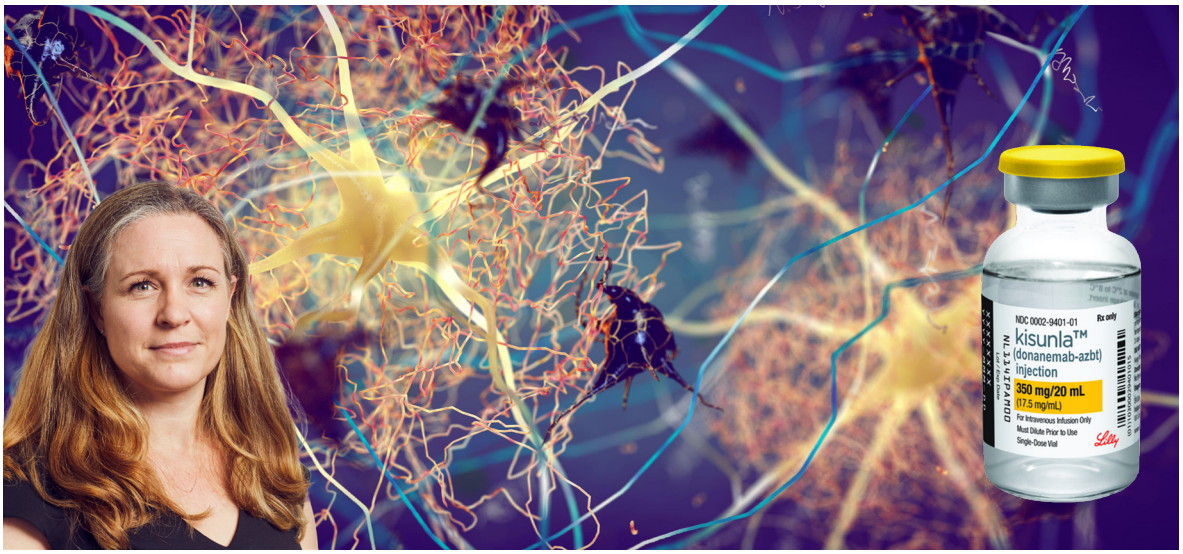
this week

FIXING THE NHS page 129 • **CHILDREN'S CARE CRISIS** page 130 • **SPECIALTY TRAINING** page 132



ALAMY

Donanemab rejected on benefit-cost ratio

NICE has rejected the Alzheimer's drug donanemab because the "relatively small benefit" it offers does not outweigh its cost.

The watchdog's draft guidelines say that, although clinical trial data suggest the monthly injection could slow disease progression by four to seven months in mild Alzheimer's disease, there is a large cost to providing the drug, which needs to be intensively monitored for side effects.

The guidance advises, "Evidence from clinical trials suggests that cognitive function continues to worsen over time with donanemab added to current treatment, but at a slower rate than with placebo. But there is not enough evidence on the long term effects." NICE also raised concerns over "significant health risks," noting that a third of patients taking the drug experienced amyloid related imaging abnormalities caused by brain swelling and bleeding.

The rejection came days after the MHRA approved the drug for adults with mild cognitive impairment and dementia resulting from Alzheimer's disease who are apolipoprotein E ε4 heterozygotes or non-carriers.

Each vial of the monoclonal antibody costs around £540. The drug has a recommended maximum treatment duration of 18 months. If it had been approved around 70 000 adults in England might have become eligible.

Helen Knight, NICE director of medicines evaluation, said, "The cost effectiveness estimate for donanemab is five to six times above what NICE normally considers an acceptable use of NHS resources. This will be disappointing news, but there are other treatments being developed."

Eli Lilly, the manufacturer of donanemab, said it "remains confident in the clinical and cost effectiveness" of the drug. It added it would "work closely with NICE during the consultation period before a final reimbursement decision for use in the NHS."

Donanemab has been approved in the US, after the FDA concluded the modest benefits outweighed the risks. *The BMJ* has previously revealed that three of the advisers who recommended approval had received direct payments or research funding from Eli Lilly.

Hilary Evans-Newton, chief executive at Alzheimer's Research UK, said the rejection was yet "another frustrating setback" and called on Wes Streeting, the health secretary, to say "how he plans to break the deadlock, where research is delivering new treatments but they remain out of reach for NHS patients."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;387:q2342

Helen Knight, a NICE director, says donanemab for all patients with mild Alzheimer's would cost more than five times as much as considered acceptable for the NHS

LATEST ONLINE

- Entire Gaza population is at risk of genocide "executed under our watch," says UN expert
- Digital avatars help to relieve distress among patients who hear voices, finds study
- Regulator censures Novo Nordisk over promotion of weight loss drugs

SEVEN DAYS IN

Children's respiratory admissions fell in Birmingham's clean air zone, data show

The number of children admitted to Birmingham Children's Hospital, which lies in a clean air zone, fell from 1382 in 2022 to 1080 in 2023, a 22% reduction, show figures obtained by freedom of information requests. At the same time the total number of admissions at the three hospitals outside the clean air zone rose by 16%, from 3186 to 3685.

A clean air zone was introduced in the city in July 2021. Drivers of cars that do not meet emission standards have to pay a fee to go into the centre.

Last year in Birmingham 4765 children aged up to 5 years were admitted to hospital because of respiratory problems, up 4% on the previous year, show figures obtained by the charity Mums for Lungs. Tim Dexter, clean air lead at the charity Asthma + Lung UK, said, "Clean air zones are having a real impact on reducing levels of air pollution. Evidence shows they are the most effective way to tackle the problem in urban areas. Bold schemes are vital to tackle this public health emergency, and targeted interventions, such as clean air zones, are needed to protect the most vulnerable."

Dexter urged the government to introduce stronger, legally binding air quality targets across the country that align with World Health Organization guidelines.

Jacqui Wise, Kent Cite this as: *BMJ* 2024;387:q2369

Life expectancy

Data show "concerning lack of progress"

Life expectancy at birth was 83 years in females and 79 years in males in England and Wales in 2021-23, showed figures from the Office for National Statistics. Life expectancy at birth was 26 weeks lower in males and 13 weeks lower in females than in 2017-19, the last complete period before the start of the covid pandemic. David Finch of the Health Foundation noted a "concerning lack of progress." He added, "We are now seeing over a decade of stalling health in parallel with an extended period of weak economic growth."

Prostate cancer

Queries surge after Chris Hoy's diagnosis

Visits to the NHS website for advice on prostate cancer rose by 672% after Chris Hoy's announcement that his cancer was incurable. Figures from NHS England show 14 478 visits to the prostate cancer symptoms page in the 48 hours after the six time Olympic champion cyclist made his statement, up from 1876 in the same period the previous week. NHS England's clinical director for cancer, Peter Johnson, said, "His decision to speak so openly could save lives by encouraging people to come forward sooner with their symptoms."

Workforce

Isle of Man doctors vote on industrial action

Doctors on the Isle of Man are set to vote on whether to take industrial action for the first time, the BMA has said. The doctors, who are employed by Manx Care—the healthcare system operated by the island's government—are asking for a 12.6% backdated pay rise for 2023-24. With inflation on the island rising by 56.3% since 2008, while the maximum consultant's salary rose by just 27.3%, this is a cut of 29% in real terms, said the BMA. In total 155 doctors will be eligible to vote.

BMA condemns use of PAs to cover doctors' shifts

Channel 4 News has revealed that physician associates are covering doctors' shifts in hospitals. Freedom of information figures showed that, of the 145 trusts that responded, 11 said that they had used PAs to cover rota gaps, mainly for newly qualified or resident doctors. Fourteen trusts said that they did not keep the data. The BMA has called for a full government inquiry. Its council chair, Philip Banfield, said, "This is an appalling situation. PAs do not have the clinical expertise, experience, or training to cover doctors' shifts and should never, ever be asked to do so."

