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assisted dying – RCGP makes a stand

Following an all-member consultation, the RCGP Council voted in February against a change in the law regarding assisted dying, which is currently illegal throughout the UK. Less than 15% of members responded to the online survey but 47% of those that did were opposed to any change. It was, however, a close-run thing because 40% of members were in favour of a change, with appropriate safeguards; and 11% were in favour of the neutral stance adopted by the RCP.

Meanwhile, cardiologist Dr Dermot Kearney MRCP, retired palliative medicine consultant Dr Kathy Myers FRCP and renal medicine registrar Dr David Randall MRCP (two of whom are CMF members) challenged in court the RCP's decision to take a neutral stance on the strength of a very strange voting process that required 60% of members to vote against neutrality in order for it to be rejected. This process is now concluded, and the RCP has issued a statement including the words 'so that there can be no doubt, the RCP clarifies that it does not support a change in the law to permit assisted dying at the present time'.

'Infodemics' and how to combat them

Epidemics are inevitably accompanied by 'infodemics', and the World Health Organization (WHO) is working hard to combat the excessive and sometimes inaccurate information being disseminated about COVID-19. Social media is mainly responsible for spreading misinformation, but regular news outlets are also sometimes guilty of sensationalising events in such a way as to cause unnecessary fear and anxiety.

The WHO's aim is to give people ready access to the information that will enable them to protect themselves and others without causing panic, and thus mitigate the impact of the global pandemic. To this end they are engaging with all forms of social media and making sure that when people search for information online, reputable sources are at the top of the list.

David Heymann, Professor of infectious disease epidemiology at the London School of Hygiene & Tropical Medicine stressed the need for the public health community to help all forms of social and traditional media to 'better understand what they should be looking for, because the media sometimes gets ahead of the evidence'.

a future for the world's children?

The question mark says it all. A report published by a WHO–UNICEF–Lancet Commission found many causes for concern about the future of children world-wide, including climate change, ecological degradation, mass migration, war, inequality, and self-interested commercial practices.

Although children in developed countries may, on the whole, be doing better than those in less well-resourced parts of the world, it is those countries that are contributing the most to the emissions that appear to be driving global warming, which threatens the future of all children everywhere.

The report also highlights the damage that commercial interests are doing to impressionable children and young people, encouraging them to consume unhealthy foods or engage in potentially destructive behaviours (alcohol, gambling, smoking, etc). Social media poses a threat to children's well-being when it exposes them to bullying and exploitation by sex offenders and drug pedlars.

Sustainable Development Goals (SDGs) agreed by all nations five years ago, have been met by hardly any of them. The report urges governments everywhere to 'harness coalitions across sectors to

overcome ecological and commercial pressures to ensure children receive their rights and entitlements now and a liveable planet in the years to come.'

Lancet, bit.ly/3fr0sm6

learning health systems for low- and middle-income countries

'Institutions in high-income countries (HICs) are the main funders and generators of academic knowledge on health systems in low-income and middle-income countries

(LMICs), and much too often this knowledge reflects their priorities rather than the needs of health systems in LMICs.' This is the problem that a recent report by the World Health Organization seeks to address.

It recommends that LMICs take greater responsibility for disseminating knowledge that results from their own unique experience of dealing with the health challenges that they face. This can be difficult when leaders in healthcare are preoccupied with day-to-day planning and implementation and when systems for accumulating and recording learning are fragmented and not well organised.

To overcome these obstacles, the report recommends that healthcare learning be 'consistent with stated missions and values' rather than prioritising specialist services that attract investment and confer prestige. Learning needs to include the ability to anticipate and respond to emerging developments so as to deal effectively with health crises. Learning in LMICs needs to become more dynamic and collaborative rather than static.

'Ultimately,' the report concludes, 'learning is an important path to the greater self-reliance of national and subnational health systems.'

Lancet, bit.ly/3dbxqFw

medicine shortages in Europe and rising costs in the USA

A Medicine Shortages Survey carried out last year by the Pharmaceutical Group of the European Union (PGEU) found that, of the countries participating, two-thirds were having problems with the supply of over 200 medicines, including vital respiratory and cardiovascular drugs. Countries within the EU with weaker economies were disproportionally affected, but wealthier countries like Finland and the UK were not exempt.

Most of the active pharmaceutical ingredients (APIs) found in drugs are produced in just a few production plants based mostly in China and India. So the problem is caused partly by the inability of these plants to meet rising demand, but also because emissions and quality control inspections take up valuable time and sometimes lead to plant closures. Pandemics like COVID-19 are likely to have a negative impact on output as well.

Jaume Vidal of Health Action International suggests that poor planning by the drug companies in Europe that rely on APIs further exacerbates the problem. It takes time for new drugs to be authorised for use in the EU and local packaging regulations can add to the delay.

Some countries are finding solutions by, for example, allowing pharmacists to substitute a generic version or a therapeutically similar drug for the prescribed medication if it is in short supply.[1]

At the same time, a recent report published in the online journal *Neurology* indicates that the rising cost of medication in America is forcing some people with neurological disorders such as Parkinsons and multiple sclerosis to go without, at the expense of their quality of life.[2]

1. *Lancet, bit.ly/2UX7eIy*
2. *Neurology, bit.ly/2UUuCX4*

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the other epidemic – loneliness

It's not just the UK that has recognised the prevalence of loneliness and is doing something about it. Despite being better connected than ever, loneliness is on the rise, especially amongst older people in developed nations, although younger age groups are not immune.

