, such as dementia.

Exclusions may also be implicit to the trial design, such as recruiting mainly from people attending cardiology clinics, who are likely to be less frail than those referred to geriatric medicine clinics for management of heart failure alongside other conditions. As a result, participants in trials are, on average, younger than those seen in clinical practice, and have fewer comorbidities and lower mortality.<sup>7-17</sup>

Many older people admitted to

hospital with heart failure would not meet the enrolment criteria for major clinical trials. For example, one study from 2003 found that 75-87% of patients aged over 65 years admitted for heart failure would have been excluded from relevant trials.<sup>18</sup>

Frailty describes a state of vulnerability due to advanced biological age as opposed to chronological age.<sup>25</sup> Frailty is a continuum and can be categorised, for example, into mild, moderate, and severe states,<sup>26</sup> each conferring increasing vulnerability to adverse health outcomes such as unplanned admissions,<sup>27</sup> polypharmacy and (independently) medication related harm,<sup>28</sup> and all-cause mortality.<sup>29</sup>

Unfortunately, because biological ageing is hard to measure, there is no simple universally accepted way to assess frailty. Surrogate assessment methods have been developed, such as frailty indexes. These use the proportional presence of a selected number of indicators (eg, diagnoses, physiological measures, or laboratory test results) in an individual to calculate a score between zero (not frail) and one, the logic being that people with frailty have more things wrong with them.

In a wider population, a validated frailty index score increases with increasing age, reflecting a normal though non-linear increase in biological age alongside chronological age.<sup>25,30</sup> However, when this approach was applied to data from heart failure clinical trials, the average age of patients in the “most frail” categories was similar to that of the least frail group.<sup>31-34</sup> For example, in a study of empagliflozin, the average age was 70.7 (SD 10) for people rated as non-frail and 71.0 (9.4) for people rated as having severe frailty.<sup>34</sup> This could suggest that differences in frailty score

## KEY MESSAGES

- Guidelines recommend treatment with a combination of medications for people with heart failure
- Trial data used for guidelines often exclude people with moderate or severe frailty
- Older people with frailty may benefit less because of combinations of multimorbidity and reduced life expectancy
- The vulnerability of frailty increases the risk of harm from medications
- People with moderate or severe frailty may benefit from an individualised multidimensional approach that acknowledges uncertainty about the evidence in this population

in such study populations may not be the result of biological age but reflect inconsistency between the items included in the index used.<sup>35</sup>

Trials, including post hoc analyses, have used novel frailty indexes that include a disproportionate number of items relating to heart failure severity, which could be expected to improve with heart failure treatments, while omitting criteria commonly seen in people with frailty such as falls, incontinence, or cognitive problems.<sup>31-34</sup> In addition differing cut-off criteria have been applied for frailty categories.<sup>31-34</sup> These limitations make it hard for clinicians to understand how well their patient is represented by a particular clinical trial population.

Analysis of trial data according to frailty subgroups showed similar benefit in all groups, and harms were not more common with treatment compared with placebo or comparator medication in any subgroup.<sup>31-34</sup> One interpretation of these results is that the net benefits of treatments recommended by guidelines apply to all people, irrespective of frailty. Alternatively, because people with true moderate or severe frailty were largely excluded from these trials, the findings may not apply and may provide false reassurance of net benefit.

## Benefits

Guideline directed treatment has been shown to reduce deaths and hospital admissions from heart failure and may improve quality of life. Logic suggests that older age plus the vulnerability of frailty makes adverse outcomes more likely, so medications could offer greater benefits to this group. Prescriber concern about potential harms, including polypharmacy, could promote unjustified undertreatment.