Public health

England to ban disposable vapes from next summer

Doctors' leaders have welcomed the government's move to ban single use vapes in England from 1 June 2025. Steve Turner, president of the Royal College of Paediatrics and Child Health, said, "Disposable e-cigarettes are disproportionately used by children and young people and also create extreme levels of hard-to-recycle waste, with nearly five million thrown away every week." David Strain, chair of the BMA's board of science, and Heather Grimbaldeston, chair of its Public Health Medicine Committee, said a ban was long overdue and called for a tougher stance on flavours, packaging, advertising, and marketing of vapes.

Scottish agency calls for targeted TB screening

People entering the UK seeking refuge or asylum should be targeted for tuberculosis screening, Public Health Scotland advised, after seeing cases in the country rise by their highest ever number last year. A total of 283 cases were recorded in Scotland in 2023 (5.2 in 100 000 people), up from 201 cases the previous year. More than two thirds of these (67%) were in people born abroad. "The most reported risk factor for tuberculosis was being a refugee or asylum seeker," said the report. These groups accounted for 32 cases.

Cocaine deaths rise more than 30% in a year

The Office for National Statistics reported that 5448 deaths were related to drug poisoning in England and Wales in 2023. This was up 11% on the previous year and the highest level since records began in 1993. Just under half of drug poisoning deaths involved an opiate. Cocaine was involved in 1118 deaths, 30.5% higher than the previous year (857) and nearly 10 times as high as in 2011 (112). The highest rate of drug related deaths was in men, particularly those aged 40-49.

MEDICINE

Weight loss drugs

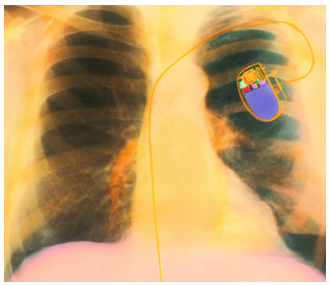
Doctors are reminded to advise on side effects

The Medicines and Healthcare Products Regulatory Agency has reminded healthcare professionals to ensure that patients are aware of the side effects of glucagon-like peptide-1 (GLP-1) receptor agonists, such as vomiting and diarrhoea. Doctors should also be alert to signs of their patients misusing these medicines. Alison Cave, the regulator's chief safety officer, said, "The balance of benefits and risks outside the licensed indication has not been shown to be favourable. Please report cases of misuse, especially if harm occurs." Some fake GLP-1 medicines have been found to contain insulin, the agency warned.

Doctors have been warned to be alert to signs of patients misusing GLP-1 drugs

Heart failure

Algorithms can be used for remote monitoring



NICE has said that people with a heart failure diagnosis can be remotely monitored through two algorithm based technologies, HeartLogic and TriageHF, which work alongside cardiac implantable electronic devices such as pacemakers. The two technologies can accurately detect signs of worsening heart failure by monitoring parameters such as a person's general activity, heart rate variability, and heart sounds. Data collected from the device can be sent in real time, or at a designated time, to hospital staff who can provide care over the phone and determine whether the wearer needs to go to hospital.

Bowel surgery

Audit shows unacceptable delays for surgery

Patients needing emergency bowel surgery face "unacceptable delays" at hospital to get into theatre—as much as five times longer than recommended, the national emergency laparotomy audit has found. Data also show that 14% of patients at high risk did not receive immediate postoperative critical care, contrary to published guidance. Instead they were transferred to a normal ward after surgery, and 7% of these patients subsequently died. The audit analysed care received by 27 863 patients in 173 hospitals in England and Wales from December 2021 to March 2023.

Assisted dying

Vote is defeated in Welsh parliament

Senedd members including the first minister, Eluned Morgan, and the health secretary, Jeremy Miles, voted against a motion calling for a law to allow assisted dying in Wales and England. In total 19 members voted in favour of the motion, with 26 against and nine abstaining. However, as the Welsh parliament does not have the power to change the law on assisting dying, the vote was symbolic. MPs in Westminster will vote next month on plans for an assisted dying law tabled by the Labour backbench MP Kim Leadbeater.

Cite this as: *BMJ* 2024;387:q2383

BIRTHS

Live births in England and Wales numbered **591072** in 2023, the lowest since 1977 (when it was 569 259). The total fertility rate fell to **1.44** children per woman, the lowest since records began in 1938 *[ONS]*

SIXTY SECONDS ON . . . **FIXING THE NHS**

IS IT BROKEN?

Have you been living under a rock? The government has talked about little else since taking office in July. But now that Ara Darzi has diagnosed the problem, ministers want to move on to the solutions stage. Which is where you come in.

WHAT, ME?

Yes, you. The government wants doctors, the public, experts, and their dogs to help shape its 10 year health plan for England by taking part in a consultation dubbed the "biggest ever national conversation" about the future of the NHS.

HOW IS THE CONVO FLOWING SO FAR?

It has been positively loquacious, but it has gone off at a few tangents.

SUCH AS?

Early suggestions for policies included free waffles (below) for every patient, a maximum BMI for nurses, installing Madrí lager on tap in all hospitals to "help patient morale," replacing health and social care secretary Wes Streeting with a dog, and putting Arsenal manager Mikel Arteta in charge. It's a rich tapestry.

BOATY McBOATFACE DEJA VU?

Come on, that was the will of the people. But while Streeting has laughed off the japery—saying a recommendation to put a Wetherspoons pub in every hospital had been "sadly vetoed by the chancellor"—the health department has said it will remove or hide material that is "clearly inappropriate or irrelevant."

THE MODERATORS WILL BE BUSY

Indeed. But there have also been plenty of sensible suggestions. Limiting the use of paper letters, making it easier for general practices to access patients' records from hospitals, and scrapping university fees for nurses are among those that ranked most popular by users on the consultation site.

SHOULDN'T IT BE MINISTERS HAVING THE IDEAS?

Streeting insists he has plenty but pointed to the furore over the 2012 Lansley reforms as a cautionary tale. "Be careful what you wish for when you say politicians should just come in and impose change without involving patients and NHS staff," he said.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024;387:q2354

NHS to get £1.57bn boost to cut waiting times, chancellor announces

The NHS in England will get an additional £1.5bn for new surgical hubs and scanners, and another £70m for new radiotherapy machines, the government has announced ahead of the autumn budget.

The funding boost is part of plans to enable the NHS to deliver an extra 40 000 elective appointments each week—or two million a year—and reduce waiting times so that 92% of people wait less than 18 weeks to start their treatment.

The chancellor, Rachel Reeves, said, "Our NHS is the lifeblood of Britain. It exemplifies public services at their best, there for us when we need it and free at the point of use, for everyone in this country. That's why I am putting an end to the neglect and underinvestment it has seen for over a decade now."

Reeves was set to unveil the government's autumn budget on 30 October, with an expected focus on "investment, investment, investment to get the economy moving again."

The BMA described the funding announcement as a "promising start." Its chair of council, Philip Banfield, said, "[This] will certainly go some way to relieving pressure on the health service, but we have a waiting list of 7.64 million cases—that's 6.33 million individual patients waiting in England. There must of course be additional consequential funding to help relieve waiting lists in the devolved nations too." The government must now outline how it will staff these newly funded hubs and scanners and its longer term workforce plans to increase staff numbers, Banfield said.

Tim Mitchell, president of the Royal College of Surgeons of England, also welcomed the news but said the extra funding was "just one part of the solution," as "urgent investment" was also needed in NHS buildings and IT.

The funding is just one part of the solution; urgent investment is needed in IT and buildings Tim Mitchell

Unlikely to meet 18 week standard

Looking at the effects the funding might have over the next five years, Jennifer Dixon, chief executive of the Health Foundation, said that if it were

CQC: Delayed care for children risks lifelong consequences

Delays and inequalities in access to health and care services in England are risking lifelong consequences for children and young adults, the Care Quality Commission has warned.