So why should medics be concerned? Surely it's a psychological problem?

The impact of loneliness on physical as well as psychological health and well-being is now well established. While it certainly leads to mental health problems like anxiety and depression, loneliness has also been linked to increased susceptibility to non-communicable diseases, unhealthy lifestyles, stress, sleep problems and even premature death.

More research is needed to fully understand the sometimes reciprocal causality between loneliness and specific health issues, and to develop effective therapeutic interventions that address the root causes.

Lancet, bit.ly/37EnblB

speaking out against medical malpractice

A report by the 'Independent Inquiry into the Issues raised by Paterson' published on 4 February highlights failures in the healthcare system that allowed a rogue surgeon to continue practicing on thousands of patients for nearly twenty years.

In a damning indictment on both the NHS and private health sector, the report criticises a 'healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe, and where those who were the victims of Paterson's malpractice were let down time and time again.'[1]

The few whistleblowers who dared to break ranks were ignored because they were not backed up by colleagues who might have supported their claims with their own experiences of his 'abhorrent and unsafe activities'.[2]

It was not a lack of regulations and guidelines that led to this appalling state of affairs which undermined confidence in the healthcare system, but the 'complicit silence' of medical professionals who for various reasons, chose not to expose a colleague whose wrongdoing should have been obvious to them.

1. *Paterson Report, bit.ly/2AJ4kjo*
2. *Lancet, bit.ly/2UTbQz4*

environmental change and human health

The health of the planet has a direct impact on the health of human beings in a shrinking world that is increasingly affected by human activity – so much so, that our current geological era has been designated the 'Anthropocene' by some scientists.[1]

In May last year, the London School of Hygiene and Tropical Medicine and World Resources Institute, with funding from the Wellcome Trust, hosted a webinar mooting the formation of a Planetary Health Watch with the purpose of monitoring all the different aspects of environmental change that affect human health. It would also investigate what is driving change and consider protective public policy measures that might mitigate harm.[2]

One of the contributors identified 'nine planetary boundaries that if transgressed could lead to non-linear, abrupt environmental change'. These include 'climate change, ocean acidification, depletion of stratospheric ozone, biogeochemical flows, atmospheric aerosol loading, land-system changes, global use of freshwater, biosphere integrity, and novel entities'.[3,4]

With extreme weather events already increasing in frequency, resulting in severe drought, extreme heat and extensive wild fires in some parts of the world and flooding in others (and sometimes both), it is difficult to see how a monitoring agency with no political power can make a difference at this late stage. We already know what we need to do – but the will, and sometimes the ability, to do it is lacking.

1.   Lancet, bit.ly/3enn2f2
2.   London School of Hygiene and Tropical Medicine, bit.ly/2BiUJjg
3.   Nature, doi.org/10.1038/461472a
4.   Science, doi.org/10.1126/science.1259855.

abortion in Northern Ireland

The 1967 Abortion Act was never applicable in Northern Ireland, with abortion there governed both by the Offences Against the Person Act (1861) and the Infant Life (Preservation) Act of 1945. There has been increasing pressure for a change in the law, with a High Court Case in 2019 declaring the law in Northern Ireland incompatible with the Human Rights Act (1998). A change in the law in the Republic of Ireland also added to pressure.

The campaign became entangled in the complex parliamentary situation at Westminster in the latter part of 2019, with efforts to restore the power-sharing executive in Northern Ireland seen as an opportunity by some campaigners to change the law. The UK parliament eventually backed legislation legalising both abortion and same-sex marriage in Northern Ireland if the executive, which had not sat for several year, was not operational. Although the executive did meet on one day in October 2019, no way forward was found, and thus abortion became legal in Northern Ireland.

Initially operating under interim regulations, the new regime has now been finalised in a vote in the Westminster parliament. This leaves abortion law in Northern Ireland still different from that in Great Britain, but now with less protection for unborn children than in the rest of the UK. The new rules effectively allow abortion 'on demand' until the 24th week of pregnancy, and do not require two doctors' opinions in the way that the rest of the UK does. These changes are only likely to add to pressures for a similar weakening of safeguards in England, Scotland and Wales.

rare diseases – how much should we invest?

Investing in treatments and drugs for conditions and diseases that affect a relative handful of people in every country is difficult to incentivise to pharmaceutical companies that expect a good return on their investment. So the research either doesn't get done, or the treatments developed are prohibitively expensive, both for individuals, insurance companies and state healthcare systems like the UK's NHS.

Yet the numbers affected by rare conditions globally are not trivial – around 400 million worldwide.[1] There may be as many as 8,000 rare diseases and, as most of them are genetic, developments in gene manipulation technology like CRISPR may eventually lead to gene therapies that can help many of them – at least in the developed world.

Solutions must include international collaboration in research and the development of treatments and organisations that are leading the way include the European Reference Networks, the International Rare Disease Research Consortium and the EU Framework Programme for Research and Innovation Horizon 2020.[2] ■

1.   Lancet, bit.ly/37C3zVw
2.   Rare Disease Today, bit.ly/2N9IWYq