However, competing causes of death may attenuate any survival benefit. For example, with statins, increased non-cardiovascular mortality in older age may negate the survival benefit of reduced cardiovascular mortality seen in younger people.<sup>36</sup> People with heart failure with preserved ejection fraction, who tend to be older, are more likely to die from non-cardiovascular than cardiovascular

**Table 1 | Example exclusion criteria that may prevent older people with moderate or severe frailty from participating in clinical trials**

Medication	Mean (SD) age of participants	Example exclusion criteria
<b>Empagliflozin</b>		
Emperor investigators, (HF <sub>r</sub> EF) <sup>12</sup>	67 (10.8)	Presence of any other disease than heart failure with a life expectancy of <1 year (in the opinion of the investigator)
Emperor investigators, (HF <sub>p</sub> EF) <sup>13</sup>	72 (9.3)	Any other clinical condition that would jeopardise patient safety while participating in this trial or may prevent the participant from adhering to the trial protocol
<b>Dapagliflozin</b>		
Solomon et al <sup>14</sup>	72 (9.6)	A life expectancy <2 years because of any non-cardiovascular condition, based on investigator's clinical judgment Inability of the patient, in the opinion of the investigator, to understand or comply with study medications, procedures, or follow-up or presence of any conditions that, in the opinion of the investigator, may render the patient unable to complete the study
<b>Sacubitril-valsartan</b>		
McMurray et al (HF <sub>r</sub> EF) <sup>15</sup>	64 (11.5)	Presence of any condition outside the cardiovascular and renal disease area with a life expectancy of <2 years based on investigator's clinical judgment
Solomon et al (HF <sub>p</sub> EF) <sup>14</sup>	73 (8.3)	Life expectancy <2 years because of any non-cardiovascular condition, based on investigator's clinical judgment
<b>Spirolactone</b>		
Pitt et al <sup>19</sup>	65 (12)	Any life threatening disease (other than heart failure)
SOLVD <sup>20</sup>	61	Age >80 Any other disease that might substantially shorten survival or impede participation in a long term trial
<b>β blockers</b>		
Merit-HF <sup>21</sup>	64 (9.6)	Any other serious disease that might complicate management and follow-up
Cibis-II <sup>22</sup>	61 (range 22-80)	Life threatening (eg, malignant) diseases Limited legal capacity, psychiatric disorder, or suspected poor compliance Age >80
Seniors <sup>23</sup>	76 (4.8)	Other major medical conditions that may have reduced survival during the period of the study
<b>Combined treatment</b>		
Strong-HF <sup>24</sup>	63 (13.5)	Age >85 Psychiatric or neurological disorder Significant pulmonary disease contributing substantially to dyspnoea Discharge for the acute heart failure hospitalisation anticipated to be >14 days from admission, or to a long-term care facility

HF<sub>p</sub>EF=heart failure with preserved ejection fraction; HF<sub>r</sub>EF=heart failure with reduced ejection fraction.

**Table 2 | Inclusion of frailty in international guidelines on management of heart failure**

Guideline	Mention of frailty	Suggested intervention(s) regarding frailty	Acknowledges limitations of evidence
American College of Cardiology/ American Heart Association, 2022 <sup>8</sup>	States frailty is associated with increased risk of mortality and hospitalisation and impairs self-care Acknowledges frailty as common in people with HF	Cardiac rehabilitation and nutritional assessment Palliative care consultation Emphasises shared decision making	No
European Society of Cardiology (ESC), 2021 <sup>9</sup>	States frailty is common, and prognostically important	Screening, assessment, and multifactorial approach Cardiac rehabilitation	No
ESC focused update, 2023 <sup>10</sup>	None	—	No
National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand, 2018 <sup>11</sup>	States frailty is important	Comprehensive assessment may provide prognostic benefit	No

causes, and this difference increases with age.<sup>37</sup> Reducing cardiovascular mortality therefore may not change overall mortality. One cause of death or hospital admission may simply be exchanged for another.

Modern clinical trials for people with heart failure tend to report a composite primary outcome of hospital admission for heart failure or cardiovascular death. The number needed to treat to prevent an adverse

event typically ranges from 19 to 31 over trial durations of 1.3 to 2.2 years.<sup>12-23</sup> Thus, most people prescribed these medications will not avoid an adverse event because of the medication in any given year.