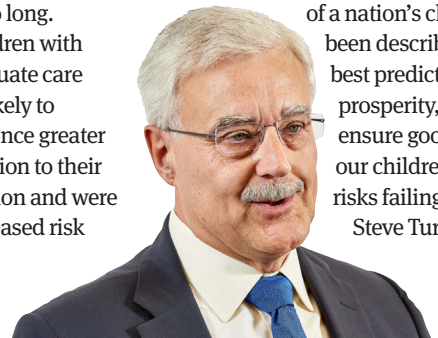
In its annual assessment of the state of health and social care in England, the CQC said children and young adults were not always able to access services quickly in planned care, emergency care, or mental healthcare. It called for a greater focus on young people's services, noting the opportunity to intervene can be missed entirely if the wait for a diagnosis was too long.

Children with inadequate care were likely to experience greater disruption to their education and were at increased risk of having long term mental or physical illnesses in adulthood, which could affect their quality of life and their ability to contribute to society, it added.

Key to future prosperity

CQC chair Ian Dilks (below) said, "Action now—targeted funding for early intervention, better understanding of local need and improved management of demand, and genuine two way communication with children and families—will help to ensure a healthier population tomorrow.

"The health and wellbeing of a nation's children has been described as the best predictor of its future prosperity, and failing to ensure good, safe care for our children today also risks failing their future."



Failing to ensure good, safe care for children today risks failing their future Ian Dilks

Steve Turner, president of the Royal College of Paediatrics and Child Health, said the report painted an "alarming" picture of child health services, with rising need, increasing waits, and poorer outcomes. "As a nation we are failing our children," he said. "Despite the best efforts of paediatricians and the wider child health workforce, the CQC's assessment is a clear message that not enough priority has been given to recover child health and care services post-pandemic."

The report raised particular concerns about mental health services, where demand continues to rise and services struggle to recruit staff, including consultant psychiatrists.

Mental health difficulties experienced by adults often began in childhood or young adulthood, the report said. Early intervention increased the prospects of good mental health in later life, but delayed or inadequate intervention decreased these chances, it said.

Training and safeguarding gaps

The CQC's inspections of urgent and emergency care services raised concerns about triage and patient flow that affected care for all patients but identified specific issues in care for deteriorating children. Low numbers of children's nurses and gaps in staff training in safeguarding and recognising sepsis meant that in some services there was a risk that a deteriorating child might not be identified quickly.

Ingrid Torjesen, London

Cite this as: *BMJ* 2024;387:q2368

WAITING LIST of 7.64m cases—that is 6.33m individual patients waiting in England

sustained it "could reduce the waiting list for routine hospital procedures by up to three million by the end of this parliament." However, she warned that it would be "unlikely to be enough to enable the NHS to meet the 18 week standard."

Dixon said, "While this is a boost to NHS capital investment, it needs to be seen within the context of the £13.8bn maintenance backlog and many years of underinvestment in NHS capital. We estimate that between 2010 and 2019 the UK would have invested £33bn more in healthcare capital had we matched the average across the EU."

As such, she said the government's announcement should be the "opening salvo in a wider programme of investment and reform."

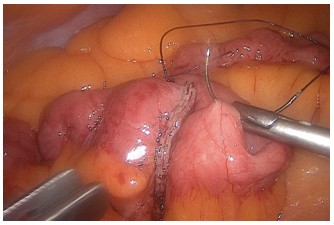
Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;387:q2394

"Income rises after bariatric surgery"

Bariatric surgery may lead to an increase in average earnings, mainly because people are more likely to be employed, the Office for National Statistics has found.

ONS used anonymised data from NHS England and HM Revenue and Customs, together with census data, to assess changes in pay and employment status before and after bariatric surgery. It found that among working age people in this group there was a "sustained average increase in earnings" from six months to five years after surgery.



Around 50 000 people with a primary or secondary diagnosis of obesity had bariatric surgery between 1 April 2014 and 31 December 2022, NHS England's hospital statistics show. Looking at these patients, ONS reported that while average monthly pay decreased immediately after surgery, it hit pre-surgery levels by the fourth month. Pay then continued to rise, reaching an average of £84 more a month (4.3 percentage points higher) by five years after the operation than before.

ONS said this increase was largely because people were more likely to be in work rather than a rise in hours worked or hourly pay.

The report formed part of evidence gathering being carried out by ONS to "help policy makers and healthcare providers better understand employment barriers for people with health conditions." Future analyses are set to investigate the effects of NHS talking therapy and endometriosis diagnosis.

Earlier this month the government announced a five year, real world trial in collaboration with the drug company Eli Lilly to examine the effects of the weight loss drug tirzepatide, a glucagon-like peptide-1 receptor agonist that's similar to semaglutide (Wegovy, Ozempic), on people's health outcomes, employment status, and number of sick days they take.

Current plans suggest, however, that a wider rollout of tirzepatide on the NHS could take up to 12 years because of the financial and resource burden it would place on the system.

In September *The BMJ* reported only half of England had comprehensive access to weight management services, with nearly a fifth of health areas not providing bariatric surgery.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;387:q2365

Peers call for total ban on junk food advertising

A total ban on the advertising of unhealthy foods across all physical and digital media has been called for by a House of Lords committee as part of a comprehensive strategy to turn the tide on the obesity public health emergency.

The government recently announced that a 9 pm watershed for television advertising of less healthy food and drink and a total ban on paid-for online advertising will come into force on 1 October 2025.

The House of Lords Food, Diet, and Obesity Committee said that, while this move was welcome, the ban did not go far enough. It calls for a ban on advertising of foods and drinks that are high in energy, fat, salt, and sugar across all physical and digital media, as well as advertising by businesses that fail to reach mandatory health targets. This should be initiated no later than October 2026, with a total ban by the end of this parliament. As part of this the government should ban the sponsorship of sports events by and celebrity endorsements of large food businesses that fail to reach mandatory health targets.

The committee's report said that successive governments had utterly failed to tackle the obesity crisis, with nearly 700 policies in England between 1992 and 2020 having produced minimal effect. Joan Walmsley, chair of the committee, said, "This failure is largely because of policies that focused on personal choice and responsibility out of misguided fears of the 'nanny state.' Both the government and the food industry must take responsibility for what has gone wrong and take urgent steps to put it right."

> THE GOVERNMENT AND FOOD INDUSTRY MUST TAKE RESPONSIBILITY
> Joan Walmsley

She added, "We hope, given the recent comments from the prime minister, Lord Darzi, and the secretary of state for health, that there is now an appetite to shift towards prevention of ill health. We urge the government to look favourably on our plan to fix our broken food system and accept not only that it is cost effective but that it would lead to a lot less human misery."

Integrated food strategy

The report calls on the government to publish a comprehensive and integrated food strategy that includes mandatory regulation. It states that voluntary efforts to promote healthier food have failed, as the industry has strong incentives to produce and sell highly profitable unhealthy products, whereas the soft drinks industry levy led to a reduction of more than a third in the sugar content of soft drinks in just four years.

The report also recommends giving the Food Standards Agency independent oversight of the food system, with responsibility for reporting to parliament on progress against targets and introducing a salt and sugar reformulation tax on food manufacturers.

Jacqui Wise, Kent Cite this as: *BMJ* 2024;387:q2329

Medical leaders call for more training posts as competition for places increases

Applications to previously unpopular specialties are rising. But royal colleges say this alone won't ease shortages of doctors, reports **Gareth Iacobucci**

It shouldn't be a competition; we need more doctors across the board Kamila Hawthorne

Competition for specialty training places in key shortage areas such as general practice and psychiatry is intensifying, with rising numbers of applications, a *BMJ* analysis of NHS data has shown.

Increased applications to general practice and psychiatry, which have historically struggled to recruit doctors, is good news, medical leaders agree. But without an adequate expansion in training posts this enthusiasm will fail to translate into more doctors at the front line of care, they have warned.

