Doctors “culpable” in blood scandal

The former Labour health secretary for England has told The BMJ that he has seen evidence of individual clinicians’ wrongdoing during his research into the scandal over contaminated blood in the 1970s and 1980s.

In an interview with The BMJ Andy Burnham, currently mayor of Greater Manchester, who has been one of the most vociferous advocates for a fresh inquiry into how contaminated blood transfusions infected thousands of people with hepatitis C and HIV, said that he had evidence that could show that doctors and nurses acted unethically when treating patients who had received contaminated blood products.

In July this year the UK prime minister, Theresa May, pledged to set up a full inquiry after many years of lobbying by MPs and campaigners.

Burnham, who has urged the government to move the new inquiry out of the hands of the Department of Health to ensure it has the backing of affected patients and their relatives, wants its scope to include the role of individual clinicians. “I have many examples of individual malpractice: tests being done without people’s consent; test results being withheld, which in the end lead to secondary infections,” he said.

“That is unethical and seems to me to break the code of ethics that all doctors work under.

“I have two examples of medical records [having been] amended, [in one case] to suggest that liver damage was self inflicted rather than caused by contaminated blood. There are multiple examples of individual wrongdoing or malpractice or unethical behaviour.”

Burnham said that the inquiry should consider whether individual clinicians’ behaviour was in response to “a central instruction of some kind or a professional body giving instructions,” and said a government inquiry was more appropriate than seeking to refer individuals to the police or the General Medical Council.

“If you just approach this from examining the individual cases, I don’t think you’ll understand the context of what lay behind this, and clearly there was context at the centre,” he said.

“I think it’s only when you put together papers held at local level with what was going on at national level that the full picture will emerge.

Cite this as: BMJ 2017;358:j4121

Thousands of people in the UK were infected with hepatitis C and HIV in the 1970s and 1980s as a result of receiving contaminated blood products

LATEST ONLINE

• Ministers must act “without delay” to solve GP indemnity crisis, defence bodies warn
• Revamp of GP inspections will not reduce bureaucracy, says royal college
• Abbott recalls hundreds of thousands of pacemakers owing to hacking fears
GP faked consultations “to reduce workload”

A medical practitioners tribunal has taken the “exceptional course” of taking no action against the registration of a GP whose partners asked him to retire after learning that he had deleted some of his appointment slots to reduce his patient workload.

Andrew Thomson (left), who qualified in Dundee in 1996, made several admissions of dishonesty relating to the “coping mechanism” he employed to deal with his workload at the Academy Health Centre in Forfar, Scotland.

The tribunal held that Thomson’s fitness to practise was impaired but took no action after finding “powerful mitigating factors” in his case.

He deleted some of his appointment slots using the practice’s IT system and also changed some of his 10 minute slots to 20 minutes. In one case, when a member of staff had freed up a gap in his schedule, he filled it by creating a fictitious appointment with a patient he called “M Mouse M” and subsequently recorded having seen that patient.

But Thomson’s dishonesty was of a “highly unusual nature,” said the tribunal chair, Robin Ince. “The tribunal accepts that in the time freed by the deleted appointments you were either seeing other patients, or working on external activities for the benefit of the centre,” he said.

Clare Dyer, The BMJ

Cite this as: BMJ 2017;358:j4141

Finance

NHS needs extra £350m to cope this winter

The NHS will need an emergency cash injection of £200m-£350m to manage patient demand this winter, said a report from NHS Providers. Last winter was widely regarded as the worst for the NHS in recent times, and this year’s is predicted to be worse. NHS trusts are not benefiting consistently from the extra £1bn of social care investment announced in the spring budget, and the government’s target to reduce delayed transfers of care to 3.5% in September will be missed, the report said. Meanwhile, demand for Emergency care is continuing to rise, shortages of key staff are growing, primary and social care capacity is stretched, and trusts are under greater financial pressure than last year.

Hospital overspend is £3bn more than reported

NHS trusts ended last year with an overspend almost £3bn higher than reported in their official accounts, a Nuffield Trust analysis found, using accounts and financial data from NHS regulators from 2016-17 and deducting temporary funding and one-off savings. It found that NHS trusts ended the financial year with an underlying overspend of £3.7bn, much higher than the £791m reported by NHS regulators.