In a real world setting, the benefit of guideline directed treatment could weaken for people with reduced ejection fraction and multimorbidity, a common companion of frailty. In one study from Japan, the composite

outcome of all-cause mortality and readmission for heart failure among people prescribed guideline directed treatment compared with those who were not was reduced by 47% for people with two comorbidities but only 18% for people with three or four.<sup>38</sup>

These data raise the possibility that the beneficial effects seen in trials may be less pronounced in unselected populations with heart failure, including older people with frailty. However, the only way to be certain would be to perform trials in a wider range of people. Life expectancy may influence personal choice regarding medication, as may prescribers and patients having a better understanding of uncertainty regarding the likely magnitude of benefit from drug treatment.

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## Harms

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Frailty is a state of vulnerability, and affected people are at increased risk of medication related harm.<sup>28</sup> One study found that adverse drug reactions are a causative factor in around a sixth of hospital admissions.<sup>39</sup> For example, many cardiovascular drugs are associated with an increased risk of falls.<sup>40</sup> Medicines prescribed to people with heart failure and frailty could potentially prevent or cause hospital admissions.

Clinical trials tend to recruit people at lower risk of medication related harm, which may mask the probability of adverse effects in wider patient groups. For example, observational data showed rates of hyperkalaemia increased substantially after publication of a clinical trial showing the benefits of spironolactone for heart failure.<sup>41</sup>

One observational study found high rates of adverse effects, including hypotension (40%) and urinary tract infection (15%), among people classified as frail receiving SGLT-2 inhibitors<sup>42</sup> compared with those reported in randomised studies (9-10% for hypotension and 10% for urinary tract infection).<sup>12-14</sup>

Another problem is that clinical trials are often designed to focus on the benefits of medications. Beneficial effects are grouped together to form composite outcomes but the same is

not done for potential harmful effects (eg, hypotension, fluid depletion, falls, and syncope).<sup>12-15</sup> Benefits become magnified and potential harms relatively understated. The use of run-in phases in clinical trials may also disguise risk. For example, combined angiotensin receptor neprilysin inhibitors (ARNI) have been shown to be beneficial in people who have reduced ejection fraction, but the key trial had two run-in phases before randomisation: 10% withdrew during the enalapril-only phase, and another 10% withdrew during ARNI exposure.<sup>43</sup> Thus, only those who tolerated the medications for several weeks entered the trial.

Not knowing the actual benefit or risk of medication for the patient we are treating makes it difficult to implement genuine shared decision making. The prescribing guidelines for heart failure promote polypharmacy for people with multimorbidity. Harms of medication also include therapeutic burden on both patient and caregiver, potentially leading to non-concordance and waste. When asked, most older people with polypharmacy would like to reduce their medication if possible.<sup>44</sup> We must not assume that patients and prescribers share the same values.

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## Individualised approach

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Clinicians urging wider use of guideline directed treatment and those arguing for greater caution may both be right. Evidence based therapies should be offered to those likely to benefit, yet the evidence for guideline directed treatment in people with moderate or severe frailty is limited.

Clinical guidelines seek to standardise care but should acknowledge they are based on data derived from selected populations with poor representation of older people with more than mild frailty. Extrapolating outcome and safety data from younger people with single organ disease to a more vulnerable population is unwise.

Complex combinations of frailty and multimorbidity, along with potential polypharmacy and therapeutic burden, require

**Not knowing the actual benefit or risk of medication for the patient we are treating makes it difficult to implement genuine shared decision making**

an individualised approach that acknowledges goals and values.

Future studies must recruit people with greater degrees of frailty to obtain a population more representative of that seen in clinical practice. Greater collaborative working between cardiology, primary care, and geriatric teams could enable this and improve care outside trial settings.<sup>45</sup> Clinicians should acknowledge current uncertainty to allow patients to participate meaningfully in shared decision making about their treatment.