The analysis of NHS data shows that in 2024 a total of 59 698 applications were made in England for the 12 743 specialty training posts available at all training levels, giving an overall competition ratio of 4.7. This was a substantial increase in the ratio from 3.4 in 2023 (42 766 applications for 12 670 places) and 3 in 2022 (36 563 for 12 075) and continued an upwards curve since 2019, when the ratio was 1.9 (23 040 for 12 175).

Doctors can apply to as many different specialties as they wish. But the data don't tell us how many applicants there were in each year or the number who didn't get a training post. Doctors who fail to secure the specialty training place they want may opt to work as a locally employed (LE) doctor or a locum, switch to a different specialty, work abroad, or leave medicine.

Commenting on the 2024 data, Kamila Hawthorne, chair of the Royal College of General Practitioners, said, "We know that in specialties where demand for services is high, like general practice, there are many more applications than training places available. It shouldn't be a competition; we need more doctors across the board, but general practice is where the majority of patient care is delivered and we are currently in a workforce crisis, so we need to be attracting as many future GPs as possible."

Core training places must be expanded to address the scale of mental health need in the population Lade Smith

Fewer training posts

The BMJ's analysis shows that competition for GP specialty training year 1 (ST1) almost doubled from 2.1 applications per post in 2022 to 3.7 in 2024 (see table). But while the number of applications to general practice nearly doubled from 8549 in 2022 to 15 036 in 2024, the number of training posts fell from 4137 to 4096.

Similarly, competition for entering core training (CT1) in psychiatry more than doubled from 3.9 applications per post in 2022 to 9.5 in 2024. Again, the total number of applications rose substantially, from 1876 in 2022 to 4650 in 2024, but the number of posts remained static, at 484 in 2022 and 492 in 2024.

In emergency medicine, another area where shortages have been highlighted, the competition ratio for entering the acute care common stem (ACCS) emergency medicine (CT1/ST1) training programme rose from 4.5 in 2022 (1606 applications for 361 posts) to 7.6 in 2024 (2718 for 359).

Calls for a rethink

The NHS long term workforce plan, published in June 2023, stated a commitment to increasing medical training places and specifically pledged to expand GP training places from 4000 in 2022 to 6000 in 2031. The latest data have prompted calls to speed up this expansion.

Victoria McKay, co-chair of the BMA's GP registrars committee, said that while it was "very encouraging" to see more applications to general practice, "it is disappointing that NHS England is not putting in place adequate numbers of appropriately funded training places to accommodate the rising number of interested applicants." Denying potential GPs the possibility of training "could have a catastrophic impact on the future of our profession and on safe patient care," she added.

The Royal College of Psychiatrists' president, Lade Smith, welcomed the increase in applications to psychiatry but added, "Core training places must now be expanded to ensure we can grow the workforce and address the scale of mental health need in the population." The college has estimated that England has a shortfall of 690 consultant psychiatrists. Smith called for forecasts for the expansion of the psychiatric workforce in the short, medium, and longer term to be included in the refreshed long term workforce plan, expected in 2025.

Adrian Boyle, president of the Royal College of Emergency Medicine, said the college wants next year's updated NHS workforce plan to include an additional 30-40 emergency medicine training places in England, sustained each year for seven years. "While this number might seem modest, it is responsible, tangible, and achievable and will help to plug the future gaps in our workforce," he said.

Bottlenecks in system

Hawthorne said that other "bottlenecks in the system," not only training capacity, needed to be tackled for the commitment to increase GP training places by 2031 to become a reality. She said, "Our existing trainers are already at capacity, and many

MALCOLM WILLET

report being burnt out. We need to ensure they have protected time and appropriate resources to continue to teach. Alongside this we need to recruit more GP educators by ensuring it is an attractive career option, especially for later career GPs."

Hawthorne also urged the government to invest in practice infrastructure, as a lack of physical space was limiting practices' ability to take on trainees. She added that there also needed to be enough jobs on the other side of training to keep doctors in the NHS as well as a focus on retaining existing ones.

Responding to calls to further increase the number of specialty training posts, an NHS England spokesperson said, "While there were a record number of specialty training places made available this year, there was also an unprecedented rise in the numbers of doctors wanting to train in the NHS. The NHS will be working closely with medical specialties to look at how we can improve the experience for applicants next year and will ensure that training programmes are aligned with the needs of the service."

Asked how the Department of Health and Social Care will respond to calls to increase training places in key specialties, a spokesperson said, "We are determined to work with the NHS to fix the front door of our health service and ensure everyone can access GP and psychiatric services.

"As a first step we have cut red tape to allow surgeries to hire 1000 more newly qualified GPs and have increased funding for practices to manage rising pressures. We are also working to improve our broken mental health system, starting with the recruitment of 8500 more mental health workers to cut waits for treatment."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024;387:q2366

TOP 10 MOST COMPETITIVE SPECIALTIES IN 2024

Specialty NHS training programme	Applications/ posts	Competition ratio
General practice and public health medicine ST1 (dual CCT programme)	1794/16	112.1
Cardiothoracic surgery ST1	408/9	45.3
Community sexual and reproductive health ST1	461/18	25.6
Neurosurgery ST1	354/18	19.7
Public health medicine ST1	1816/104	17.5
Ophthalmology ST1	1383/96	14.4
Clinical radiology ST1	3719/312	11.9
Allergy ST3	30/3	10
Core psychiatry training CT1	4650/492	9.5
Paediatric surgery ST3	84/9	9.3
Selected other specialties		
Emergency medicine (ACCS) ST3	217/25	8.7
Emergency medicine (ACCS) CT1/ST1	2718/359	7.6
General practice ST1	15036/4096	3.7

Source: NHS England data

Seven principles aim to "change cover-up culture," says patient safety champion

Health leaders have been urged to unite behind seven patient safety principles designed to reduce the risk of harm and end cover-ups.

The patient safety commissioner for England, Henrietta Hughes, said the principles would drive a "change in the culture" and would direct leaders at all levels on how to plan and deliver safer care for patients. The Patients Association and leading experts welcomed the principles but said the challenge would be to turn them into everyday practice across the NHS.

The principles, developed after a public consultation, aim to create a culture of safety, put patients at the heart of their treatment, treat people equitably, identify and act on inequalities, identify and mitigate risks, be transparent and accountable, and use information and data to improve care and outcomes.

They are meant to be followed in the planning of care, moving care closer to home, or tackling gaps in care between various parts of the system. Hughes said patients, workers, and communities should be encouraged and empowered to proactively identify and speak up about risk, hazards, and potential improvements.

Candour should be the default position
Henrietta Hughes

Candour should be the "default position" to support a model of continuous improvement and ensure people "do not face avoidable harm due to a cover-up culture," she said. Health inequalities, and their drivers, should be identified and acted on at every stage of healthcare design and delivery to drive improvements in patient safety and experience. And the patient voice must be central in the design of services.

Measuring success

A glaring feature of many recent care scandals has been the failure to implement previous recommendations, as highlighted earlier this year by the Health and Social Care Committee's panel of independent experts. Jane Dacre, emeritus professor of medical education at University College London, who chairs the panel, told *The BMJ*, "The principles are all great. My main concern is that we are good at coming up with these high level statements, and they are welcome, but the complexities on implementation are often overlooked. These statements run the risk of being left on the shelf gathering dust.

"The challenge is to make the necessary change happen and to embed a method of measuring success. My work as chair of the panel, whose job is to evaluate the implementation of pledges made in health and social care, has shown that pledges made in good faith do not often happen."