Lack of funding to cover inflation means that trusts will need to cut operating costs by 4.3% to meet targets for 2017-18, equivalent to £3.6bn in total savings.

Acid attacks

Guidance on treating victims is published

The rising number of acid attacks has prompted NHS England and the British Association of Plastic, Reconstructive and Aesthetic Surgeons to issue guidance to the public on how best to provide assistance. It highlights the “three Rs”: report the attack; remove contaminated clothing carefully; and rinse the affected area in clean water. The number of people requiring specialist medical help after acid attacks, where corrosive substances are used in an assault or robbery, has increased from 16 patients in 2014 to 32 in 2016.

Medicolegal

GP charged with 118 sex offences

An east London GP appeared in court to face charges of 118 sex offences against 54 victims, including a child under 13, after a four year investigation. Manish Shah (right), 47, from Romford, appeared at Barkingside Magistrates’ Court to face charges of 65 counts of sexual assault, and one of assault by penetration, 52 of sexual assault, and one of assault on a child under 13. The offences were alleged to have happened from June 2004 to July 2013, when Shah was arrested.

Junior doctor suspended over annual leave claim

A junior doctor who claimed to be off sick when he was really in Spain, leaving a hospital ward without cover, was suspended for two months by a medical practitioners tribunal. Robert Coddington was a foundation year 1 doctor working at Nottingham University Hospitals NHS Foundation Trust in 2015 when he left for four days in Spain. He had initially asked for four days’ leave ending on 31 July but, after failing to find cover for the final two days, ultimately submitted a formal request for leave up to 29 July. (Full story doi:10.1136/ bmj.j4055)

Inequality

Avoidable deaths are higher in poor areas

More than twice as many deaths from avoidable causes occur in the most deprived parts of the country as in the least deprived areas, data from the Office for National Statistics showed. In 2015 some 16 686 deaths from avoidable causes were recorded in the poorest parts of England, compared with 7247 deaths in the richest areas. The largest relative inequality in avoidable mortality was in deaths from respiratory diseases, which were 4.8 times (males) and 7.7 times (females) more likely in the most deprived populations.

9 September 2017 | the bmj
MEDICINE

Sexual health
PHE issues sexual health services warning
A review of sexual health service commissioning by Public Health England warned of fragmentation and increasing demand, accompanied by financial pressure from budget cuts. The survey of clinical commissioning groups, local councils, and NHS England was done in response to concerns raised after the commissioning of some sexual health services moved from the NHS to local authorities in 2013.

Boots cuts cost of morning-after pill after backlash
The pharmacy chain Boots agreed to reduce the price of emergency contraception in its stores after a backlash against its initial refusal to do so on the grounds that it may incentivise inappropriate use. Boots was charging £28.25 for Levonelle and £26.75 for its own generic version but said that it had “listened to its customers’ feedback” and would now offer a cheaper generic version of the pill in all 2500 of its stores by next month.

Cancer drugs
Fulvestrant is not recommended by NICE
In draft guidance this week the National Institute for Health and Care Excellence did not recommend fulvestrant for use by the NHS in England to treat women with oestrogen receptor positive metastatic breast cancer not previously treated with hormonal therapy. The appraisal committee found that, although fulvestrant delayed cancer growth by around three months when compared with current standard treatment with aromatase inhibitors, the available evidence did not show that this leads to increased overall survival.

Social care
Social care is not fit for purpose, MPs warn
Only one in 10 MPs in England believes that the current social care system is suitable for the UK’s ageing population, a ComRes poll found. The cross party survey of 101 MPs, commissioned by the charity Independent Age, also found that 86% of MPs in England believe that a cross party consensus is needed for a lasting settlement on health and social care. Only 13% of Labour MPs and 35% of Conservative MPs believed that social care services in their constituencies were fit for purpose.

Research news
Supplemental oxygen may not cut MI mortality
Routine use of supplemental oxygen in patients with suspected myocardial infarction (MI) but who are not hypoxic is associated with no reduction in mortality at one year, a randomised trial reported. The study allocated 6629 patients presenting to Swedish ambulance or hospital services with suspected MI and oxygen saturations of 90% or higher to receive oxygen or ambient air. Results reported in the New England Journal of Medicine showed no difference in all cause mortality at one year (hazard ratio 0.97; P=0.80).

