Saturday October 22, 2011

The voice of doctors

bma news

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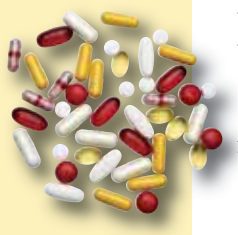

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REGULARS

BMA
STANDING UP FOR DOCTORS

BMA News is a supplement of BMJ Vol: 343 No.7828

BMA rejects pensions hike as 'barely concealed tax'

BY LISA PRITCHARD

THE BMA has rejected entirely suggestions that doctors should pay up to £200,000 more for their pensions.

In its response to a consultation on raising NHS pension scheme contributions from 2012, the association says doctors see the rise as 'a barely concealed tax on the membership of the NHS pension scheme, a levy on them to pay for an economic deficit that they did nothing to … contribute to'.

The BMA warns that if many doctors end up paying 14.5 per cent of their salaries into the NHS pension scheme, which would be higher than the employer contribution, many senior doctors will almost certainly consider early retirement and drawing of their pensions.

The Department of Health and the Welsh government want to increase contributions by some pension scheme members by up to 6 per cent by 2014.

Modelling by actuaries commissioned by the BMA suggests this would mean a junior doctor aged 25 today, planning to work as a consultant and retire at the age of 68, would have to pay almost £200,000 extra for a smaller pension.

The BMA points out that members' contributions already rose by up to 42 per cent when the NHS pension scheme was reformed just three years ago.

Contributions increased from 6 per cent to 8.5 per cent of pay.

BMA pensions department head Andy Blake says that implementation of the latest proposals would mean some doctors' contributions increasing by 142 per cent in the six years since 2008.

Doctors leaders also object to the fact that the consultation is not about the extent of the overall increase in contributions but only about how it should be applied.

Mr Blake says: 'The government has flatly refused to enter into negotiations on this fundamental point about contribution increases, and neither is it showing any sign of genuine engagement about its wider plans for changes to the NHS pension scheme under the Hutton review.'

The BMA response uses a comparison of the relative starting points for NHS and civil service pension schemes as evidence of unfairness in government policy.

Civil servants in the 'classic' section of their pension scheme currently pay 1.5 per cent, set to increase to 7.5 per cent in three years' time; doctors earning the same amount will be paying 14.5 per cent.

When *BMA News* went to press, more than 1,000 doctors had responded to the consultation. A similar consultation was launched in Scotland earlier this month.

The BMA is still awaiting an announcement on plans for pensions in Northern Ireland.

● The BMA and other health unions met health secretary Andrew Lansley last week to discuss the various attacks on the NHS pensions, but left disappointed by a lack of flexibility on proposed changes.

BMA council chairman Hamish Meldrum said: 'While we will want to continue to engage in dialogue, industrial action at a future date remains an option.'

Day of action

The BMA has issued guidance on what members can do to show their support for the TUC pensions day of action on November 30.

See how to get involved at www.bma.org.uk/nhspensionreform

Public heath manifesto agreement

NHS REFORM

THE BMA has joined other leading organisations to agree a set of principles for the new public health system in England.

The other parties are the LGA (Local Government Association), the Faculty of Public Health, the Association of Directors of Public Health, the NHS Confederation and the Royal College of Midwives. A joint statement aims to shape national discussions on legislation, guidance and implementation of government reforms.

It outlines priorities for the national public health system, and makes several recommendations on the transfer of functions to local government.

BMA public health medicine committee co-chair Richard Jarvis said: 'We have set up, developed and supported a close working relationship with the LGA to address the key issues over how public health will work in the new system. The progress has been very encouraging.'

➤ *From the chair, page 2*

Island contracts reinvigorate associate specialist grade

CHANNEL ISLANDS contracts negotiated by the BMA have breathed new life into the associate specialist grade for hospital doctors.

New SAS contracts for Jersey retain the ability for the regrading and appointment of doctors to associate specialist posts, a grade closed to applicants on the UK mainland since April 2008.

Jersey's 53 staff grade and associate specialist doctors will also benefit from higher salaries and quicker pay progression than is possible with the 2008 contracts for Great Britain and Northern Ireland.

BMA industrial relations officer Richard Griffiths said: 'The deal reflects the need for Jersey to recruit and retain excellent SAS doctors, and should be seen as a very positive development.'

A single new Guernsey SAS contract, for the island's sole SAS doctor, is based on the associate specialist contract, and follows the UK single pay spine for the grade.

The BMA staff, associate specialists and specialty doctors committee hopes the contracts will boost the case for reopening the associate specialist grade in the UK.

SASC chair Radhakrishna Shanbhag said: 'Having had difficulty in recruiting doctors to the SAS grade, Jersey and Guernsey have realised the importance of developing a recruitment package attractive enough for doctors to enter the SAS grade, and have delivered a series of improvements to the existing contract. I wish such a contract was available on the mainland.'

Jersey General Hospital managing director Andrew McLaughlin said: 'We believe that the new contract and pay structure will help us attract, recruit and retain SAS doctors, and provide a broad improvement on the NHS.'

Other benefits of the contracts include:

● A single pay spine that includes the associate specialist grade

● Annual increments for all but the top two points of the staff grade/associate specialist pay spine

● Additional availability pay supplements for on-call work

● A £3,600 sign-on supplement.

JANE CRICK

FLOWER POWER: a Suffolk GP practice has opened an art exhibition for staff, patients and visitors. Flowers in Medicine explores the medical use of plants such as St John's Wort (pictured), which can be used to treat mild depression. The artworks are by Suffolk artist Jane Crick. The exhibition is at StowHealth practice, Stowmarket, until the end of January. See www.stowhealth.com

FROM THE CHAIR

THIS WEEK, the BMA and five other organisations, including the Local Government Association, issued a robust statement on the future of public health.

It says the design for England's public health system should reflect the contribution of each of the specialty's three domains — health protection, health improvement and improving health services — at every level.

Funding should follow this design, and not be based on historic budgets. We have serious concerns about the Department of Health's exercise to identify current PCT public health funding, as this will not be a sufficient basis for the future.

Some functions, such as infection control and disease surveillance, need to be organised at a supra-regional or UK-national level. It is also vital that directors of public health enjoy the professional independence they need.

Staff joining local government from the NHS must have access to the NHS in areas such as revalidation.

This statement will shape our ongoing national discussions on the reforms.

Hamish Meldrum, BMA council chairman

Retention fear for forensics

BY LAURA SLOMAN

FORENSIC MEDICINE doctors leaders have spoken of the steady decline in morale among doctors providing the service.

BMA forensic medicine committee chair Michael Wilks said such an erosion of morale could lead to problems retaining skilled forensic medical examiners, which would in turn lead to a loss of trust by the police and courts.

His comments were made at a seminar on the state of forensic medicine, organised by BMA Cymru Wales.

Dr Wilks said: 'When we look at the provision of custody healthcare, I'm afraid we do see quite a gap between the ideal that we would want to see and what's actually happening.

'We have a very, very wide mix of provision; the NHS and the police services are free to decide whatever size budget they choose to spend on healthcare.

'If we look to the basics, we want something that balances cost with safety and quality. If you have got evidence of what works you should be promoting that but so much of the evidence of what works comes against the big negative driver of cost and cost containment.'

He said the FMC view was that forensic services should be provided by teams with a mix of healthcare and forensic expertise.

Dr Wilks added: 'As we're seeing in London, there can be a steady reduction in morale and commitment in the doctors and nurses used there.'

WILKS: morale under threat

He said expertise could 'quietly dissolve away', which could result in there being 'no kind of retained skill within a depleted workforce of forensic medical examiners and, therefore, we will find a certain loss of trust by police, by the courts and by our patients'.

BMA Welsh secretary Richard Lewis, who chaired the seminar in Cardiff, added: 'For some time we have been concerned with the disproportionate number of people entering the criminal justice system with complex health problems; the missed opportunities for early recognition of mental health problems, learning disabilities and problems of drug and alcohol dependence.'

Dr Lewis said there was a worrying lack of recognition of the importance of the role of forensic medicine in such areas, as well as its crucial role in forensic evidence gathering.

He added: 'Our vision is to see the development of forensic medical services that deliver consistency and excellence in forensic medicine in the custody setting, which will need cooperation and integration between health and justice, as well as social services, the voluntary sector, education, and housing.'

Call for more explicit alcohol guidelines

THE RECOMMENDED limit on alcohol consumption should not be raised but the guidelines should be more explicit, MPs have heard.

BMA board of science chair Averil Mansfield made the call last week when she gave evidence to the Commons science and technology select committee's inquiry into the evidence base behind alcohol consumption guidelines.

Professor Mansfield joined former Royal College of Physicians of London president Professor Sir Ian Gilmore in urging MPs not to recommend that either the daily or weekly limit on alcohol is increased.

Professor Mansfield said she was more in favour of a daily rather than a weekly limit as a guideline. However, she added that the current daily guidelines — of three to four units of alcohol for men and two to three units for women — gave a 'green light' to drinking this amount each day and there should be days of alcohol abstinence.

She said units should continue to be used as a way of measuring alcohol consumption.

'I think, for better or for worse, it should be a message that should be retained because it's fairly widely understood. But what is not quite so well appreciated is what each [alcoholic drink] that we take contains in terms of units,' she said.

Earlier, Sir Ian said it was important to have a 'single and consistent' message on alcohol guidelines for the general public, and for health professionals to give to patients.

Sir Ian added that doctors had moved from top of the table for alcohol-related mortality to almost the bottom and he hoped that meant the medical profession was beginning to take the lead on the issue as they had done with smoking.