Matthew Limb, London

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EDITORIAL

Tackling structural racism in health for London

Strategies must be based on equity and grassroots experience

A new report on structural racism and health inequalities in London by Michael Marmot and colleagues at the UCL Institute of Health Equity puts racism front and centre of public discourse after race related political upheaval in the UK and elsewhere.[1]

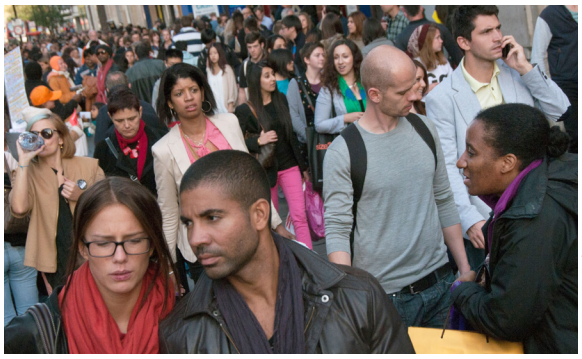
The report documents widespread and pervasive racial inequalities in health, social determinants of health, and experiences of healthcare and other public services in a city where one in three residents were born abroad, more than 300 languages are spoken, and attitudes to migration are predominantly positive. Using case studies, the report highlights the work of grassroots and other organisations that have supported community action despite inadequate funding and support.[2]

The recommendations are high level and based on principles of proportionate universalism, aiming for equity rather than just equality. The report acknowledges that racism affects physical and mental health directly, and indirectly through the social determinants of health, the healthcare system, and other public services.

Discussions were informed by community engagement, and recommendations were co-produced with a working group "comprising individuals with lived experience, representatives from voluntary, faith, and community organisations, and statutory health and care organisations." However, the report contains limited information on the methods of community involvement, the depth of consultation, and whose voices were and were not included. It is unclear, for instance, how ethnic minority people with protected characteristics were represented.

Omissions

Missing from the report is the activism of medical students and healthcare professionals to decolonise healthcare curriculums.[3 4] Such efforts have been instrumental in raising awareness and promoting change—for example, through the removal of ethnic adjustments to estimated glomerular filtration rate from guidelines on chronic kidney disease.[5]



JANINE WIEDEL/ALAMY

Absent from the report is any discussion of social integration

Regarding education on bias, cultural competency may risk the promotion of ethnocentrism and stereotyping, and a "cultural safety" approach might be better.[6 7] This requires healthcare professionals to examine how their culture influences everyday clinical interactions: a constant process of self-reflection for professionals and organisations.[6]

The report's recommendations address welfare, employment, schools, housing, and the criminal justice system, as well as health and social care. The most impactful are likely to be those that propose legislative changes, such as on non-discriminatory recruitment and co-designing support and advisory services with the most affected ethnic minority groups.

Furthermore, the emphasis on actions to tackle child poverty is welcome. However, some changes seem premature. For example, the report recommends a "tax and benefit system reoriented to reduce ethnic as well as socioeconomic inequalities" while asking for more data to assess the system's impact on these inequalities. Such reorientation without a strong evidence base could be unjust and challenging to implement, given that ethnicity relies on self-identification and many people have mixed ethnic heritage.

In parallel, gaps in wealth between ethnic groups in the UK are incompletely understood but may be due to factors such as home ownership, education, and social norms such as the participation of women in employment.[12]

Integration

Furthermore, a sustainable economic strategy for London would inevitably need to be set within a national strategy for socioeconomic equity.[13] And in that context, it is disappointing to see no recommendations on "the hostile environment" for migrants[14] despite the report highlighting its negative effect on migrants' health.

Recent data show that people from ethnic minority groups believe there has been progress in racial equality, yet discrimination affects their lives on a daily basis and there is still much to be done.[15 16]

Absent from the report is any discussion of social integration. Research and analysis undertaken by the Social Integration Commission suggests that London is less integrated by social grade, ethnicity, and age than the rest of Britain.[17] Social integration may promote better physical and mental health and wellbeing[17] through enriching social connectivity and trust, improving access to healthcare, and addressing the wider determinants of health such as employment. It could therefore be a platform for addressing the structural barriers to race equality.

It is time to give leaders and grassroots workers with demonstrable track records of driving change the opportunity and funding to dismantle structural racism. Otherwise, the report risks becoming another missed opportunity to truly transform the lives of underserved ethnic minority communities.

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EDITORIAL

Assisted dying: balancing safety with access

International experience should inform implementation and regulation

The UK parliament is due to debate MP Kim Leadbeater's bill on medically assisted dying for terminally ill adults in England and Wales in November 2024.[1] Leadbeater's bill has yet to be published. Scotland and Ireland are considering similar bills.

More than 300 million people across the world already have access to the option. Decades of international experience can inform UK law making and how the bill might be implemented to optimise safety and access for local context, including concerns such as eligibility, safeguards, conscientious objection, oversight, and reporting.[2]

In terms of eligibility, all jurisdictions that permit assisted dying require that the requesting patient is capable and fully informed, and most restrict access to adults with terminal illness (eg, the US and Australian states that permit assisted dying and New Zealand). Some jurisdictions restrict the option to patients within six or 12 months of death while others such as Canada, Belgium, and the Netherlands do not specify a timeframe to death. Some jurisdictions also permit assisted dying for non-terminal conditions, but such deaths are rare[3,4]; most assisted deaths globally (70-80%) are in people with advanced cancer or neurodegenerative disease.[5]

Common safeguards include independent assessment of eligibility and a pause between the request and provision of assisted dying.[6,7] Many eligible people making requests lose capacity during these reflection periods,[8,9] so some jurisdictions have shortened (eg, California, Washington) or eliminated them (eg, New Zealand). Ensuring requests are enduring must be balanced with maximising access.

To make a competent decision, patients must be fully informed about other means of alleviating suffering, including palliative care. In Belgium, for example, palliative care services are integrated with assisted dying, but this is not universal.[10] Regardless, 70-90% of people globally who have an assisted death have received palliative care.[4-15] Mandating consultations could increase this number but could make palliative care providers gatekeepers for assisted dying, which they may not welcome. Moreover, palliative interventions may offer little respite from the existential distress that prompts most requests for assisted dying.[11]

Global evidence should inform the debate on Kim Leadbeater's bill

MATT CROSSICK/ALAMY

70-90% of people globally who have an assisted death have received palliative care

Clinicians should be able to choose not to participate in assisted dying, but in some jurisdictions conscientious objectors must refer patients to a willing provider. The balance of respecting conscience rights while ensuring access remains contentious.[20,21]

Monitoring and research

Oversight varies internationally.[22] Assisted deaths are generally reviewed retrospectively by a dedicated committee. Prospective review also occurs in some jurisdictions. This can identify ineligible patients, but in practice may be purely administrative, offering little plausible safety while creating delay that is a substantial access barrier for patients with advanced disease.[23]

Almost all jurisdictions publish data on recipients[5] and compliance with safeguards. Such reports suggest that safeguard violations are rare[3-25] but show barriers to access in some jurisdictions.[7-23] Such reports also enable evaluation of concerns that vulnerable groups could be coerced into an assisted death. Data from Canada, Oregon, Washington, Switzerland, Belgium, and the Netherlands indicate that objective measures of vulnerability, such as low income or institutionalisation, are associated with a lower likelihood of assisted death, however.[14-29]

In Canada, 35% of people who received assisted dying reported feeling that they were a burden[4]; however, studies of people with advanced cancer who are not pursuing assisted dying report a much higher prevalence of self-perceived burden (up to 73%),[31] suggesting this is a cohort effect instead of a specific driver of assisted dying.

Laws are only part of regulation.[32] An implementation period, with consultation with experts and stakeholders, should be designated.[33-35] Assessors and providers need education,[36] communities of practice, and medication protocols. All clinicians need guidelines about their obligations when responding to requests. Patients need resources to support informed decision making and a care coordination system that facilitates access while reducing the burden on professionals who object.[37,38] Oversight and reporting systems should promote transparency and research.

Leadbeater's bill comes at a time of high public support, shifting medical views,[44] and increasing consideration and legalisation of assisted dying internationally. Parliamentary consensus depends on local considerations, such as applicability of existing oversight mechanisms and data infrastructure, and availability of willing providers. International evidence should inform the debates to ensure lawmaking and implementation maximise both safety and access if the bill passes.