FIT NOTES
Mental health and behavioural conditions were the most common reasons for “fit notes,” accounting for 31% of over 12 million issued by GPs in England from December 2014 to March 2017. The next most common were musculoskeletal conditions and connective tissue disorders.

Cite this as: BMJ 2017;358:j4139

SIXTY SECONDS ON…

THE PRIVATE FINANCE INITIATIVE

PFI—HOW VERY 1990s! DIDN’T IT GO OUT OF THE WINDOW WITH NEW LABOUR AND COOL BRITANNIA? It’s definitely “still a thing,” to use a catchphrase that probably didn’t exist in 1997. A report from the Centre for Health and the Public Interest says that the NHS and local authorities in England are still in hock to the private companies running the initiative, with taxpayer funds “leaking out of the NHS” into their coffers.

HOW MUCH ARE PFI DEALS COSTING US? The capital value of assets that have been built is £12.4bn, the report says. Over the course of the contracts, however, the NHS will pay around £80.8bn to private companies.

SO, SOMEONE’S DOING WELL OUT OF THESE SCHEMES? Yes, but not the NHS. The PFI companies holding the NHS contracts have made £831m in pre-tax profits in the past six years alone, the report states.

GIVE ME A BIT OF BACKGROUND ON PFI It was introduced by John Major’s Conservative government but was enthusiastically adopted by Labour post-1997, as PFI enabled the construction of voter pleasing new hospitals and schools with no payments up front. However, repayment contracts are lengthy at 25 to 30 years and, in some cases, 60.

PFI HAS BEEN AN UNMITTIGATED DISASTER FOR THE NHS, THEN? Many would say so—the academic Allyson Pollock has been a vocal critic, describing it as “locking the taxpayer into long term debt.” She wrote, “PFI, once trumpeted as the largest hospital-building programme, was in fact the largest NHS hospital and bed closure programme.”

DOES ANYONE SUPPORT IT?

Anne Gulland, London
Cite this as: BMJ 2017;358:j4119
Doctors’ use of Facebook, Twitter, and WhatsApp leads to 28 GMC investigations

The General Medical Council closed 28 investigations related to doctors’ use of Facebook, Twitter, or WhatsApp between 1 January 2015 and 30 June 2017, figures obtained by The BMJ have shown.

The GMC provided the data in response to a freedom of information request from The BMJ.

In three cases, doctors received a warning from the GMC. A warning indicates to the doctor that a certain conduct, practice, or behaviour is a departure from the standards expected of the medical profession and should not be repeated.

A further three cases were referred to the doctor’s employer, and two doctors had their registration suspended as the result of an investigation. A suspension is issued when a doctor’s misconduct is so serious “that action must be taken to protect members of the public and maintain public confidence in the profession.”

In one case the doctor was issued with an undertaking, and in another the doctor was issued with a condition on their registration. Undertakings are restrictions on a doctor’s practice that are agreed between the doctor and the GMC. They could, for example, stop the doctor from carrying out a particular procedure or commit the doctor to undergo medical supervision or retraining. Similar to undertakings, conditions restrict a doctor’s practice or require them to do something. They are imposed, rather than agreed upon, for up to three years.

Fourteen cases were closed without any further action being taken, and a further four were closed with advice being issued to the doctor.

The GMC said that in over half of the cases, the complaint that sparked the investigation was made by someone acting in a public capacity; that is, someone working for an employer or a public body. In seven cases the investigation was triggered by a complaint from a patient or member of the public. Six complaints were made by “other,” which could be a non-health body or a doctor self referring.

The GMC could not say how many complaints were closed at the triage stage and not investigated further because the nature of complaints is not recorded at that stage.

In total, 20 investigations were directly related to a doctor’s use of Facebook (10 in 2015, eight in 2016, and two in 2017 up to 30 June). Six were related to a doctor’s use of Twitter (three in 2015, two in 2016, and one in 2017), and three were directly related to activity by a doctor on WhatsApp, with one investigation being conducted each year. In one case, both Facebook and Twitter use featured as part of the investigation.

The BMJ also asked the GMC if there were any investigations related to doctors using Snapchat, but the regulator said that none had occurred.

Abi Rimmer, The BMJ
Cite this as: BMJ 2017;358:j4099

NHS orders peer review of all referrals by GPs

GPX will be expected to discuss with GP colleagues their decision to refer any new patients to hospital, as part of a push by NHS England to curb inappropriate referrals to secondary care.