Comprehensive geriatric assessment for selected patients with heart failure could help clinicians promote guideline directed treatment for those likely to benefit while allowing modification for those with moderate or severe frailty. Comprehensive assessment also facilitates non-pharmacological approaches (including increased exercise,<sup>46</sup> which may be even more important in people at greater risk of medication related harm) and encourages deprescribing medications of lower benefit, including those promoting peripheral oedema.<sup>47</sup>

Clinical guidelines could clarify palliative approaches to enhance the care of people with severe frailty and limited life expectancy.

In the absence of reliable clinical trial data, how could we rapidly identify those who need a different approach? Observational data and expert opinion suggest people living in care homes, people with moderate to severe cognitive impairment, or people who require help with personal care may not attain the same benefit from drugs used to treat cardiovascular diseases.<sup>48 49</sup>

The presence of any of these factors could prompt a careful consideration of the potential risks, benefits, and uncertainties of the guideline directed approach for heart failure.

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# LETTERS Selected from rapid responses on bmj.com

## VOLUNTARY ASSISTED DEATH: ENSURING ACCESS AND SAFETY

### LETTER OF THE WEEK

#### What, if any, should be the role of doctors in assisted dying?

The *BMJ*'s coverage on assisted dying (Editor's Choice, 2-9 November) ignores a key question: what, if any, should be the role of doctors?

In Leadbeater's bill our role is central and decisive: not only do medical criteria define what constitutes an acceptable reason to end one's life, but doctors are both the arbiters and administrators. This has deeply problematic implications.

This bill would legally require doctors to treat terminally ill patients saying they want to end their lives in a radically different way to all other patients, based not on their clinical need but on their life expectancy. The firsthand accounts published in *The BMJ* starkly illustrate what this means in practice—with the usual medical role of exploring and addressing patients' suffering either entirely absent or even negatively redefined as an obstacle to accessing an assisted death.

By normalising assisted dying as just another medical procedure, every terminally ill patient would have to consider whether they should be opting for it. Given the inherent power imbalance in the doctor-patient relationship, this inevitably bakes pressure and indirect coercion into the foundations of the practice. In all jurisdictions that monitor why patients access a medically assisted death, increasing numbers do so because they "feel like a burden on others." Canada demonstrates the disproportionate effect on the most marginalised and vulnerable people in society when assisted dying is fully embedded into a universal healthcare system.

There is, however, nothing inevitable about any aspect of this highly medicalised approach. Decisions about access to assisted dying could be made by courts or specialist panels, and non-clinical practitioners could be trained and regulated to deliver it, with doctors required only to provide relevant medical evidence.

Completely separating assisted dying from healthcare would not only provide a safer model of assisted dying, but would ensure that all patients, whatever their medical condition or life expectancy, continue to receive the same patient centred healthcare.

H Lucy Thomas, consultant in public health and specialty doctor in palliative medicine, Hertfordshire

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#### Assisted dying poses serious risks to disabled people

I'm concerned that disability isn't mentioned in *The BMJ*'s recent articles on assisted dying (Editor's Choice, 2-9 November).

I'm not fundamentally opposed to assisted dying for terminally ill people (other arguments notwithstanding), but my experiences as a disabled person and doctor tell me this cannot be achieved in the current sociopolitical climate without putting disabled people at significant risk.

As a visibly disabled resident doctor, I can say with confidence that most healthcare professionals have limited knowledge of disability issues. Frequent comments from colleagues, although usually well meaning, belie a major lack of awareness.

This isn't a criticism; it's inevitable as most medical schools don't teach about the sociopolitical barriers affecting disabled people—not limited to housing, employment, transport, and health and social care.

I was 11 when a stranger first told me that they'd rather be dead than like me. It's happened periodically since and to almost all visibly disabled people I know. Sometimes even doctors express this view. It's ironic—the negative and prejudicial attitudes of non-disabled people limit us more than the impairment itself.

In 2024 the UK government was found to have committed "grave and systematic violations" of the UN Convention on the Rights of Disabled Persons.

How can we allow a society that views disability so negatively, and fails to make basic provisions, any potential control in the ending of disabled lives?