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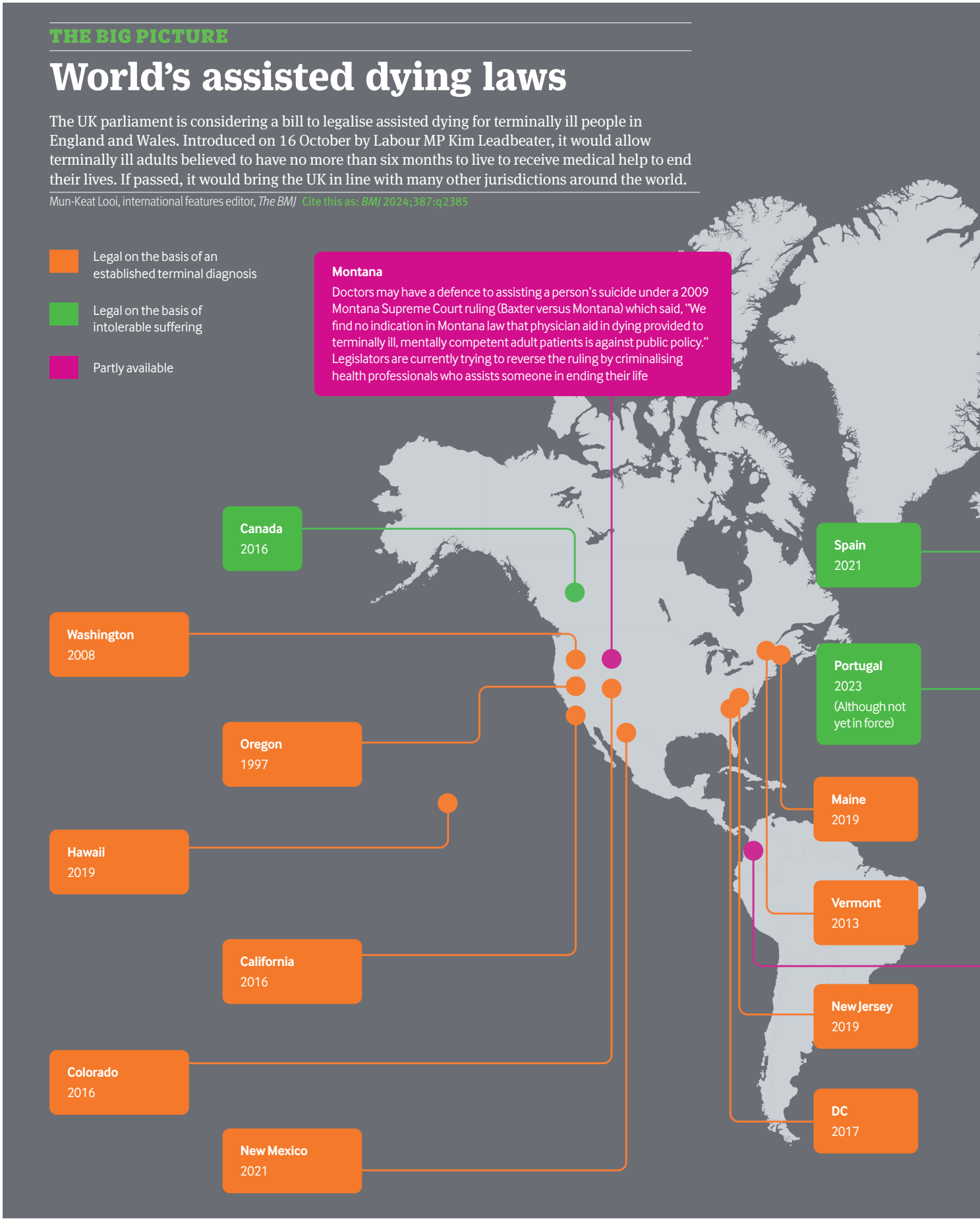
THE BIG PICTURE

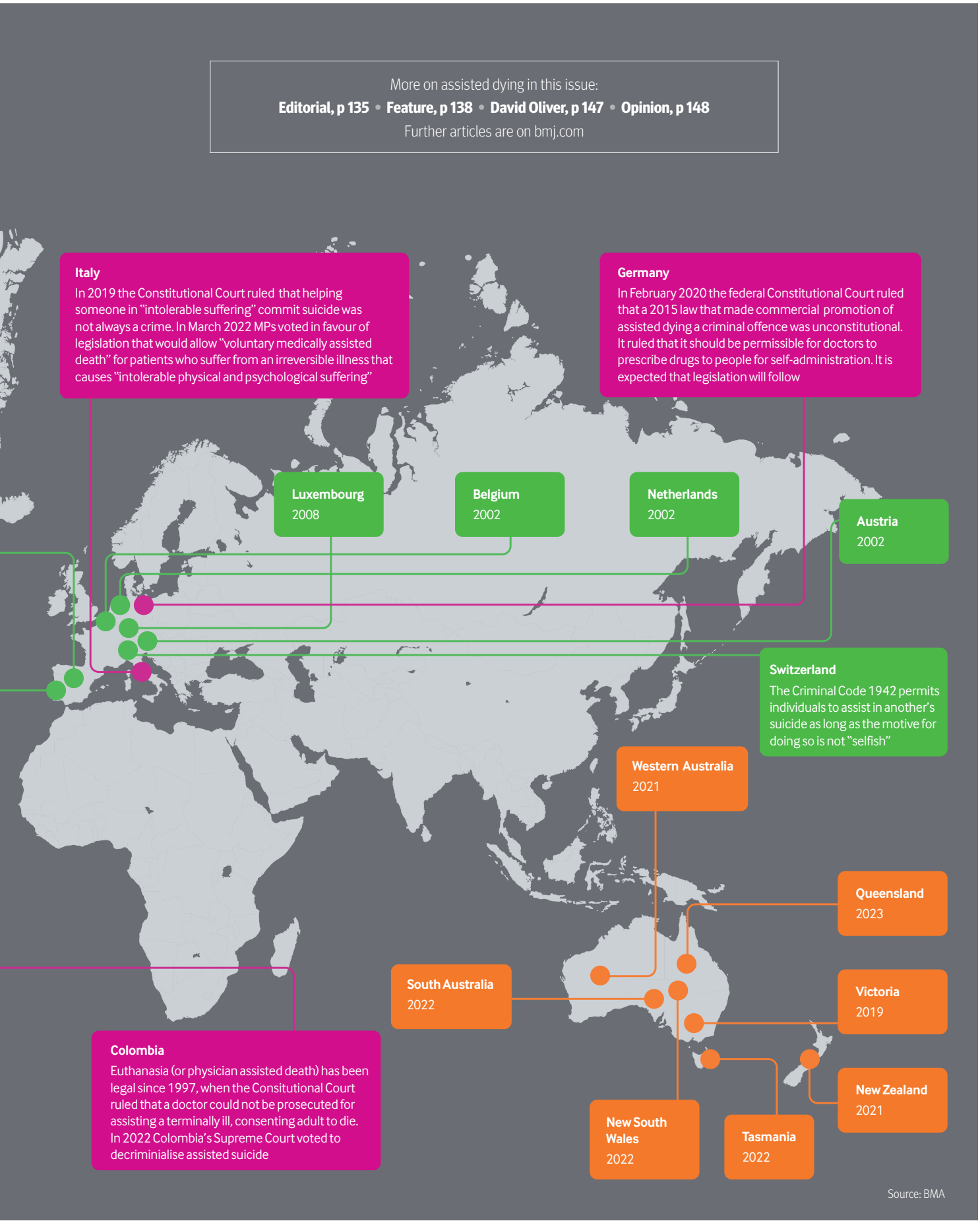
World's assisted dying laws

The UK parliament is considering a bill to legalise assisted dying for terminally ill people in England and Wales. Introduced on 16 October by Labour MP Kim Leadbeater, it would allow terminally ill adults believed to have no more than six months to live to receive medical help to end their lives. If passed, it would bring the UK in line with many other jurisdictions around the world.