Concern over section 12 approval

NHS REFORM

DOCTORS LEADERS have raised concerns about the section 12 approval functions should the Health and Social Care Bill become law.

The CC psychiatry subcommittee has written to the mental health minister Paul Burstow to call for amendments to the bill.

Under clause 35 of the bill, the responsibility of approving section 12 doctors — those who have the powers to section patients under the Mental Health Act 1983 — and other approved clinicians will be devolved from strategic health authorities to any qualified provider.

The subcommittee says its first concern is one of 'probity' and that bodies granting approval should be independent of clinical commissioning groups and provider organisations.

Doctors also raise issues about the funding stream. They point out there is a 'lack of clarity' about how costs associated with the maintenance of approved clinician registers and with providing training for approval and re-approval of doctors will be met.

Doctors fear charges will be transferred to individual psychiatrists and GPs, amounting to a 'tax on work'.

OFF THE RECORD

ENGLAND

'Peers were concerned about the accountability and constitutional issues the bill raised'

IT WAS testament to the significance of the Health and Social Care Bill that its first debate in the Lords last week attracted major attention.

NHS REFORM

Turnout was impressively high, with approximately 100 peers indicating that they wanted to speak. This meant the second reading debate, which would normally last a day, was spread over two. Peers were also the focal point of intense lobbying and received a plethora of emails, letters and briefings from organisations and individuals in the run up to the debate.

But with so many peers wanting to speak, speeches inevitably had to be succinct in order to accommodate as many contributions as possible.

Much interest centred on two motions at second reading. There was one from Labour peer and former GP Lord Rea calling for a halt to further progress of the bill and another from Lord Owen, a former GP and Labour health minister, now a crossbench peer, asking for parts of the bill to be referred to a special select committee for further scrutiny.

The debate made fascinating viewing and while most speeches concentrated on health and social care, at times the discussion strayed into other areas.

Constitutional matters featured prominently on two levels. Some peers were concerned about accountability and the constitutional issues the bill raised, such as the government's and Parliament's constitutional responsibilities to the NHS and, namely, the health secretary's duties.

Other peers also raised the constitutional role of the Lords itself in scrutinising legislation.

Such was the impact of the motions tabled that, at times, peers wrestled with questions such as whether the Lords should be able to reject legislation that had already been through the Commons or whether a special select committee was indeed needed to investigate parts of the bill.

When it came to the votes, both motions were lost, which means that the bill will start a normal committee stage later this month.

In the Lords, this means that it will be a 'committee of the whole house' that will enable all peers to participate in votes and discussions on detailed aspects of the bill.

After this stage is finished, it is expected that the bill will have its report stage and third reading early next year followed by a 'ping-pong' stage between the Lords and Commons before Royal Assent — making the bill law — in the spring.

As the bill continues its progress, the BMA will continue to lobby peers hard to ensure further government concessions. Read the latest at www.bma.org.uk/nhsreform

Robert Okunnu is BMA head of parliamentary relations

Doctors outline donor opt-out template

THE BMA has unveiled its vision of how an opt-out system could work if Wales were to go it alone on changing organ donor laws.

The Welsh government has said it will introduce a white paper later this year, detailing the move to an opt-out system.

BMA Welsh secretary Richard Lewis has outlined how the system, with safeguards, could work.

He said: 'The system which could operate in Wales would consist of creating a list of people who are eligible to become donors with a considerable lead-in time…

'Every opportunity would be provided to the people of Wales to make the choice of removing their names from that list if they did not wish to donate, with no obstacle in their path.

'I do not perceive there would be any element of coercion … as people would be given a long lead-in to make their choice to either leave their name on the proposed list or to remove it.

'The opt-out system with safeguards should, in my mind, offer every opportunity for people to choose not to donate their organs if that was their wish.'

It is understood that relatives and loved ones would still be consulted about donation under the opt-out system being considered by the Welsh government.

The BMA reaffirmed its support for an opt-out system at the BMA annual representative meeting in Cardiff earlier this year.

SAS and locum bottlenecks point to delayed revalidation

BY ANITA WILKINSON

NHS ORGANISATIONS are gearing up for revalidation but will need to do more before its introduction next year, a report suggests.

The update on organisational readiness from the NHS Revalidation Support Team suggests progress is being made in clinical governance and appraisal systems, but points to several areas of concern.

In particular, it highlights low levels of appraisal among staff grade, associate specialist and specialty doctors, and a lack of insight into the readiness of locum agencies. It also shows that more help is needed for doctors in difficulty.

BMA council GMC working party chair Brian Keighley said: 'The BMA recognises there is a political imperative to bringing in revalidation by the end of next year, and that the NHS Revalidation Support Team is working to assure that process.

'However, we are aware of a very patchy application of appraisal across many areas of the profession in England, especially among locums and SAS doctors.

'There is still no information on arrangements for remediation. And whilst progress is being made, the jury is still out as to whether the date for implementation will be achieved.'

The ORSA (Organisational Readiness Self-Assessment) report provides a window on the progress made by 507 designated bodies in England by the end of March this year. While nine out of 10 of the organisations approached responded to the questionnaire, only five of 55 locum agencies did so.

Nearly all (98 per cent) responding organisations had responsible officers three months after regulations requiring their nomination or appointment came into effect.

In addition:

- 52 per cent had medical appraisal policies with core content
- 92 per cent had governance structures in place
- 83 per cent had processes for investigating concerns about doctors' practice
- 30 per cent had policies for rehabilitation, remediation and targeted support.

Nearly three-quarters (74 per cent) of doctors had completed appraisals since April last year, but this dropped to less than a third (31 per cent) for SAS grades.

In his foreword to the ORSA findings, NHS medical director Professor Sir Bruce Keogh says: 'Whilst the report shows that systems of clinical governance and appraisal have improved over the past two years, I have a sense from the report that not all organisations grasp the importance and benefits of this process either for their staff or for the organisation.'

Attacks on staff demand integrated response system

DOCTORS LEADERS have called for a joined-up approach to tackling abusive patients.

The BMA responded after it emerged that NHS employees in Northern Ireland had reported more than 11,000 physical attacks since April 2009.

At the moment, there is no system across the health service in Northern Ireland to warn workers when they are treating potentially dangerous patients.

BMA Northern Ireland council chair Paul Darragh said that it would be difficult to find a frontline NHS employee who had not been assaulted while they were at work.

He said: 'That is particularly true if you've worked in an emergency department. I've been assaulted a number of times.

'On one occasion, a colleague of mine was punched in the face by a patient and his glasses were broken.

'This is a problem that is getting worse. I think we need to get the message across that violence towards healthcare employees is unacceptable.

'The health, social services and public safety minister has mentioned the possibility of introducing a flag system for patients who have been violent, and that is something we would welcome.'

ROAD TO WELLVILLE: three hundred patients benefited from a partnership between optician chain Vision Express and health charity Second Sight last week. The company funded 300 cataract operations provided by Second Sight on World Sight Day on October 13. Second Sight, was founded and is run by London staff-grade ophthalmologist Lucy Mathen. Bhagelu Manhji (pictured) had lost his job pulling a plough after he went blind. He walked 28km to hospital, guided by his young son. He was able to walk home unaided. See www.secondsight.org.uk

Lords reject health bill delay

NHS REFORM

Peers rejected moves to block or delay the Health and Social Care Bill last week. The bill will now be subject to detailed scrutiny by the Lords until the end of the year. The BMA, which wrote to peers highlighting key fears about the bill before the two-day second reading debate, will continue to press for major amendments. BMA council chairman Hamish Meldrum said: 'It remains the BMA position that the bill should be withdrawn, or that it should be substantially amended, and we will continue to raise our concerns at every available opportunity as the bill progresses through the House of Lords.' For updates go to www.bma.org.uk/nhsreform

GP survey results due next week

The BMA GPs committee is due to release the final results of its National Survey of GP Opinion 2011 next week. More than 18,000 GPs took part in the postal questionnaire. Interim analysis, published in June, found that one-third of the first 10,000 respondents were extremely concerned about potential conflict of interest between members of GP consortia and patients. More than three-quarters disagreed or strongly disagreed with 'quality premium' proposals to link practice income to consortia financial performance. See www.bma.org.uk/gpc

BMA to meet care review team

Doctors leaders are to meet the team carrying out a review of health and social care in Northern Ireland. Health and Social Care Board chief executive John Compton is leading the team, which is expected to report in November. BMA Northern Ireland has raised concerns about the short timescale. BMA Northern Ireland GPs committee chair Tom Black will meet Mr Compton soon, while other committee representatives are expected to meet the review panel. BMA Northern Ireland secretary Danny Lambe said doctors were keen to engage with the review team as much as possible to ensure any changes improved patient care.

GMC launches twin consultations

The GMC wants doctors' views on its proposals for supporting professional development and revalidation. The consultations end on January 27, 2012, and follow-up guidance will be issued in the spring. Find out more at www.gmc-uk.org

SAS blogs focus on bullying

Personal perspectives on work-life balance, bullying and harassment have been added to a BMA resource for staff grade, specialty and associate specialist doctors. The Strength to Strength blogs can be seen at blogs.bma.org.uk/strengthtostrength/2011/
The BMA staff, associate specialists and specialty doctors committee e-newsletter is also now available at www.bma.org.uk/sasc

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Language testing gains momentum

The GMC must be allowed to test the language skills of all non-UK applicants who want to work in the UK, peers have insisted. There should also be an alert mechanism for regulators to share fitness-to-practise information and warn each other about practitioners who have been subject to disciplinary procedures, according to a Lords subcommittee. *Safety First: Mobility of Healthcare Professionals in the EU*, published this week, says the current rules allowing health professionals to work in other European states 'pose an unacceptable risk to the safety of patients'. The BMA has been calling for the rules to be changed on language testing.