Tirion Hughes, academic foundation year 1 doctor and disability campaigner, Oxford

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#### Dying with dignity?

Downar and colleagues wrongly claim that "eligibility criteria have little effect on who actually receives an assisted death" (Editorial, 2-9 November), but evidence shows that expansion of medical assistance in dying (MAID) in Canada has led some people to seek death as an escape not from illness but from life and social suffering.

MAID for terminal conditions (track 1) was introduced in 2016, then expanded to any adult with a disability who was not dying (track 2) in 2021. Over a third of the 13 000 Canadians euthanised in 2022 cited feeling a burden as fuelling their request, and over a fifth cited loneliness.

Coroner's reports from Ontario show that disabled people being euthanised in track 2 are much more likely to live in neighbourhoods with higher levels of residential instability, material deprivation, and dependency than those in track 1. Downar has argued that the higher rates of death provision in track 2 for disabled marginalised populations are not problematic as marginalised people have higher death rates anyway, an argument I find indistinguishable from eugenics.

Instead of euphemisms like MAID, Friedrich Engels's term "social murder" seems more fitting. If we falsely medicalise and sanitise MAID as always being for relief of illness suffering, we might pretend we are supporting "dying with dignity," but in reality we become complicit in something entirely different.

K Sonu Gaiand, professor and governor and chief of psychiatry, Toronto

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## Death is not a “treatment option”

It is important to recognise the consequences of construing assisted dying as a “treatment option” in the conventional sense (linked Feature, 2-9 November). In Canada, doctors “must take reasonable steps to ensure persons are informed of the full range of treatment options available to relieve suffering” including medical assistance in dying (MAID). Doctors have an obligation to tell patients if they are eligible, except where this would not be “consistent with the person’s values and goals of care.” In practice, patients are often unhappy when a doctor raises this option.

The Canadian Practice Standards do not follow the logic of this position consistently, stating that “advising persons of potential eligibility for MAID is distinct from counselling persons to consider MAID.” But if MAID is a treatment option for the relief of suffering, then in some cases doctors should counsel a person to consider it, just as they would for other effective forms of pain relief.

If giving lethal drugs was a treatment option for intractable suffering, then doctors would have an ethical obligation to administer such drugs without consent, when this was “of overall benefit” to a patient who lacked capacity. This might include lethal injection of a patient with dementia under restraint. The BMA is right to insist that providing a lethal drug with the intention to cause death must not be regarded as a treatment option.

David A Jones, director, Anscombe Bioethics Centre

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## RESPONSE

### Association for Palliative Medicine replies to Ahmedzai and Fingas

On behalf of the Association for Palliative Medicine of Great Britain and Ireland (APM), we welcome discussion around assisted dying. But we have been misrepresented in comments raised by Ahmedzai and Fingas and three of their colleagues (Opinion, 2-9 November).

We understand and respect the range of views among palliative medicine professionals around assisted dying. But repeated surveys have shown that the majority of palliative medicine doctors (70-84%) are not in favour of legalising assisted dying, and 75-84% of them would be unwilling to participate in the process. The APM’s position statement on assisted dying acknowledges the variation in views of our members.

Our approach has been to respond to the view of the majority of our members, while again acknowledging that this is not the view of all. In response to calls from our members, we made available a template letter to send to members of parliament and resources including the House of Commons Health and Social Care Committee’s 2024 report on assisted dying and assisted suicide, the King’s College London based Complex Life

### APM and dissenting views

We do not contest the figures provided by the APM in response to us [above], but we want to express our concern that the views of the one in four or five who dissent are being overlooked.

We disagree that the APM’s position statement on assisted dying acknowledges the variation in members’ views: it says only that there is dissent. It mainly repeats the APM’s opposition on the basis of three “concerns”—protection of vulnerable people; lack of funding for specialist palliative care; and concern about trust and doctor-patient relationships. It does not recognise any refutations of these concerns based on dissenters’ experience and publications; or through published views from other palliative medicine doctors working comfortably alongside legalised assisted dying.