Mun-Keat Looi, international features editor, *The BMJ* Cite this as: *BMJ* 2024;387:q2385



More on assisted dying in this issue:
Editorial, p 135 • **Feature, p 138** • **David Oliver, p 147** • **Opinion, p 148**
Further articles are on bmj.com



ASSISTED DYING

What is it like for doctors working under assisted dying laws?

As the UK again considers allowing assisted dying to be legal, doctors and patients in countries where some form of law is in place tell **Sammy Chown, Anna Volkmer,** and **Mun-Keat Looi** of their experiences

MALCOLM WILLETT

My first case under Australia's assisted dying law

Victoria was the first Australian state to enact a voluntary assisted dying (VAD) bill in 2017. **Niroshe Amarasekera**, a GP at the Carnegie Medical Centre in Melbourne, tells *The BMJ* what it was like as a working clinician at that time.

Members of Victoria's parliament celebrate (below) after a 2017 vote to pass an assisted dying bill.

SCOTT BARBOUR/GETTY IMAGES

"I was about seven years into working at my practice when Victoria's bill came in in 2017. I don't remember a lot of information communicated to doctors. I remember thinking, 'It doesn't affect us. If a patient asks, we refer them on. And we can't bring it up as a care option.' That's it.

"It is against the law for us to bring VAD up. I still can't start the conversation. You can get into trouble, get sanctioned.

"I've had three long term patients either accessing or exploring the option for accessing VAD. The first was about three years ago: she was elderly with diagnosed bowel cancer. The prognosis was poor, and the hospital had referred her. She asked me to be her second approving person—two doctors need to approve VAD under Victoria's laws. One of them can be your GP but the other needs to be external [independent], and you both have to agree that VAD is in the best interest of the patient. But the doctor who prescribes or administers the drugs can be your GP if they are trained to do so.

"I hadn't had any training in assisted dying, and the law was new at the time. Still, I said I'd support her and she put me in touch with her assisted dying navigator—that's the patient's primary contact throughout the process [separate from the two doctors who approve the process]. They're usually a clinical nurse but can be another health professional.

"The navigator talked me through the process and told me I needed one day of training that ran only at specific times. Finding time to do it was hard. Most GPs in Australia do not get paid when they are not working and doing such training. It's a big investment because I lost a whole consulting day. I've got to keep up with professional development as well, so it's even more of an investment. As much as I want to help my patients who request VAD, if I'm not doing it regularly enough, I'll de-skill.

"The same factors affect VAD consultations. If I spend 30 minutes with a VAD patient, that's the equivalent of three other 10 minute appointments. And in Australia payment is per consultation. And that's before we get to the paperwork, which is quite onerous. So between the training, the cost, and the paperwork, it's not that attractive for GPs to help patients with VAD requests.

"By the time I found time to do the training, my patient's navigator had found another doctor. That doctor offered to mentor me through the training.

"In the end my patient didn't access VAD. But she wanted that option, and I felt honoured to be included in that process. It's a personal decision that patients share only with people they're really close to. To be included in that circle was a real privilege."

What does a doctor have to do at the time of death?

"You can only prescribe or administer the drugs if you're qualified. When the patient is ready, the patient, a family member, the navigator, or the GP [if they have had training] can administer the drugs. It depends on what the patient prefers—some don't want to administer themselves, others might prefer to." [Some countries distinguish between these as "assisted euthanasia or suicide" and "assisted dying."]

Are doctors allowed to object to VAD? And what happens if they do?

"I don't know of anyone in my colleague group who conscientiously objects to VAD. But I can tell you about conscientious objectors to medical terminations and vaccination. If you're a conscientious objector, it's still your responsibility as a doctor to say, 'This is not something I can help you with, but here are the details of a service that you can talk to and that will discuss options with you. I'll send you to my colleague.'

"Doctors do not need to reveal whether they do or don't object. But I suspect a lot of doctors when asked about VAD say, 'No, there's nothing I can help you with.' I've certainly seen people who say their doctor didn't know what to do. But how could you not know what to do? Just refer. Give them a phone number."

Victoria's assisted dying laws

Enacted in 2017 and revised in 2021, the law permits doctors to prescribe drugs for self-administration. Doctors can also administer the drugs themselves in cases where a patient is physically unable to self-administer.

A doctor cannot raise the conversation about assisted dying in the first instance—it must be initiated by the patient. According to the act, a person's decision to ask for VAD must be:

- Voluntary (the person's own decision)
- Enduring (the person makes three separate requests for VAD during the process)
- Fully informed (the person is well informed about their disease, and their treatment and palliative care options).

To be eligible, people must meet all the following conditions:

- They must have advanced disease that will cause their death and that is:
  - Likely to cause their death within six months (or within 12 months for neurodegenerative diseases like motor neuron disease)
  - Causing the person suffering that is unacceptable to them.
- They must have the ability to make and communicate a decision about VAD throughout the formal request process
- They must also:
  - Be an adult 18 years or over
  - Have been living in Victoria for at least 12 months
  - Be an Australian citizen or permanent resident.

Two doctors need to review a request separately and make an assessment. The patient must be acting without coercion from anyone else.

Besides Victoria, five other states in Australia have legislation on "voluntary assisted dying," which permits assisted suicide and voluntary euthanasia in specific circumstances.

DON RYAN/AP/ALAMY

I was ambivalent—until I had to do it

The US state of California introduced the End of Life Option Act in 2015. **Ryan Spielvogel**, a primary care physician in Sacramento recalls the ambivalence he initially felt before it became a big part of his job.

Activists (above) in Oregon in 1997 celebrate the failure to repeal a 1994 vote to allow assisted dying. Oregon was the first US state to pass such a law

California passed assisted dying legislation, with the support of activists (above right), in 2015

"The End of Life Option Act went into effect in 2016 and I've been involved since then. [Similar legislation is currently legal in 11 jurisdictions in the US covering around 22% of the US population.]

"How many people do we see for assisted dying services each year? Our health system covers about 3.4 million patients and we have a few hundred referrals a year. It trickles in. Sometimes we'll go weeks without a referral, and then we'll get five. The stats work out that about one in 80 hospice patients will elect for assisted dying.

"I was never taught about any of this in medical school or in residency, probably because at the time it was only legal in Washington and Oregon, not in California. In 2016 I had literally never thought about it before. I hadn't formed an opinion one way or the other.

"A couple of months before the law was to go into effect, our health system emailed all 5000 physicians to gauge individual physicians' comfort and desired level of involvement. They gave us several options from 'I want nothing to do with this in any capacity for my patients or anybody else's patients' to 'I would feel comfortable seeing my own patients for this or even other people's patients for this.'

"I had been in practice for two years and I thought, if my patient asks me for this, I'd figure it out. I'm not going to turn away a patient in need. And I decided that in the rare case that a primary care physician didn't want to take care of them, sure, I'll see somebody else's patient. I'm not going to leave a patient in the lurch. So I chose the most permissive option and didn't think much of it.

"A week before the law went into effect, I got an email from the coordinator of the assisted dying programme who said, 'You were one of eight out of 5000 physicians who chose the most permissive options. Congratulations, you're now one of our expert, go-to assisted dying physicians. Here's a list of seven referrals that we've had over the past two months who are waiting for the law to go into effect. These are now yours.'

"I saw my first patient the week after the law went into effect. I was struck by how determined this person was.

"It was an epiphany for me, seeing not just how important it was for this man to have agency and have a little bit of control in his last months of life but also how much of a gift it was to his family to be able to have a memorial for him, surrounded by friends and family, while he was still alive.

"There are definitely times when family members might not be on the same page with the patient, but that's also the case with most families as someone is passing. And you might say, surely not everyone can be that determined? But most of the time people who access assisted dying fall into one of two categories.