Take patients off list as a 'last resort'

Removing patients from a GP practice list should only be done in exceptional circumstances and as a last resort, according to the BMA. The comments come in response to a report by health ombudsman Ann Abraham, *Listening and Learning: the Ombudsman's Review of Complaint Handling by the NHS in England 2010/11*. The report says 21 per cent of the 48 complaints about GPs investigated by the ombudsman were about patient removals. The BMA pointed out the complaints involved a very small minority of GPs. The Medical Defence Union said it has received calls to its advice line on the topic and urged GPs to think carefully about resolving disputes.

Schools receive migraine guidance

Guidance to help schools, teachers and parents cope with the impact of migraine and headaches in school-aged children has been published. *School Policy Guidelines for Students with Migraine and Troublesome Headache*, developed by the Royal College of GPs and the charity Headache UK, provides advice on identifying the causes of the problem, tips on reducing the impact of migraine and headache and easy-to-follow treatments. Schools are also provided with a series of sample policies, letters and documents that they can adapt and issue to parents and students. Download the guidance at www.rcgp.org.uk

The story so far on providers

NHS REFORM

A new BMA briefing on foundation trusts and other healthcare provider models is available on the BMA website. *What We Know So Far … Foundation Trusts and Other Provider Models* outlines the policies that have led to the introduction of new models for healthcare providers in England and identifies the NHS reform proposals that will affect them. It also highlights gaps in the available information and areas where uncertainty remains. Download the briefing at www.bma.org.uk/nhsreform

Concern over dementia attitudes

Almost half of people questioned in Northern Ireland believe people with dementia are not treated like thinking human beings, a study claims. *Dementia: Public Knowledge and Attitudes* by teams at Queen's University Belfast and Ulster University, who questioned 1,200 people, also finds the majority believe those with dementia should be involved in activities in the community. Report co-author Maria McManus said: 'The views reflected by the survey confirm much of what needs to be challenged about attitudes, care and services for people with dementia and the need to address this in public policies and research, as well as in practice through the provision of services.'

Call to respect neutrality of physicians

Healthcare professionals 'must not be prevented from fulfilling their ethical, moral and professional duties' during armed conflicts or violent civil unrest. This new statement from the WMA (World Medical Association), issued during its general assembly in Uruguay, also insists the neutrality of physicians, other healthcare personnel and the institutions in which they work must be recognised, respected and protected in such situations. The WMA called for international bodies to start collecting data about assaults on physicians, other healthcare personnel and medical facilities in armed conflicts. It also suggested a new United Nations post of rapporteur on the independence and integrity of health professionals. Find out more at www.wma.net

Council co-operation pays off

BY ANITA WILKINSON

NHS REFORM

THE HEART of new health and social care structures across the NHS and local authorities must include commissioning groups, a leading council figure has insisted.

North Tyneside Council strategic director of community services Paul Hanson said GPs and other clinicians had been valuable in shaping commissioning arrangements for his council-hosted shadow health and well-being board.

Under the Health and Social Care Bill, such boards are meant to promote integrated working between the NHS, public health and social care in England.

Mr Hanson told last week's BMA North-East regional council meeting that initial investigations had revealed a 'very stretched' relationship between how the senior local government team and senior clinicians spoke to each other.

But he added that when the council approached GPs to be part of the commissioning structure for adult social care 'they grabbed that with both hands and it made a real difference'.

Mr Hanson said clinicians had provided input into strategies to avoid hospital admission and for the management of long-term conditions.

He said the council was also considering altering its learning disability commissioning to reflect the clinical approach.

He said: 'It's been really good for us, having those GPs and one or two of our local surgeons just turn up and think about this differently.'

Mr Hanson said the initiative had been beneficial for doctors. He said: 'It's also allowed some of them to indulge their passions.

'We have one GP who is absolutely committed to non-clinical responses to health improvement and we have put her in a room with my head of sport and leisure and housing team.'

North Tyneside Council's health and well-being board has representatives from the local clinical commissioning group, the new health and social care 'consumer champion' Healthwatch and directors of public health, children's and adult services.

for GPs

● Doctors in the North East backed the BMA stance on NHS reforms at their regional council meeting.

More than three quarters of doctors at the meeting voted to support action by BMA council chairman Hamish Meldrum in his dealings with the Health and Social Care Bill.

BMA North-East regional council chair George Rae wrote to Lords Labour health spokesperson Lord Beecham last week outlining 'grave concerns' in the north-east over the government bill.

Deanery transition uncertain

THERE IS still uncertainty as to how deanery functions will be transferred to HEE (Health Education England), a meeting has heard.

Postgraduate deaneries are currently due to become part of HEE by April 2013 under the government's reform plans.

Chris Welsh, the newly appointed medical director of the merged strategic health authority NHS Midlands and East and interim postgraduate dean for NHS Yorkshire and the Humber, said: 'There is a joke that two things will survive a nuclear war — cockroaches and deaneries … [Deaneries] have survived.'

The future for postgraduate deaneries looked uncertain under the government's plans for education and training as part of its wider NHS reform proposals.

The BMA was one of the organisations insisting the deanery structure be retained and the government has since agreed to safeguard it.

Professor Welsh told last week's BMA Yorkshire regional council meeting that he did not yet know how the transfer to HEE would work.

He said: 'Deaneries over the next 18 months will have to change into HEE, precisely how that will happen I can't tell you.'

He said HEE would receive all the money within the NHS currently used for health education.

Regional council chair David Pring told the meeting in Wakefield that one of the great worries for doctors was the aspiration to have multidisciplinary training funding coming from one budget.

The meeting also heard Doncaster GP Rosie Hamlin, acting chair of Yorkshire and Humber Local Medical Committees Alliance, raise concerns that emerging CCGs (clinical commissioning groups) were putting 'downward pressure' on GP practices to control costs.

Obesity drive not enough, says BMA

The government's bid to tackle obesity is a welcome move but does not go far enough, according to the BMA. The Department of Health announced an obesity call to action last week, to reduce the number of overweight or obese people in England by 2020. Health secretary Andrew Lansley wants businesses to play a greater role in helping slash five billion calories off England's daily diet while chief medical officer for England Professor Dame Sally Davies (pictured) wants everyone to be more honest about their own eating and drinking habits and cut down accordingly. However, the BMA would prefer to see legislation such as mandatory food labelling, restrictions on advertising unhealthy food and reductions in salt, sugar and fat content in pre-prepared meals.

Website tackles breast cancer in men

Breast cancer among men is the latest topic to be covered via real-life stories on a website. The condition appears on www.healthtalkonline.org, an award-winning website about patients' experiences of illness. It aims to raise awareness among patients and GPs that the condition affects men as well as women.

Commissioning board chair emerges

An environmental lawyer and academic has been named as health secretary Andrew Lansley's preferred choice to chair the NHS Commissioning Board. University College London president and provost Malcolm Grant appeared before the Commons health select committee in a pre-appointment scrutiny hearing this week. As chair of the board, which is a central part of the government's health reforms, he will provide strategic leadership and vision for NHS commissioning. Professor Grant has previously chaired the Local Government Commission and is a UK business ambassador.

NHS REFORM

Pressure builds for fair medics retrial

Leading doctors from around the world have signed a joint letter to the King of Bahrain urging him to protect the physicians of his country. The appeal by members of the World Medical Association council, including the BMA's former president Professor Sir Michael Marmot, calls for the Bahraini physicians and other health professionals facing lengthy prison sentences for treating people during the civil unrest, to be given a fair retrial. King Shaikh Hamad bin 'Issa Al Khalifa was also urged to reinstall the elected leadership of the Bahrain Medical Association after its recent takeover by the government.

