

highest risk, the relative decrease in risk was consistent across subgroups. Moreover, the oral administration of SGLT2i is patient-friendly and the safety profile is, in general, favourable. Adverse effects, such as genital infections, can be reduced through improved hygiene and patient education.

Timo E Strandberg and colleagues suggest that octogenarians might have been under-represented in clinical trials. We note that none of the three SGLT2i cardiovascular outcomes trials excluded potential patients on the basis of advanced age.²⁻⁴ Given the ageing of the population, we agree that additional data on octogenarians would be welcome. Fortunately, available evidence does not indicate any attenuation in treatment effect;⁵ however, dedicated subgroup analyses of efficacy and safety by age have not yet been published. In terms of more detailed data on the prevention of heart failure, at the American College of Cardiology 2019 Scientific Sessions, we presented and published data showing that dapagliflozin reduces the risk of hospitalisation for heart failure in patients regardless of their history or type of heart failure, and appears to reduce the risk of cardiovascular death in patients with heart failure with reduced ejection fraction.⁶ Ongoing dedicated trials of SGLT2i in patients with heart failure with reduced and preserved ejection fractions should provide more definitive data.

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Health worker gap in Italy: the untold truth

I read with interest the World Report by Marta Paterlini¹ about the shortfall of doctors in Italy. I commend Paterlini for highlighting this unsolved problem, but unfortunately, the piece fails to identify its real cause. Born, raised, and trained as an anaesthesiologist in Italy, then re-trained in the USA, I have had the privilege of living and working in different countries, and in my opinion,

this issue is far from being addressed in a thorough and systematic way.

It is true that a real emergency now exists, up to the point where several Italian regions are trying to recruit doctors from Eastern Europe and Pakistan, are hiring Italian trainees in their last year of training, and doctors with no specialisation in emergency departments. Nevertheless, a couple of crucial points are missed in the World Report.

There is some uncertainty about the exact number of Italian doctors working abroad; EU data² suggest that 1000 doctors leave the country every year, but this is probably an underestimate. Retaining these doctors in Italy could at least partially solve the problem.

Yes, not enough training positions exist compared with the number of graduates. Simply increasing the number of training positions (with no reassessment of the training pathway) would result in an uncertain curriculum. The number training positions have not been substantially increased this year; however, hiring doctors straight out of medical school with no specialisation (which is mainly being done in emergency departments) poses serious questions about quality of care. Hiring doctors in their last year of specialisation is allowed as long as they start working once their training is complete.

The real problem does not lie in the mismatch between the number of new specialists entering the workforce and the number of doctors who retire at the end of their career, but in the mismatch between the number of doctors leaving (ie, either retiring or leaving the country to work abroad) and entering the system. The real problem is not the scarcity of specialists but rather how unattractive the Italian system is to foreign specialists.

Have those politicians, press journalists, and representative of doctors' unions who have been making their opinions known ever wondered why no doctor wants to move from France, Germany, the UK, or North America



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to Italy to work? Why does Italy have to recruit from countries with a lower income and worse working conditions rather than just improving its own working environment and ultimately becoming a more attractive place to work? The benefits of making these improvements would be enormous for patients and the whole medical community.

Italy is not an attractive place to work. Inadequate working conditions, little stability, growth, or potential for career progression, low salaries, the commixture of politics and the health-care system, and fake recruitment committees (the notorious *Concorsi Truccati*) hit the headlines regularly. Many other countries have plenty of well educated Italian and non-Italian doctors with great skills and ideas who would be willing to work in Italy if circumstances changed.

I do not think (and certainly do not hope) that politicians, doctors' unions, and journalists are purposefully hiding the problem and diverting the public attention from what the issues are, but I do think that there is inadequate understanding of the real problems. The rest of the world is moving fast, and Italy is reaching a point of no return.

I declare no competing interests.

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Scientific leadership: the Italian Government's perspective

A number of articles in high impact medical journals in the past few months¹⁻³ report on the alleged anti-scientific attitude of the present Italian Government.

We read with interest Richard Horton's Comment about scientific leadership,³ in which he compares the incapacity of British scientists to react to Brexit (the result of a free vote of British citizens) with the pro-Europe initiative by some Italian scientists. The argument is interesting, although the case appears to be mainly made to emphasise internal problems in the UK's scientific community. However, Horton goes beyond this scholastic representation and makes some personal considerations on the Italian Government and on the two parties of the governing coalition and their leaders (also the result of a free vote by Italian citizens). Specifically, Horton states that in Italy, "there is now an unprecedented assault on science",³ a statement that echoes one made between Italy's current leadership and the US President Trump, who recommended that the National Institutes of Health avoid the term evidence-based to improve chances of getting research funding.⁴

On what scientific evidence is Horton's Comment based besides a quite apparent disagreement with the opinions freely expressed by citizens of two of the largest countries of the European continent? Not too many details are given in this regard, with the exception of some vague views from Gualtiero Ricciardi, a respected Italian scientist and former employee of the Italian Government, who alludes to unscientific and even anti-scientific positions of representatives of the Italian Government on many issues. Ricciardi also accuses the Italian Government of "wasting public resources and cutting investments", as many scientists do when their projects are not financed.

In the interest of a better contextualisation of Horton's political comments on the Italian Government, some points can be useful. First, I, Giulia Grillo, have only served as Minister of Health since June, 2018. While I cannot take credit for our health system, which is recognised worldwide

for its efficiency, I cannot be charged full responsibility for not having yet solved its challenges. These challenges involve demographic changes and the availability of new diagnostic and therapeutic innovations, which are putting stress on the sustainability of our system. My team should be evaluated honestly and objectively based on the reforms we accomplish during my term. In a country that has been repeatedly accused of nepotism, corruption, and stagnancy of high-ranked positions, the advent of a young woman not compromised by the past and willing to modernise the system should not be criticised in principle but on specific decisions and actions, if the evidence-based method should be applied also in politics.

Second, many medical doctors work at the Italian Ministry of Health. Some of them have worked long term in teaching, clinical activity, and research, and they do certainly agree with the methods, aims, and rules of science, including the fundamental role of evidence. A strong commitment to the improvement of our health system was the reason for us and our colleagues to serve for the Ministry of Health. We are confident that applying the scientific method in selecting people called to serve Italy in each public institution would increase the quality of the global activity of our ministry. This use of the scientific method will allow us to better satisfy the urgent demand from our citizens for quality of care, meritocracy, and political independence, granting at the same time compliance with the highest scientific standards. This approach was recently used for the selection of the members of the new Consiglio Superiore di Sanità (CSS), which now includes some of the top Italian scientists. Franco Locatelli, a world recognised authority in paediatric oncohaematology, was elected as its president. The system was also used for the selection of the general director of the Agenzia Italiana del Farmaco (AIFA), the Italian Drug