We argued that the APM had misinformed members about Chris Whitty’s letter by saying that it contained “advice to doctors in terms of speaking about their concerns on assisted dying” when the letter clearly recognised that

and Death Decisions Group’s publication on assisted dying, and Chris Whitty’s letter as chief medical officer giving advice to those wishing to speak on this topic. The template is for APM members to edit “as they see fit,” and the other three are helpful non-partisan resources.

We are surprised and distressed that the authors consider this approach leaves some doctors in fear of repercussions if they speak openly about supporting a change in the law on assisted dying. We have been open in all our communications, including listening to the view in favour of assisted dying with openness and respect. We reject the representation of the APM as misinforming on palliative medicine doctors’ stance and of stifling debate.

We have included a session in our next conference in Belfast, where we hope we will see Ahmedzai and his colleagues.

Sarah Cox, president; Suzanne Kite, vice president; Matt Doré, honorary secretary; Natasha Wiggins, honorary treasurer; Feargal Twomey, president support, Association for Palliative Medicine of Great Britain and Ireland

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doctors could hold a range of views. Coupling concerns with a template for members to write back with the APM’s own pre-formed concerns was likely to lead to the same concerns being forwarded.

We do not expect that a minority should change the position of the APM, but we think there is room for debate about moving to a neutral position, in keeping with many medical bodies including the Royal College of Physicians, to which we all belong.

We thank the APM for including a session at its next conference.

Sam H Ahmedzai, emeritus professor of palliative medicine, Brockhampton; Samuel Fingas, consultant in palliative medicine, Sheffield, on behalf of three anonymous coauthors

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## OBITUARIES

### Jacob Kwadwo Afuakwah

GP (b 1935; q St Andrews 1964), died of vascular dementia on 18 October 2024



Jacob was born in Ghana on Christmas Day 1935. He obtained a scholarship to St Andrew's University, and after qualifying he moved to Ghana with his Scottish wife, Violet, a nurse. In Ghana he practised obstetrics, then returned to Scotland, where he worked in obstetrics and gynaecology for 10 years. In the early 1980s he switched to a career in general practice in Erskine, where he was loved by his GP partner, practice staff, and his patients for his warm and genial manner. He was proud of his Ghanaian heritage and was a prominent leader of the Ghanaian Welfare Association in Glasgow. As sons we are sad, but happy at what he achieved in providing care to his patients, the joy and educational opportunities he afforded to us, and the love and strength he gave to Violet, who he survived by 14 years.

Charles Afuakwah, Richard Afuakwah

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### Francis Conrad Gormley

GP (b 1934; q Dublin 1958), died of old age, complicated by severe aortic stenosis, on 15 October 2024



Frank was born in Plumbridge, County Tyrone, and studied medicine at University College Dublin. He did house jobs in Dublin and worked in casualty at Baggot St Hospital before returning to Northern Ireland, initially to Musgrave Park Hospital in Belfast. He joined general practice in Belfast in the early 1960s but left for London at the end of 1975 and took on a single handed practice at the Finsbury Health Centre, Islington, where he worked until his retirement in 1997. His later years were spent in Cornwall, where he maintained a keen interest in politics and is fondly remembered for always being impeccably dressed. He married former nurse Anne Greene in 1962. They had two children: Mark, a journalist, and Jane, a GP. Frank died three and a half weeks after Anne and they are both much missed by their children and two grandchildren.

Mark Gormley, Jane Gormley

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### John Hunter Dagg

Haematologist and consultant in medicine (b 1933; q Glasgow 1958; FRCP), died of probable carcinoma and pulmonary embolism on 20 October 2024



John graduated from Glasgow University, then did training positions in Glasgow and Edinburgh. From 1962 he held research posts at Glasgow University, then took up senior fellowships in Glasgow and Seattle. In 1970 he took charge of clinical haematology and in 1972 was appointed a consultant in medicine at the Western Infirmary in Glasgow. John was an exceptional teacher and an excellent physician, busy but never hurried. His research into iron metabolism in haematopoiesis was recognised as original and definitive. John was an excellent pianist, was widely read, and spoke fluent French and German. He and his husband Brian created a beautiful garden at their home on the edge of the Loch Lomond National Park.