Fast-track decisions on drugs reined in

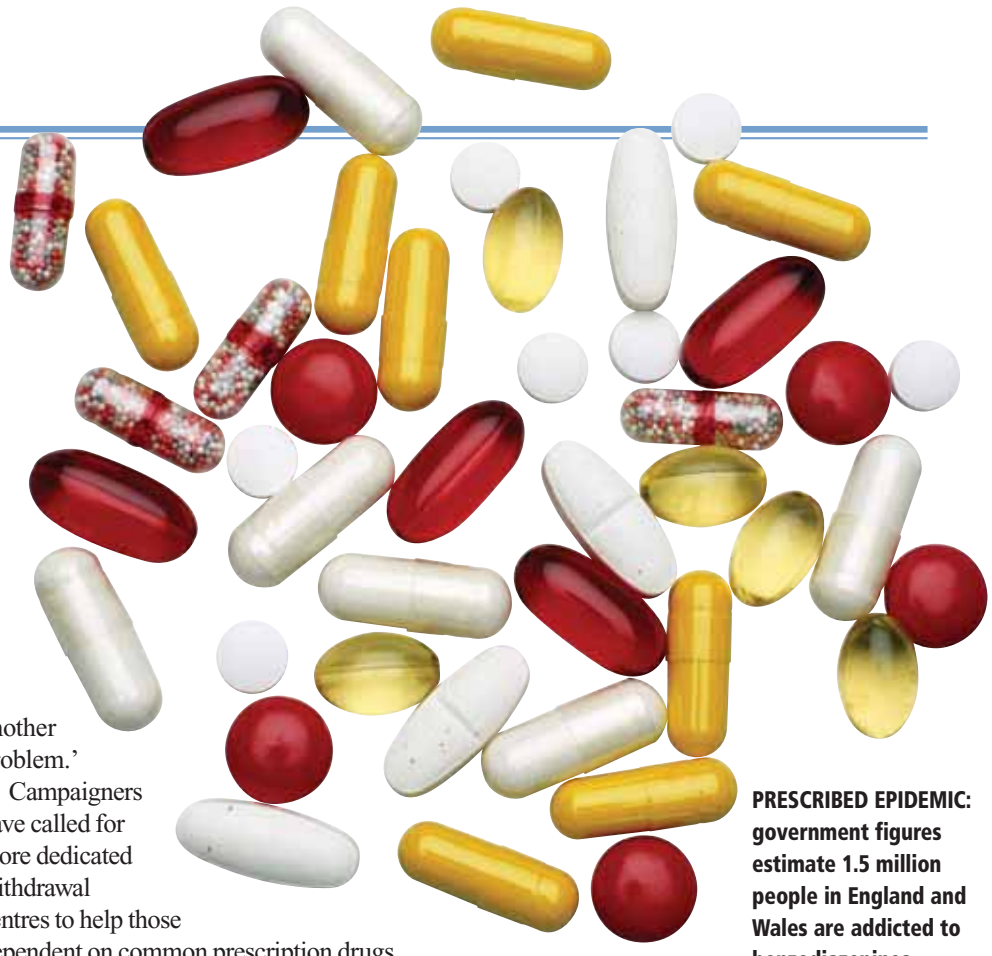
A decision framework on the use of new drugs and devices in the NHS has been published. Its aim is to reduce fast-track recommendations being made by NICE (the National Institute for Health and Clinical Excellence). York University's Centre of Health Economics, which carried out the research, found that NICE was making more fast-track decisions when the evidence base to support the technologies was limited. Researchers want NICE to make more 'only-in-research' recommendations — so a drug or device could be approved for use in an appropriately designed programme of evidence development. Read more at www.york.ac.uk/che/publications/in-house

Royal colleges launch allergy scheme

A new project has been launched to improve the quality of NHS specialist allergy services. The joint committee of the Royal College of Physicians of London and the Royal College of Pathologists created the registration scheme called Improving Quality in Allergy Service. Under the scheme, allergy services will have to meet a certain quality level. Joint committee chair Andy Wardlaw said: 'This is an important step on the road to making sure allergy services are adhering to an agreed set of standards.'

Benzo nation

Cross-bench peer John Montagu, the Earl of Sandwich, is using the passage of the Health and Social Care Bill through the Lords in a bid to secure action on benzodiazepine over-prescription and addiction. Jenna Pudelek reports



PRESCRIBED EPIDEMIC: government figures estimate 1.5 million people in England and Wales are addicted to benzodiazepines

WIDELY PRESCRIBED for anxiety and insomnia since their launch in the 1960s, benzodiazepines were seen as safe, cheap and effective, even in the long term.

Affectionately known as 'mother's little helpers', they were introduced as a safer alternative to barbiturates. But by the late 1980s concerns were raised about their potential for creating dependency.

Now, controversy is mounting over the number of patients addicted to drugs prescribed by doctors — which government figures estimate at 1.5 million in England and Wales — and the help that is available to them from the NHS.

The latest reports, commissioned by the Department of Health, show that prescriptions of these drugs have been rising since 2006.

John Montagu, the Earl of Sandwich, a cross-bencher in the Lords, has been campaigning for prescription drug addiction to be given a higher profile, claiming successive governments have ignored the problem.

Lord Sandwich says people who take 'benzos', such as sleeping pills, and other prescribed drugs — including SSRIs and Z-drugs — are not aware of the risks of addiction.

Having witnessed a relative suffering benzo addiction, he says withdrawal could cause 'pain in excess of withdrawal from heroin'.

Some say doctors have not been doing enough to discourage the use of these drugs or to help those dependent on them.

However, GP leaders say that the problem is far too complex to simply blame 'bad' doctors.

Unsupported withdrawal

Baylissa Frederick, who runs Recovery Road, a helpline for prescription drug addicts, says she found no support available during her withdrawal from clonazepam, which was prescribed for a facial tic.

Ms Frederick says that when she gradually stopped taking the pills, she suffered seizure-like involuntary movements, hallucinations, dizziness, profuse sweating and jelly legs, and felt as though insects were crawling over her skin.

She adds that before her tapered withdrawal between 2005 and 2007, she had begun to lose her memory and had to give up her job as a mental health counsellor.

Ms Frederick says: 'I think the problem is getting worse. There has not been that much research. The last set of reports [by the National Addiction Centre and National Treatment Agency for Substance Misuse] showed an increase in the number of prescriptions.

'In terms of helpline usage, I've noticed an increase in the number of people from the UK getting in touch with me.

'I don't think GPs are being given good advice in terms of discouraging [the use of prescription drugs] and coming off them.

'I have a lot of alarmed people calling to say their GP has told them they must come off and they are being rushed off the medication, which in itself causes another problem.'

Campaigners have called for more dedicated withdrawal centres to help those dependent on common prescription drugs.

Lord Sandwich's family member began withdrawal from clonazepam two and a half years ago. He was told to stop 'cold turkey', which left him leading a half-life in his room, suffering from agoraphobia, panic attacks, dizziness and insomnia.

Since then, the peer has led a short debate in the Lords, and asked questions to highlight the issues. He hopes to use the progression of the Health and Social Care Bill through the Lords to raise the subject further.

He says: 'The health service created the problem of prescribed drug addiction, so why can't they find the funding and design best practice to help its victims?'

At the moment, there are just a handful of specialist treatment centres for involuntary tranquiliser addiction.

'These people are not being recognised because they are suffering at home,' Lord Sandwich says. 'If they are no trouble, they are not a state concern.'

His wife Caroline, Countess of Sandwich, agrees, saying: 'One of the reasons there has been so little publicity [about benzo addiction] is that people on the whole feel terrible and do not want to move. They do not go and steal to feed their habit. They have not been a threat to society, so they have been ignored.'

The couple's relative was prescribed a benzodiazepine after reacting to an anaesthetic in the 1980s. Lady Sandwich describes doctors at the time as being 'pill happy'.

Short-term goals

In 1988, the then Committee on Safety of Medicines recommended that benzos should be prescribed for just two to four weeks for relief of severe or disabling anxiety, and not for the treatment of mild anxiety.

The guidance was repeated in 2004 by the then chief medical officer for England Professor Sir Liam Donaldson and again in 2007. But the latest figures show that prescriptions have been rising again: according to NHS Prescription Services, in England they stood at 11.5 million in 2010.

Lord Sandwich says: 'Because [doctors] are so busy, they are primarily concerned with the patient now and not the patient in six weeks or 12 weeks. These cases are often forgotten, and I think that doctors, usually unconsciously, have worsened the process [with repeat prescriptions].'

But GPC clinical and prescribing subcommittee chair Bill Beeby says: 'It is not

BMA Q&A

BMA REPRESENTATIVE BODY CHAIR STEVE HAJIOFF ANSWERS YOUR QUESTIONS

'We will continue to work to defeat the attack on our hard-earned pensions'

Q How did you find your first BMA annual representative meeting as RB (representative body) chair?

A I enjoyed the ARM greatly. Cardiff is a wonderful city, and we had many excellent debates. I have been involved in the running of the ARM for many years, and yet every year I am impressed by the standard of debate, and the thoughtful and balanced policies our representatives develop. I am fiercely proud of this association and its members, and it is an enormous honour for me to have been elected to chair the ARM. The meeting is the highlight of the BMA's year, and a celebration of our democratic values.

Q How are policies set at the ARM being taken forward?

A The BMA council has the responsibility to ensure policy is delivered. The council either does that itself, or it asks the most relevant part of the association to deliver the policy on its behalf. The key, however, is that the BMA must deliver on all its policies, not cherry-pick those that are easy or those that particular members want. This requires wise heads and a lot of hard work.

Q What do you think worked well at this year's ARM?

A I am tempted to say that everything went well, but perhaps I am a little biased. For me, some of the highlights were at the very beginning: the welcome to representatives; the introduction of the senior officers, the agenda committee and our guests from overseas; and the moment of silence for those members who had died in the preceding year. The BMA is about its members. Saying hello and saying goodbye to members at the beginning of the ARM reminds us all who we are there for, and what we are there to do.

I also enjoyed the session with Ben Page, chief executive of market research firm Ipsos MORI, who ran an interactive session on the values and perception of the medical profession, with real-time polling through the meeting.

Finally, there was the on-screen ticker, which allowed members using Twitter to feed their views into the meeting in real time. This was part of a fascinating programme to strengthen dialogue with members across the country, not only during the ARM, but all year round.

Q What kind of issues will you be tackling over the next few months as RB chair?

A I think I have heard the words 'interesting times' more often in the past few months than in the rest of my life put together, and I see no sign of that changing. In England, the Health and Social Care Bill requires continued careful attention to protect our members, our patients and our NHS.

Pensions is an issue of enormous importance to our members, and we will

as simple as saying rogue or bad doctors are the cause; it is far more complicated.'

He adds: 'Patients can become addicted to the medications we prescribe, and we need to be careful about prescribing because it is terribly easy to end up in the wrong situation, having prescribed for the right reason.'

Just stopping not the answer

Dr Beeby says there is a willingness among doctors to recognise that what was normal practice 20 years ago is no longer acceptable. Recently, increased access to psychological therapies has offered an alternative to medication, but he says waiting times for them must be cut.

'It is about being fair, but also being firm and explaining to patients that they cannot just keep swallowing tablets,' he says.