"One, they are actively suffering at the end of their life, in ways that they are very uncomfortable with, so it's somewhat urgent to them. I've never seen someone change their mind in that circumstance. They want it right now, and they take it the moment that the process is completed.

"Two, the person is someone who has thought about this for a long time. There's always this fear: what if someone changes their mind at the last minute. What if they take half the dose and then say this isn't what I want? That's fantasy. People have numerous chances to change their mind before they actually take the drugs. It's an erroneous notion that the patient is thinking about it for the first time when they talk to me the first time about assisted dying.

"People have been thinking about it for a while before they feel comfortable admitting to a loved one that they're thinking about it. It's often weeks or months, from the time that they first start considering it to the time that they are sure enough, or have got over whatever stigma

It's an erroneous notion that the patient is thinking about it for the first time when they talk to me the first time
Ryan Spielvogel

RICH PEDRONCELLI/AP/ALAMY

they feel was attached to it enough, to actually talk to a physician about it. This is not a willy nilly decision that people have come to. When I tell people, legally, there's a waiting period, we need to make sure that you're sure about this, they're like, 'What do you think I've been doing for the past two months?'

"What does happen is you have people who have planned ahead. Somebody, for instance, who has metastatic cancer who says, I'm doing okay right now. I'm able to take care of my own body without my family members having to wash me. But I took care of my wife, or my mother, through cancer, and I know how bad it can get. And if it starts to get bad like that, I'm done. For those people, I say, okay, if you are eligible, so we can go through the whole process in terms of getting through the requirements. And then let's see how things go. If it gets to the point where you are suffering in a way that is unacceptable to you and you're ready for this, you give me a call.

"This puts the patient in the driver's seat. And maybe they don't reach a point where they feel they need this, and I never hear from them again. Either way, I got you.

"That choice is incredibly important for the people who want it: knowing that you don't have to go through the suffering if you don't want to—it's up to you to decide when the suffering is too much for you. In a way it's similar to, say, epidurals in labour. I don't think anybody would argue that labour epidurals are immoral. It's about alleviating something."

Patient perspective

Mary Cate Pickett's husband was among the first in the Australian state of Tasmania to use new rules around assisted dying. She tells *The BMJ* about their experience.

"My husband John and I moved to Tasmania in January 2020 just after I retired. A bit over 18 months after we moved he was diagnosed with stage 4 colorectal cancer. It was quite a shock. John was a very active, fit, healthy man of 72.

"He went through some treatment, and after a couple of rounds of chemotherapy we were told that because of a genetic mutation in his cancer there were no other treatments available, and because it was stage 4, surgery wasn't an option.

"That was about four or five months after diagnosis—from diagnosis to the time he died was 17 months. So there was a bit more than 12 months where we were managing his illness through him maintaining as healthy a lifestyle as he could. But towards the end of 2022 he was starting to get weaker and sicker, and started to experience a lot more pain.

"Around that time, the legislation for VAD had just come in in Tasmania. John and I had talked about if either of us would use it, and we both agreed that we would.

"In January he made an initial contact with the voluntary assisted dying commission. They managed the whole process, linking us to prescribing doctors. We had to go through quite a bureaucratic process.

"There were many forms and it was all paper based. Some states have an online process. There is still always duplication—filling in the same details—but that may have been because it was relatively new. I think it is a matter of people feeling confident that the system is safe.

"John was told originally that finding a doctor was going to be challenging because low numbers had been trained in VAD. But John was stubborn and very determined. He maintained a good and constant relationship with the consultant at the commission, checking in regularly to say, 'I'm still here. I'm still interested. Have you found anyone?'

"Then in early February 2023 a doctor was found. It was a GP in our area who had been involved in the legislation coming in. We drove an hour up to Hobart to meet the doctor, and the VAD navigator—a consultant who was a health professional, but not a doctor or nurse. That trip was challenging, because by then John was quite sick. But it started the process—that was when we submitted the first request, as it's called.

"That was followed up by written requests and a consultation with a second doctor. Both the doctors were very supportive and clear about the process, and wanted the best for John.

"From there it was negotiations around access to the drugs for VAD, and a time that was suitable for the first prescribing doctor to be with John when the time came. In Tasmania patients can choose to be prescribed the oral drugs to take themselves whenever they want or with the doctor present. There is also the choice of intravenous administration, if the person is unable to self-administer, but John never needed that because he was still able to swallow.

John was very clear on wanting to take the substance and to die on his own terms

"The prescribing doctor attended with two pharmacists from the prescribing service in Hobart who brought the drugs. John was able to take the drugs himself so according to the law did not need to have a doctor present. That said, throughout the process, we'd had a good local GP who supported John's decision. He did not take an active role in the administration of the drugs or the process but he offered to be with John while he died.

"John died at home in February 2023. We had John's GP, as well as the prescribing doctor, who was very supportive, calm, and clear about what was going to happen. He'd always been available to take calls or answer questions. For example, one of our concerns was that John might lose consciousness before he could give his informed consent and take the drugs himself.

"John was probably one of the first 10 people who died using VAD in Tasmania. We were lucky in a sense. Several people who wanted VAD have not been able to access a doctor who has undergone the training. Some areas, including ours in the south of Tasmania, have fewer health professionals trained to provide VAD.

"The important thing for both John and me was that the two doctors involved with the VAD, as well as John's GP, were respectful of John's wishes. They could see that John clearly fitted the criteria of someone who was going to die within a prescribed timeframe, that there was no other treatment available, and that John was very clear on wanting to take the substance and to die on his own terms,

"The key thing for me was the absolute respect that came with the doctors that we dealt with, so that John felt absolutely fine with what he was doing."

Dignitas, founded in 1998 in Switzerland, the first country to legalise assisted dying, in 1942

ALL PHOTOS: GAETAN BALLY/KEYSTONE/PA

How has medical assistance in dying changed palliative care?

Palliative care doctor **Leonie Herx**, of the University of Calgary, tells *The BMJ* about her experience of assisted dying in Canada, and her worries about its relationship with her field.

"I've been consulting in palliative medicine for 17 years. I've seen patients facing frightening diagnoses and hospital admission experience a loss of dignity and worry about burdening loved ones.

"The cornerstone of palliative care is to reaffirm patients' inherent dignity, helping them live well as they navigate the challenges of serious illness, as rooted in the work of Cicely Saunders, UK physician and founder of the modern hospice. In the words of Dame Cicely, reminding patients that 'they matter.'

"Canada's medical assistance in dying (MAID) laws have affected my field more quickly than I'd expected. There's now this sense that by wanting to address the patient's suffering palliative care doctors are trying to convince someone out of getting an assisted death.

"I've seen patients receiving MAID [which encompasses both euthanasia—where the doctor administers the drug—and assisted suicide—where the patient takes the drug themselves] within 24 hours of approval. It can happen without first accessing other care options or before a palliative care specialist, like me, can meet with them—which I have experienced.

"MAID being labelled as 'end-of-life care' and being placed operationally and administratively under the same umbrella as palliative care has intensified confusion.

"I think there's been a strange shift in the culture. Addressing suffering was considered such a profound art that takes time and was valued. Now it feels like we're saying that the best way to address suffering is to end someone's life.

"Canada's initial MAID legislation was portrayed as an option in exceptional situations where suffering could not be tackled in other ways. It is now routinely offered to those who might meet the eligibility criteria. I've had patients tell me that when a trusted physician has suggested assisted dying to them, it must be a good idea because they cannot see why they would be offered it otherwise.

"We are spending increasing amounts of time dealing with the procedural matters related to MAID, for fear of being met with complaints, which is taking us away from our work in palliative care.

"Healthcare providers are getting traumatised by seeing more and more people getting euthanasia as a stopgap for other lack of resources and access to care."

It feels like we're saying that the best way to address suffering is to end someone's life
Leonie Herx

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