Archie Prentice

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### John Gareth Llewelyn

Consultant neurologist (b 1956; q Cardiff 1980; FRCP; MBE), died of glioblastoma on 31 March 2024



Gareth spent most of his childhood in Dolgellau before moving to Denbighshire. After graduation he worked in London and was appointed neurology consultant at the National Hospital for Neurology and Neurosurgery in 1996. Gareth then took up a consultant neurologist position at Royal Gwent Hospital in South Wales. His area of expertise was the peripheral nervous system. Gareth had a passion for teaching and training and cared deeply for his trainees' welfare. He was appointed as an honorary professor by Cardiff University in 2019. Gareth was a proud Welshman and worked tirelessly to ensure the equal status of the Welsh language in medicine. He was a keen sportsman and passionate supporter of the Welsh football team, following the players to the World Cup in Qatar in 2022. He is survived by his wife, Bethan, and his four children.

Dafydd Llewelyn

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### Alexander Lister Forrest

Consultant anaesthetist (b 1934; q St Andrews 1958; FFARCS), died from cardiac failure on 13 April 2024



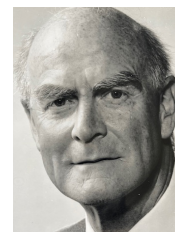
Sandy studied medicine at St Andrews, where he met his wife, Rita McIntyre. Sandy became senior registrar in anaesthesia in Dundee, where his interests were in cardiovascular anaesthesia and later intensive care. He studied cardiovascular physiology at McGill University, Montreal, and learnt continuous epidural analgesia in labour at the Royal Victoria Hospital—a technique he brought back to Dundee. In 1967 he was appointed consultant anaesthetist to Dundee Teaching Hospitals NHS Trust. Sandy was a true gentleman and was greatly liked as well as respected. He loved golf and the friendships he made on the course were enduring. Rita died of cancer in 1987 and Sandy later married Vida Simon. He leaves his wife, two children, and two grandchildren.

Katharine Forrest, Fiona Forrest

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### Neville Robinson Rowell

Professor of dermatology (b 1926; q Durham 1949), died of old age on 20 June 2024



Neville was born and educated in Newcastle upon Tyne, where he was also a medical student. He moved to Leeds in 1958 as tutor and senior registrar in dermatology and was appointed consultant in 1961, became head of department in 1973, and received a personal chair in 1988. The department became one of the first outside London to have its own purpose built laboratories and teaching area. Neville had one of the largest worldwide cohorts of patients with connective tissue disorders. He was kind and caring to patients and staff. He was actively involved in the arts in Leeds and regularly frequented the theatre, especially opera. Neville and his wife, Liza, were members of the Leeds Civic Trust. He leaves Liza, a clinical assistant in the department, and his two surviving children, Martin and Christopher.

Bill Cunliffe, John Cotterill, Mark Goodfield, Graeme Stables

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# Chris Redman

Professor of obstetric medicine whose fetal heart monitoring system has saved thousands of lives

Christopher Willard George Redman (b 1941; q Oxford 1967 ad eundem; FRCOG), died from lymphoma and pneumonia on 13 August 2024

It was a unique relationship that set a genial, good humoured “student” on course to becoming a world leader. The teacher, Geoffrey Dawes, was in his 70s; the student, Chris Redman, was in his late 40s. Redman, who described Dawes as his most important mentor, recalled that it was not “the usual student-mentor relationship,” not just because of their ages, but because they spent so much time together.

They began working together in 1977, when clinical outcomes were devastating for babies born to mothers with pre-eclampsia. Across a painstaking 13 year collaboration they helped set a new standard of care in pre-eclampsia treatment.

## Dawes-Redman system

The Dawes-Redman system was the first computerised programme for assessing fetal heart rate. It identified early indicators of distress and studies have shown it has saved thousands of lives.