'Some of my colleagues worry that if they don't prescribe [benzodiazepines], the patient may buy them on the street or turn to more harmful substances such as alcohol.

'Just stopping is not the answer. People need to be steered through a different pathway and managed sympathetically and fairly.'

He says it is better for some patients never to start them, but points out there are a lot of people already on them.

'Only with the benefit of hindsight can we appreciate the size of the problem,' he says.

'Most people did not spot it because [these drugs] tend to be relatively harmless even in long-term use, and were thought to be much safer than the older sedative drugs.'

So do doctors keep patients on benzos because it is easier and cheaper? Dr Beeby says: 'I would not buy into that one … But you cannot suddenly take every patient who is dependent and give them the appropriate amount of time.'

Asked if there is a need for more withdrawal clinics, he adds: 'A need maybe, but it will be competing for funding with many other services.

'There is certainly a need to provide a tailored service for this type of problem, rather than expecting people to attend clinics that are more focused on opiate misuse.'

If Lord Montagu gets his way, the Lords Health and Social Care Bill debates will shine a light on more than just NHS reform.

continue to work hard to defeat the government's wrong-headed attack on our hard-earned and fair pension arrangements.

Whether labelled 'productivity', 'efficiency savings', 'turnaround' or whatever, the NHS in all parts of the UK is facing significant budget cuts. We will continue to fight to protect our members and our patients and to prevent our NHS being whittled away.

There are many other issues, particularly on the professional side of the association, but there is one in particular I would highlight that is very apposite given the recent incarceration of several doctors in Bahrain. We will continue to fight for the right of doctors to be able to deliver necessary care to all those who need it without fear of persecution, arrest or dismissal wherever they are in the world.

CITY LIMITS

GENERAL PRACTICE IN THE INNER CITY

SHE IS so very young. Her name is Juliet. She left school last year and valiantly tried college but could not cope with it, largely because she did not have a moment's peace at home to study.

She was living with Dad, and Dad's friend — aged 40 — was always there, looking at her and commenting on her charms. One night he tried the door of her room and she actually climbed out of the window, fled to Mum's house and lived there for a whole week until she was told, unceremoniously, to leave.

Now she is back at Dad's. Fortunately, the friend has gone. But Juliet has been scared and weepy for months, and has acquired the label of depression and the sickness certificates to go with it. After hearing Juliet speak of her tablets and her great wish to be done with all her problems, one of my colleagues has referred her to the mental health team, who will be seeing her in a few weeks.

Reasonably enough, she has been assessed by the benefits doctors and has been found a work placement by Jobcentre Plus; the hope is that she will get back into work or training when the depression or whatever lifts.

What is quite unreasonable — to my mind quite absurd — is the nature of the placement. Juliet, weighing some 44kg (6st 13lbs), has been placed in a heavy industrial unit, where she has no hope of lifting the machinery she is meant to move about with. She has been looking at the big metal clamps in her workshop and considering putting her head in one of them, or sticking her fingers once and for all in a high voltage plug. There is no hint of melodrama as she reports this, and I believe her.

'She has been looking at the big metal clamps in her workshop and considering putting her head in one of them'

She seems extraordinarily frail and vulnerable as she sits in the surgery, but she is determined not to cry. I am struck by her isolation. By her account, neither parent is interested in supporting her financially or emotionally, and there is no one such as a college mentor or a social worker or even a friend who is entirely on her side.

As GPs, we have done what we can so far: we have listened; she is taking medication, which might help a little; she is awaiting mental health assessment; and we are also pushing forward an appointment with the practice counsellor. But it does not feel like enough. I am sorely tempted to ask her round for supper tonight with my teenagers, who are of a similar age to her, but of course that is absolutely not allowed, would blur every boundary in the book, and would probably not help that much. For the moment, and at an age only slightly more than that other Juliet, she has to shoulder her problems largely alone. I am very sorry.

Flora Tristan is an inner-city GP

SEE ONE, DO ONE

WORKING AND SURVIVING AS A JUNIOR DOCTOR

I'VE RECENTLY started doing clinics, and have discovered a whole new world of getting things wrong. I sat through scores of clinics as a student, but seemed to absorb nothing about how to navigate the logistical traps that can snare the unwary junior doctor in outpatients.

Calling patients is always tricky. On several occasions I've stuffed my head so full of side-effects to ask about, that I've forgotten the patient's name by the time I've got to the waiting room, and have had to return to my room to check. These are generally the days I have a medical student with me, who must wonder about my tendency to pace the corridor.

I also have yet to perfect my facial expression for the disorientating situation of standing in the waiting room after finding no answer to my summons. Currently, I go through a rapid succession. First, I accusingly scan everyone who remains unresponsively seated. Then I look anxious as I worry I might have got the name wrong. Then it occurs to me the patient might be in the toilet, and I look hopefully towards the door. I might catch the eye of the receptionist, and raise an eyebrow in query. Finally, I look forlorn as I accept the probable DNA. All good entertainment for those waiting, but I wish I could achieve a calm look of professional equanimity.

However, I think the greatest difficulty of all is keeping to time. And I do wonder if I have some patients who take tardiness particularly badly. On one notable occasion my first appointment of the clinic ran 50 per cent over, and I was scrabbling to make up time. I spotted a patient I recognised in the waiting room, and invited him straight in. Slick.

'It turned out that the woman I'd been late for, and bypassed in favour of someone else, had deep-seated problems with rejection and abandonment by healthcare staff'

Four minutes in, the phone went and the reception staff told me I had taken the patient after the one who was due.

'Do give my apologies to the earlier lady. I'll be with her as soon as I can,' I intoned suavely, aware of the gaze of the patient in front of me.

We continued the consultation and were just hitting suicidal ideation when the phone went again.

'You need to come out. Now. She's very angry.'

Fortunately, the incumbent patient returned to the waiting room without too much grovelling being required from me.

The ensuing consultation did not go well. It turned out that the woman I'd first been late for, and then bypassed in favour of someone else, had deep-seated problems with rejection and abandonment by healthcare professionals. My predecessor had planned this would be her last review with the service, but my tentative reminder of this fact was met with rage. So long did her anger simmer, I had to see her twice more.

Claudia Fry is a core trainee 2 in psychiatry

See One, Do One is a 450-word column about life as a junior doctor. If you would like to submit an article for this column, use the contact details on letters page 9. Payment is made for those published.

Paper doctors

While there has been a long tradition of international and European students seeking UK medical qualifications, I question the establishment of money-making overseas schemes by universities ('Education goes international', October 1, 2011, page 9).

I am also appalled to read that, following the completion of their courses, these students will not be able to achieve foundation doctor 1 competencies, and therefore will not be eligible for full registration.

I wonder what job prospects these young people have, with medical degrees but no registration in the UK or their home countries.

In my opinion, none of these courses should be approved until this question has been addressed.

Haiko Jahn MB BS
London

In search of psychiatry

Anne Pang's article epitomises everything that is wrong with British psychiatry, and does nothing to entice doctors into this sadly unpopular specialty (Voicebox, October 8, 2011, page 8).

None of the three patients she saw in a two-day period were diseased. All three were just unique people reacting to social adversities in their own ways. This might be interesting to social scientists, psychologists or the criminal justice system, but it has nothing to do with medicine.

Medical graduates want to treat ill people with evidence-based medical treatments. Thankfully, I can confirm that doctors do encounter patients with real diseases in psychiatry: schizophrenia, endogenous affective disorder, dementia and other organic illnesses of the brain.

Their assessment and treatment ensure that the practice of psychiatry, while challenging, remains fruitful and truly rewarding.

Rich Braithwaite BM MRCPsych
Isle of Wight

Cords and tweed optional

While Joseph El-Khoury might well exhort us to reject anachronistic images such as the psychoanalyst's couch, I am not sure I am ready to accept his alternative of the antidepressant capsule as a way of promoting psychiatry ('Get off the couch', October 1, 2011, page 8).

My point is not that pills are less sexy, as Dr El-Khoury suggests (although some drug-company advertising would like us to think otherwise, and I am sure Freud would have revelled in the very thought), but that the medication metaphor does seem to strip something of the heart out of the psychiatry I signed up for.

You do not need to reject biology in order to maintain a focus on our specialty's proper objects of interest: notions of despair, hopelessness, relationships, meaning, purpose in life, and so on.

It is worth noting the irony that recent advances in neuroscience have done far more to further the cause of psychotherapies than that of psychopharmacology in this regard.

What would be my own preferred image for the psychiatry of the new millennium? Perhaps a coffee table and some nice chairs.

I would like to hang on to the tweed and corduroy if possible, but accept that this is negotiable.

Andrew Flynn MB BS MRCPsych
London

London is leagues ahead

I recently moved from London to a rural area because of family commitments after completion of my psychiatry core training and membership exams.

I was surprised at the differences. In London I did paperless or paper-light clinical record keeping in Jade and Rio electronic patient record systems. It was easy to find the clinical details of patients.

Now I have one set of notes for community and one for inpatient wards, and it is difficult to find out what has happened in the community if you are an inpatient clinician. We write on continuation sheets that are photocopied and not even ruled.

In London a single admission document was printed on expensive paper, and the expectation was to fill out as much of it as possible and complete it later.

Academic meetings were once a week in London, and everyone who attended them was a trainee. If you failed to come, you would be named and shamed.

Here meetings are every fortnight and only GP vocational training scheme trainees show up.

I can understand why new doctors are reluctant to work in remote areas; I have worked in most rural areas in the UK and in affluent areas such as London.

There is a clear difference in resources and training facilities; rural practice and resources are well behind by a few years compared with London.