The pair created a prototype in 1980, but it took another 10 years to produce a marketable version that standardised trace interpretations. First sold in 1991, this is now used in more than 130 countries.

Dawes, a neonatal physiologist, was director of Oxford’s Nuffield Institute for Medical Research. Redman, a physician, was the UK’s first lecturer in obstetric medicine. His appointment to that post in 1976 initially generated hostility in the department (now the Nuffield Department of Women’s and Reproductive Health). Physicians, it was thought, did not belong in obstetrics.

The catalyst for Redman’s research was the advent, in the 1960s, of electronic fetal heart monitoring in labour. He borrowed a monitor to investigate fetal distress at earlier stages in pregnancy—provoking scepticism among his obstetric colleagues, but reflecting his innovative thinking.

He realised that fetal heart rate interpretation was subjective, and a more objective assessment was needed. Thus began his long collaboration with Dawes.

Redman’s dedication to pre-eclampsia began soon after he joined the Nuffield



## Chris Redman established the Silver Star unit for patients at risk of pre-eclampsia

department. Colleagues asked him about managing severe eclampsia while he was running a trial on hypertension in pregnancy. He had no answers and a literature search revealed very little, leaving him curious about differences between women who developed pre-eclampsia and those who did not. Interviewed by Robert Romero, editor-in-chief of the *American Journal of Obstetrics and Gynecology*, he said, “The next 45 years of my life were settled at that time.”

His research covered the role of the maternal immune system and placenta in the pathogenesis of pre-eclampsia. He considered the placenta to be the second most interesting human organ after the brain. He described the placenta as “a remarkable tissue, half fetal, half maternal, not yet innervated, that produces many of the hormones that the rest of the body produces... it’s a throwaway organ. After nine months, its job is done and it goes. And with it goes the complete history of the pregnancy wrapped up inside it.”

Redman developed new approaches to treating and preventing pre-eclampsia. The Nuffield Department said, “He pioneered the concept of a systemic inflammatory response’s role in both normal pregnancy and the clinical stages of pre-eclampsia. He led groundbreaking work on the role of extracellular vesicles in the pathogenesis of the disease.”

Redman was co-founder with Isabel Walker, a journalist and one of his patients, of the charity Action on Pre-eclampsia.

Walker said, “Chris was one of the most brilliant, wonderful, and selfless human beings I have ever known.” She and Redman co-authored *Pre-Eclampsia: The Facts*.

## Early life

Redman was one of four children of Roderick Redman, professor of astronomy at Cambridge, and his wife Kathleen (née Bancroft), a violin teacher. Chris was born in South Africa, where his father worked for the Oxford University Pretoria observatory. The family moved to Cambridge at the end of the second world war.

Redman went to Perse School and studied natural sciences at Cambridge before switching to medicine and completing clinical training in Oxford. He spent a year in a pathology post at the Johns Hopkins Hospital, Baltimore, before completing house jobs in the UK. In 1970 he joined Oxford’s regius medicine department led by Richard Doll. Six years later he moved to the Nuffield department where he was to build his international reputation.

In 1983 he established the maternal Silver Star unit at John Radcliffe Hospital—so-called because he used silver star stickers to highlight high risk patients.

Appointed professor of obstetric medicine in 1992, Redman was an outstanding teacher and mentor. Ian Sargent, professor of reproductive science at Oxford University, said, “Chris’s reputation attracted young obstetricians from all over the world to study for their doctorates under his supervision. Many of these have become professors in their own countries.”

Redmond met his future wife, Corinna Page, at school. They were married for 60 years. She became a copy editor at Oxford University Press.

Redman enjoyed crossword puzzles, sudoku, cinema, and theatre. He ran 10 consecutive London marathons between the ages of 50 and 60 to raise funds for the Silver Star unit.

The recipient of numerous awards, he is survived by his wife; their five children, Paul, Andrew, Sophie, George, and Oliver; and 13 grandchildren.

John Illman  
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