Name and address supplied

VOICEBOX

'As budgets are cut, the gaps in the rota widen as fast as the hospital's deficit'

I WAS infuriated recently to find the local branch of my bank closed to customers, after it became the target of a protest about NHS funding. I thought about the irony of the NHS taking over my bank, especially because my hospital is beholden to an investment arm of Barclays Bank.

In 2003, my hospital was built as part of a PFI (private finance initiative) partnership, with Barclays stumping up around £150m. Every year, for the next 35 years, the trust pays at least £21m back. The latest estimates are that the total amount paid back will be in the region of £1bn.

As budgets are cut and departments are closed, the gaps in the rota widen as fast as the hospital's deficit; the trust overspent to a tune of £80m last year.

Regardless of the performance of the trust, regardless of the needs of the local community, despite the changing financial environment, the bank pockets the same, nice tidy sum every year, while patients suffer the healthcare of austerity.

There are, of course, a plethora of suggested solutions. The ubiquitous management consultancy McKinsey has suggested the trust sells off some of the empty buildings — sites of now-closed departments that are not under PFI agreements. This would raise about £20m, just enough to pay the PFI for a single year — hardly a sustainable solution.

In any case, the PFI payments are guaranteed and enshrined in law; the jobs of nurses, physiotherapists and doctors are not. It doesn't take a management consultant to work out where the axe will fall when the PFI man comes knocking. Money needs to be found, and more than half the trust's expenditure goes on wages. McKinsey is not likely to suggest that we stop paying its fees.

Perhaps the protesters in my bank were on to something. It says a lot about our national priorities when banks are bailed out while hospitals get sold out.

Our current political masters have made much of the need to reduce the nation's debt, but have so far done nothing to reduce the estimated (PFI contracts are kept secret) £65bn that the NHS owes PFI consortia. There are committees to discuss it, press releases made, sound bites mouthed, but every day under these schemes is a day Barclays' investors take priority over our patients' care.

If you work in a PFI trust, look around you. If everything is running fine, and there are no financial pressures compromising patient care, then you can rest easily. If not, you should do something about it. Let's get the banks out of our hospitals; perhaps that way, we could keep the NHS out of our banks.

Name and address supplied

Voicebox is your 500-word forum to raise issues affecting today's doctors. Submit articles for consideration using the contact details in 'Contact us'. Payment is made for those published.

Satisfaction on call

I read the September 24 edition of *BMA News* during a Sunday afternoon on call — admittedly an uncharacteristically quiet one at the large district general hospital where I work.

While I am in agreement with Rosie Wellesley's support of Gopalakrishnan Deivasikamani's letter, I feel I need to comment on her recurring nightmare about being the medical registrar at the beginning of a bank holiday weekend ('Living the nightmare', September 24, 2011, page 8).

As a medical registrar, this is not a nightmare but a common reality for me. In fact, it is often the part of the job I find most enjoyable.

Yes, it is busy and there is a lack of resources, but I get to work in a close-knit team, and can do some on-the-job teaching with juniors. It is also the time when I get the most satisfaction by instigating treatment that turns a critically unwell patient into a stable one.

We all make our career choices for different reasons, and I respect my colleagues whatever specialties they work in.

Emma Johnston MB BS MRCP
London

TOP FIVE ONLINE

Most viewed stories last week on www.bma.org.uk/bmanews

1. BMA welcomes new revalidation advice
2. Instincts over insulin
3. Primary care faces crisis as reforms fuel GP retirement
4. Doctors urge peers to protect NHS
5. See One, Do One: Stuck in the shallow end

Failure to cope is a fact

Shankar Kamath takes great exception to the phrase 'failed to cope at home', and equates it with ageism ('Appalled by ageism', October 1, 2011, page 8).

This phrase is, however, often a very accurate description of patients. It is, alas, not an infrequent reason for attendance at emergency departments.

Of course, it is just a description and not a diagnosis, and it should not be used as a convenient pigeonhole to put patients in. Careful assessment is required to ascertain the reason for not being able to cope.

It is not an ageist phrase, but older patients are more likely to fall into this category because of their chronic medical conditions and often suboptimal social support.

I do hope that we will not be further constrained from using useful, descriptive terminology for fear of antagonising the politically correct police.

Michael Dudley MB BS FRCA
Keighley, West Yorkshire

Sun shines on socialist ideas

Wales has relied on a socialist health policy for the general well-being of the working class and the ban on teenagers using sunbeds seems to be a welcome new rule.

Public health is an often under-recognised component of the NHS and yet a common-sense approach results in the most significant improvements in life expectancy.

Early intervention in the teenage population may be the most effective way of minimising long-term risks.

I would like to continue supporting such policies in Wales and encourage health commissioners to keep taking bold steps.

Pappu Reddy MB BS MRCPsych
Cardiff

No reward for hard work

Pay has been frozen for many years and now pensions are being attacked, yet still we are expected to deliver the best care regardless and in an ever changing political climate.

Let the government have the dignity and decency to reward those still going the extra mile, or however far they can, by not eating away at clinical excellence awards. Please fight it on this issue on our behalf.

Peter Strouhal MB BS FRCR
Birmingham

Stamping out goodwill

Attacking CEAs (clinical excellence awards) is truly beating the stuffing out of goodwill and professionalism, which consultants in the UK have an abundance of.

I have always viewed CEAs as compensation for time spent away from my family.

I have resisted private practice to a large extent in favour of working for the NHS nationally and locally, as well as having a full commitment to research and development and training.

I, like many colleagues, will have to consider my future in a more selfish light, and perhaps divert time spent helping the NHS thanklessly to private practice, where the rewards will be more tangible.

Raj Persad MB BS FRCS(Eng)
Bristol

Improve access to vaccines

If chief medical officer for England Professor Dame Sally Davies wishes us to have flu jabs, then perhaps she — with her colleagues in the devolved nations — needs to require trusts and health boards to make access to the vaccinations straightforward ('Doctors encouraged to take flu jabs', October 1, 2011, page 2).

If I want a flu jab, then I must clear time in a clinical schedule, drive to a hospital clinic, and then surmount the inevitable challenges of hospital parking.

Is it really worth it? I think it is, but my colleagues might think otherwise.

Clive Morgan MB ChB Dip Occ Med
Cardiff

Protect family and friends

It is important that NHS staff take up the opportunity of flu jabs in order to protect themselves, their families and their patients.

It has been common practice to scare NHS staff into getting vaccinated. I used to be a naysayer and didn't get the flu jab until two years ago, when my partner had a baby. I didn't want to catch flu and bring it home. Since then I have made sure I get vaccinated each year.

This year my trust has incentivised staff to ensure that they take up the opportunity of flu vaccinations. Each employee who chooses to be vaccinated is entitled to a flu day, which is an extra annual leave day to be taken from April 2011 — a win-win situation by all accounts.

The only grumbles are heard from those who have religiously taken flu jabs year in, year out.

Should we be pushing for backdated flu jab days? And should trainees be able to take their flu days with them when they rotate to new employers in February?

Chris Smith MB ChB FRCA
York

PRIZE LETTER

GPs and the flu-jab dilemma

Department of Health immunisation director David Salisbury is arguing that GPs are being disingenuous by encouraging patients to have flu vaccines but not vaccinating themselves ('Doctors encouraged to take flu jabs', October 1, 2011, page 2).

I thought that only patients in risk groups were eligible for vaccination. In fact, GPs are not supposed to vaccinate patients who do not belong to risk groups. Are family doctors expected to take something that they are denying to other, equally deserving patients?

The argument goes that GPs might pass on flu to patients. There is no evidence to back this. If the argument is that any unvaccinated person could pass flu to others, vaccines should be offered to everyone and not just risk groups.

Hank Beerstecher Artsexamen
Sittingbourne, Kent

The BMA GPs committee responds: The BMA offered its support to the NHS Employers campaign to encourage NHS workers to be vaccinated against flu. A letter was also sent to all GPs from the chairs of the GPCs in all four nations, encouraging practices to ensure their staff were vaccinated.

CONTACT US

If you have read something you would like to comment on, reply to or share with other readers, please write to: The Editor, BMA News, BMA House, Tavistock Square, London WC1H 9JP. Fax: (020) 7383 6566 Dictate: (020) 7383 6122 Email: bmanews@bma.org.uk
WE NEED: Your full name and postal address. Your medical qualification and most recent membership/fellowship of any medical royal college. Letters should be as brief as possible. They may be edited for length and clarity.

The writer of the Prize Letter in each issue will win £50 of Random House books.

Turning the NHS into an environmentally sustainable organisation will take more than switching off the lights in unused rooms. Rather, it demands a complete overhaul of attitudes and behaviour. Polly Newton talks to the medical director of an organisation seeking this ambitious transformation

A green revolution?


MORTIMER: 'our society is not quite healthy'

LIKE MANY doctors, Frances Mortimer has tales to tell of wasteful NHS practice. The lights left on in cupboards, the windows propped open to cool an overheated ward, the packets of equipment discarded half full. All are familiar enough in western medicine.

But Dr Mortimer, medical director of the CSH (Centre for Sustainable Healthcare) and honorary renal registrar, has another story.

She says that during a stint at a major London teaching hospital she once encountered a patient who had driven dozens of miles from home for a blood test that would need to be repeated at regular intervals.

Dr Mortimer offered to arrange future appointments nearer to the woman's home.

'She said no because she would have to pay for parking at her local hospital,' Dr Mortimer recalls.

The anecdote illustrates powerfully that improving the sustainability of healthcare in the UK — the greening of the NHS — goes far beyond switching off the lights in unused rooms.

Clinicians, managers and patients must alter their attitudes and behaviour fundamentally if the carbon footprint of the health service is to be reduced in any significant way, argues Dr Mortimer.

It was in pursuit of such change that she made the decision three years ago to leave full-time clinical practice for what was then the CGH (Campaign for Greener Healthcare), established by former NHS chief knowledge officer Professor Sir Muir Gray under the wing of the healthcare charity Knowledge into Action.

In 2010 the CGH became the fully independent CSH.

It was not a move made lightly by Dr Mortimer; sitting in the CSH's Oxford offices, she describes it as 'traumatic'. But she could no longer ignore the nagging doubts about the path she had chosen.

> 'I looked at the health service and thought "maybe I could make more of a difference"'

She says: 'I was a renal registrar in London, and I'd got to a point where I'd gone through all the different stages you need to get to [in order] to progress your career. I'd done my membership exams and my SHO job.

'I had navigated Modernising Medical Careers, and got the job that I'd wanted. And I got there and I could see my life going ahead and I suddenly sat back and thought: "Is this quite where I wanted to go?"'

She loved the teamwork and the patient care, she says, but felt persistently that 'there was something else bigger going on outside' — that a doctor's role was necessarily limited in scope.

'Even if you help somebody to get well and go back to life outside medicine and hospitals, actually there's something wrong going on there, because our society is not quite healthy.

'On an individual level, a lot of people don't live in a rewarding and healthy way.

'They work too much as well as not taking exercise and [doing] all the things you think of as being bad.

'We consume resources and we see that as normal and good, but we're causing damage and we don't really recognise that.

'It was that feeling that made me step outside. Suddenly I turned around and looked at the health service and thought: "Maybe I could make more of a difference."'

The carbon footprint of care

At the heart of the CSH mission is a desire to engage clinicians and medical students in the greening of the NHS, on the basis that those who deliver care are best placed to know how it can be done with greater efficiency and less environmental impact.

For too long, Dr Mortimer believes, greening has been seen as the preserve of NHS estates and facilities departments, which has meant an inevitable focus on energy use at the expense of other sources of carbon emissions.

Dr Mortimer says: 'Energy use — even though we can all think of so many examples where the heating is on over the weekend in unused buildings, or all the windows have to be open because there's no way to cool down a building — accounts for only 24 per cent of NHS carbon. Another fifth is travel.

'The vast majority is procured goods and services. In other words, it's the actual equipment that we're using all the time and, importantly, it's the drugs as well, which have a huge carbon footprint.

'So it's the medical care itself.'

This clearly presents thorny questions about how far clinical decisions should be guided by environmental considerations, if at all.

Dr Mortimer acknowledges that this is a politically sensitive area.

'I think at the moment I would not be personally, in my clinical practice, prioritising the carbon footprint over any individual patient,' she says honestly.

But she insists that it must be on the agenda before too long. She points out: 'We have to make those decisions about money, don't we? No one likes doing it, but the truth is that if you don't make them consciously you make them unconsciously.'

She envisages a world in which individual NHS trusts have a finite amount of CO_2 to discharge annually; each would have to choose how to 'spend' their kilos, just as they weigh up how to distribute their financial resources.

'We need to start measuring the environmental impact, including the carbon impact, of different options in the same way that we measure the money,' she says.

'We don't always go for the cheapest, but we know which ones are more expensive when we're planning services and capacity, and we factor that in.'

Challenging the system

Dr Mortimer stresses again that it must be clinicians who control or at least strongly influence any decisions about service change based on environmental considerations, but points out that that will only work if doctors are willing to become involved.

For example, she says a doctor coming across yet another patient who complains of having undergone the same diagnostic test more than once for no justifiable medical reason should be prepared to ask questions about the system.

'That whole culture is missing from the NHS,' she says. 'I think people tend to feel quite powerless — that it's not really up to them to do things.

'But there isn't another agency that's going to come in and sort out all these problems.'

Clinicians need to be 'a bit braver', she says; they need to believe that they can help create a better, more modern and flexible service that makes life easier for patients at the same time as reducing carbon emissions. For example, several services could be offered at one location rather than on different sites.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'People are really defensive in the NHS; they think that things are going to be taken away and not given back,' Dr Mortimer says.

'But actually it's crazy the way that we run our real estate in the NHS, that we have all these enormous buildings and we always make everyone come in for everything, and we have these hospitals on different sites.

'We don't do our banking in the way that we did 100 years ago … Other aspects of life have moved on, but the way the health service has evolved has fossilised. It's then defended by people who are scared of cuts.'

The CSH provides a forum and networking facilities for those who want to swap ideas about reducing carbon emissions in the NHS. It played a key role in launching the Sustainable Health Education network in medical schools across England (see 'New ways of thinking', right).

It works with partners throughout the fields of healthcare and the environment, including the NHS sustainable development unit, the Climate and Health Council (see box below), the medical and ethical fair trade group of the BMA, and student network Medsin.

The centre is also encouraging suppliers and NHS procurement to introduce contractual obligations covering maximum waste emissions from equipment.

Sometimes, says Dr Mortimer, such proposals are welcomed by those who might be expected to object.

She says: 'When we've talked to some of the big suppliers, they've actually said: "Hit us with it because we will respond, but at the moment we get absolutely no benefit. We could go to all this effort and then the NHS will go for the cheapest, whatever that is, in the shortest term."

'I'm sure there will come a time when it's pretty challenging for them, but at the moment they could do a lot more than we ask of them.'

A throwaway culture

The CSH is also raising questions about the widespread embrace by the NHS of single-use equipment. Dr Mortimer says single-use equipment was introduced largely as a precaution against prion transfer, but throwaway instruments are now being used for procedures that carry no risk of any such contamination.

She points out that an estimated nine million sets of nail clippers are discarded every year. Again, she suggests that the NHS should work with manufacturers to address the problem — perhaps by making them responsible for the disposal of the goods they produce.

'There is a commercial incentive for these manufacturers to market disposable products,' she says.

'I don't blame companies for trying to make money, but we have to manage the system and make it profitable for them to make things that can be reused...

'[So] they can make disposable things, but they have to think about what happens to them afterwards. Suddenly, the incentive changes for them to make some things that they can reuse the parts from.'

She suggests that manufacturers might be encouraged to lease rather than sell major items of equipment to the NHS and retain responsibility for their service and upkeep, in the way that photocopying machines are leased to corner shops.

'People make money from the service, rather than selling you a piece of kit and making it obsolete six months later,' she says.

There is no doubt, though, that intractable arguments will take place on the route towards a greener NHS.

Dr Mortimer recounts, for example, a recent workshop in which she took to task advocates of proton therapy as a treatment for cancer.

She queried whether the damage caused by carbon emissions during the construction of a proton beam accelerator — complete with concrete bunker in which to house the machine — might actually outweigh the benefits the treatment could bring.

'You have to think about this [damage] being real,' she says. 'It is real and it's killing people. There have been floods in Pakistan worse than there have ever been before, and droughts and failed harvests in East Africa. If you relate even a fraction of any of these natural disasters to climate change, then thousands of people are losing their lives and their livelihoods, and we are buying a quarter of a quality-adjusted life year.'

● See sustainablehealthcare.org.uk/ and www.bma.org.uk/climatechange

New ways of thinking

'WE JUST need to pull people together,' says Stefi Barna (pictured right). 'Everyone feels quite isolated, and they don't feel as if they have any expertise.'

Norwich lecturer in global health and public health Dr Barna is explaining how the SHE (Sustainable Health Education) network aims to connect medical students, clinicians and academics who are interested in sustainability.

Created in 2009 and overseen by the CSH (Centre for Sustainable Healthcare), the network now has a presence in 12 of the UK's medical schools, many of which offer optional modules relating to sustainability in their degree courses.

SHE co-director Dr Barna says the goal is to prepare tomorrow's doctors for environmentally related challenges that have not been faced by today's clinicians.

'Our students are going to be living and working in a somewhat different world,' she says.

At Leeds University medical school, a five-week SSC (student-selected component) was introduced in 2010/11 by foundation doctor 2 and honorary tutor Sarah Walpole.

'I want to enable students and doctors to understand that the more sustainable healthcare systems are not only better in terms of reducing the impact of climate change, but are also likely to give benefits to patients as well,' says Dr Walpole.

At Bristol University medical school, senior lecturer Trevor Thompson broke new ground in 2006 when he launched an SSC on global environment and human health.

Now renamed 'sustainable medicine', the course covers subjects that include climate change, alternative energy sources and water scarcity.

Dr Thompson admits he has occasionally been 'a little surprised' by the scepticism of some students about climate change forecasts.

'I don't try to batter people with it because I think that's highly counterproductive,' he says. 'Really, the facts should speak for themselves.'

CSH medical director and SHE co-founder Frances Mortimer says she hopes such courses can help keep students interested in the environmental aspects of medicine.

'They're open-minded at the beginning [of their medical degree], but often by the end they're quite focused on just getting through their [foundation doctor] posts,' she says.

'So what we're trying to do is bring [sustainability] in at different stages — early on to get concepts and ethical discussions going, and ongoing to try and relate it to the clinical work that they are doing.'

The CHC (Climate and Health Council) was established in 2007 as a platform for healthcare professionals concerned about climate change.

Its board includes BMA director of professional activities Vivienne Nathanson, *BMJ* editor Fiona Godlee and NHS sustainable development unit director David Pencheon (all acting in a personal capacity). The CHC website sets out 10 practical actions for doctors to help tackle climate change.

- Inform ourselves about the basic science of climate change, the health benefits of taking action, and the urgency of doing so
- Advise our patients. Better diet and more walking and cycling will improve their health and reduce their carbon emissions
- Use less energy ourselves (and reduce costs) by more insulation in roofs, walls and floors, turning off appliances and lights, and — where possible — reducing use of goods and services
- Drive less, fly less, walk or cycle more; use public transport; drive efficient cars; share cars; hold meetings by teleconference, video conference or webcasting; attend fewer international conferences
- Influence food menus wherever we go: ask for local food, less meat and less processed food; a low-carbon diet is a healthy diet; drink tap water
- Advocate locally, especially in primary care, to maximise home insulation and uptake of relevant grants
- Advocate for personal carbon entitlements within an equitable, fair-shares global framework such as Contraction and Convergence [a global template for reducing greenhouse gas emissions]
- Advocate to stabilise population by promoting literacy and promoting women's access to birth control, through the International Planned Parenthood Federation (**www.ippf.org**) or Marie Stopes International (**www.mariestopes.org.uk**)
- Be a champion: put climate change on the agenda of all meetings — clinical teams, committees, professional networks; doctors can tip opinion with chairs and chief executives
- Gear up your own influence and that of all health professionals by joining the Climate and Health Council (**www.climateandhealth.org**).

IMPORTANT CHANGE: Prostap DCS is replacing Prostap, which will be discontinued by the end of October 2011, so it is necessary for prescriptions to reflect this change of name. To find out more visit: www.ProstateCancerUpdate.co.uk or contact Takeda UK Medical Information on 01628 537900

PRESCRIBING INFORMATION
PROSTAP* SR DCS/ PROSTAP* 3 DCS
Leuprorelin Acetate Depot Injection 3.75mg/11.25mg
Presentation: Powder and solvent for prolonged-release suspension for injection in pre-filled Dual Chamber Syringe (DCS). Prostap SR DCS Powder: contains 3.75mg of leuprorelin acetate, equivalent to 3.57mg base. Prostap 3 DCS Powder: contains 11.25mg of leuprorelin acetate, equivalent to 10.72mg base. **Indications:** Prostap SR DCS/Prostap 3 DCS: as an adjuvant treatment to radical prostatectomy in patients with locally advanced prostate cancer at high risk of disease progression; as an adjuvant treatment to radiotherapy in patients with high-risk localised or locally advanced prostate cancer; locally advanced prostate cancer, as an alternative to surgical castration; metastatic prostate cancer; management of endometriosis including pain relief and reduction of endometriotic lesions. Prostap SR DCS is also indicated for endometrial preparation prior to intrauterine surgery; preoperative management of uterine fibroids to reduce their size and associated bleeding. **Dosage and Administration: Prostate Cancer:** Prostap SR DCS: 3.75mg administered every month as a single subcutaneous or intramuscular injection. Prostap 3 DCS: 11.25mg every 3 months as a single subcutaneous injection. Do not discontinue when remission or improvement occurs. Response to therapy should be monitored clinically. If response appears to be sub-optimal, it should be confirmed that serum testosterone is at castrate level. **Endometriosis:** Prostap SR DCS: 3.75mg administered as a single subcutaneous or intramuscular injection every month. Prostap 3 DCS: 11.25mg as a single intramuscular injection every 3 months. Treatment should be for a period of 6 months only and initiated during the first 5 days of the menstrual cycle. If appropriate, hormone replacement therapy (HRT - an oestrogen and progestogen) should be co-administered with Prostap DCS to reduce bone mineral density loss and vasomotor symptoms. **Endometrial Preparation Prior to Intrauterine Surgery:** Prostap SR DCS: 3.75mg as a single subcutaneous or intramuscular injection 5-6 weeks prior to surgery. Therapy should be initiated during days 3 to 5 of the menstrual cycle. **Preoperative Management of Uterine Fibroids:** Prostap SR DCS: 3.75mg as a single subcutaneous or intramuscular injection every month, usually for 3-4 months but for a maximum of six months. **Elderly:** as for adults. **Children** (under 18 years)**: Not Recommended** - safety and efficacy in children have not been established. For chronic administration, the injection site should be varied periodically. **Contraindications:** hypersensitivity to the active substance, any of the excipients or to synthetic GnRH or GnRH-derivatives. **Women:** lactation, pregnancy, undiagnosed abnormal vaginal bleeding. **Precautions and Warnings: General:** development or aggravation of diabetes may occur; therefore diabetic patients may require more frequent monitoring of blood glucose. Hepatic dysfunction and jaundice with elevated liver enzyme levels have been reported; therefore close observation should be made and appropriate measures taken if necessary. The ability to drive may be impaired due to visual disturbances and dizziness. **Men:** a transient rise in levels of testosterone may occur initially. This may be associated with tumour flare, sometimes manifesting as systemic or neurological symptoms. These symptoms usually subside on continuation of therapy. An anti-androgen may be administered to reduce the risk of flare (see SmPC, section 4.4). Patients at risk of ureteric obstruction or spinal cord compression should be closely supervised in the first few weeks of treatment. These patients should be considered for prophylactic treatment with anti-androgens. Should urological/neurological complications occur, these should be treated appropriately. **Women:** whilst ovulation is usually inhibited during therapy, contraception is not ensured. Patients should therefore use non-hormonal methods of contraception. During the early phase of therapy, sex steroids temporarily rise, possibly leading to an increase in symptoms, which dissipate with continued therapy. Menstruation should stop with effective doses of Prostap DCS; therefore the patient should notify her physician if regular menstruation persists. The induced hypo-oestrogenic state may result in a small loss in bone mineral density over the course of treatment, some of which may not be reversible. However, during one six-month treatment period, this bone loss should not be important. In patients with major risk factors for decreased bone mineral content, Prostap DCS may pose an additional risk. Before treating these patients for fibroids, their bone density should be measured, and where results are below the normal range, Prostap DCS therapy should not be started. In women receiving GnRH analogues for the treatment of endometriosis, the addition of HRT (an oestrogen and progestogen) has been shown to reduce bone mineral density loss and vasomotor symptoms. Prostap DCS may cause an increase in uterine cervical resistance. This may result in some difficulty in dilating the cervix for intrauterine surgical procedures. Diagnosis of fibroids must be confirmed prior to treatment, by laparoscopy, ultrasonography or other investigative technique. In women with submucous fibroids there have been reports of severe bleeding following administration of Prostap DCS, as a consequence of acute submucous fibroid degeneration. Patients should be warned of the possibility of abnormal bleeding or pain, in case earlier surgical intervention is required. **Side Effects: Refer to section 4.8 of the SmPC in relation to other side effects** - very rare cases of pituitary apoplexy have been reported following initial administration in patients with pituitary adenoma. **General:** adverse events which have been reported infrequently include peripheral oedema, pulmonary embolism, hypertension, palpitations, fatigue, muscle weakness, diarrhoea, nausea, vomiting, anorexia, fever/chills, headache (occasionally severe), hot flushes, arthralgia, myalgia, dizziness, insomnia, depression, paraesthesia, visual disturbances, weight changes, hepatic dysfunction, jaundice, and increases in liver function test values (usually transient). Reactions at the injection site have been reported rarely. Changes in blood lipids and alteration of glucose tolerance have been reported which may affect diabetic control. Thrombocytopenia and leucopenia have been reported rarely. Hypersensitivity reactions including rash, pruritus, urticaria, and rarely, wheezing or interstitial pneumonitis have also been reported. Bone mass reduction may occur. Anaphylactic reactions are rare. Spinal fractures, paralysis, hypotension and worsening of depression have been reported. **Men:** if tumour flare occurs, symptoms and signs due to disease may be exacerbated e.g. bone pain, urinary obstruction, weakness of the lower extremities and paraesthesia. These symptoms subside on continuation of therapy. Impotence and decreased libido will be expected with Prostap DCS therapy. Hot flushes and sometimes sweating are often associated with administration with Prostap DCS. Orchiatrophy and gynaecomastia have been reported occasionally. **Women:** side-effects reported are mainly those related to hypo-oestrogenism e.g. hot flushes, mood swings, including depression (occasionally severe) and vaginal dryness. Breast tenderness or a change in breast size, and hair loss, may occur occasionally. A small loss in bone density may also occur, some of which may not be reversible (see Precautions and Warnings). Vaginal haemorrhage may occur due to acute degeneration of submucous fibroids. **Legal Category:** POM. **Package Quantities:** Prostap SR DCS: one dual chamber pre-filled syringe containing 3.75mg leuprorelin acetate powder in the front chamber and 1ml of sterile solvent in the rear chamber. One 25 gauge needle, one syringe plunger and one injection site swab are included in a single injection pack. Prostap 3 DCS: one dual chamber pre-filled syringe containing 11.25mg leuprorelin acetate powder in the front chamber and 1ml of sterile solvent in the rear chamber. One 23 gauge needle, one syringe plunger and one injection site swab are included in a single injection pack. **Basic NHS Cost:** Prostap SR DCS £75.24; Prostap 3 DCS £225.72. **Marketing Authorisation Numbers:** Prostap SR DCS: 16189/0012; Prostap 3 DCS: 16189/0013. For full prescribing information and details of other side effects, see Summary of Product Characteristics. **Full prescribing information is available on request from:** Takeda UK Limited, Takeda House, Mercury Park, Wycombe Lane, Wooburn Green, High Wycombe, Bucks, HP10 0HH, UK. Telephone: 01628 537900; Fax: 01628 526617. **Date of Prescribing Information:** September 2011. *Registered Trademark of Takeda. PS110937.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Takeda UK Ltd on 01628 537900.

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