Guidance issued by NHS England to clinical commissioning groups in May stated that all areas of the country should have a system in place from September 2017 to ensure that all new GP referrals are subject to clinical peer review.

A spokesman for NHS England told The BMJ that around half of CCGs already had a peer review process in place and that it was up to the other half to follow suit. NHS England emphasised that any system should not be “established as an approval process and the referring GP retains responsibility for the patient and makes the final decision.”

The spokesman said, “We’re not being prescriptive—it is between CCGs and GPs to work out what’s best for them. The issue repeatedly reported to us is that patients are turning up to appointments they don’t need. This is taking up hospital time, and [this guidance is] aimed at reducing that.”

The guidance was sent to CCGs in May in a document called Elective Care High Impact Interventions: Clinical Peer Review, which was seen by Pulse magazine. NHS England has been promoting the idea of referral peer review for some time, but this is the first time it has said that it is mandatory.

An investigation by The BMJ earlier this year found that many CCGs in England were already committing millions of pounds to schemes designed to screen GPs’ referrals to specialist services. But the investigation found that only a small fraction of these were being fully evaluated in terms of their cost effectiveness.

Andrew Green (right), clinical lead for the BMA’s General Practitioners Committee, said that he was sceptical of the process, which he said would increase workload. He said, “I wish that NHS England put a 10th of the effort it expends on reducing pressure on hospitals into reducing pressure on GPs, which is the area of the health service with the biggest growth in workload.”

Anne Gulland, London
Cite this as: BMJ 2017;358:j4106

In total, 20 of the INVESTIGATIONS were directly related to a doctor’s use of Facebook
Andy Burnham’s calls for a fresh inquiry into the long-running scandal have been answered. The mayor of Manchester now believes that only a Hillsborough style inquest will get to the truth. Abi Rimmer reports

Former health secretary still pushing for justice over contaminated blood scandal

After years of lobbying from campaigners and politicians alike, the UK government announced in July that it would establish a fresh inquiry into the contaminated blood scandal, in which thousands of patients became infected with HIV and hepatitis C through blood imported from the US in the 1970s and ’80s, much of it bought from high risk donors, such as prisoners.

Andy Burnham, the former Labour health secretary, was one of several MPs who pushed for the government to re-examine the evidence. In April this year, before the government’s announcement, Burnham used his final speech in the House of Commons before stepping down as MP for Leigh, Greater Manchester, to call for a fresh inquiry into the scandal.

Although Burnham is no longer an MP and was elected mayor of Greater Manchester in May, he remains fully committed to securing answers and justice for the survivors of the scandal and the families of those affected. Speaking to The BMJ he is passionate about his long term campaigning on the issue, which he says has disturbing parallels with the Hillsborough tragedy, another issue on which he has campaigned vociferously.

The new inquiry will focus on the institutional failings that led to the contaminated blood scandal, but Burnham says that he has found evidence that could potentially show that doctors and nurses acted unethically when treating patients who had received contaminated blood products. This, he argues, should not be ignored.

He says that a key question for the inquiry is whether the behaviour of individual clinicians was in response to “a central instruction of some kind or a professional body giving instructions.”

The government’s announcement of a fresh inquiry marks the latest instalment of a long running saga. In 2007 an independent inquiry into the scandal led by Peter Archer, a Labour peer and former solicitor general, was launched. It reported in 2009, and the government issued its response shortly before Burnham became the Labour health secretary that year.

At the request of his friend and fellow Labour MP Paul Goggins, Burnham then began to look into the issue in more depth. “I actually sat and listened to people who had been affected, and it really came through to me what had happened and how unjust it had been and how devastating for people.”

As health secretary in February 2010 Burnham called for the Department of Health to reopen the question of support for the victims. The review began despite some “institutional resistance” from the department, but it was not concluded before the general election that year in which Burnham lost his seat. As shadow health secretary from 2011 to 2015, he says that he made a commitment to Goggins to reopen the inquiry if he returned as health secretary.

Burnham, who says that the case for an inquiry was overwhelming, is pleased that the government has accepted this. After his work on the Hillsborough inquest, he recommends a similar style of inquiry into contaminated blood.

Because of a loss of trust in the health department Burnham would advise handing the inquiry to another department

Because of a loss of trust in the health department from the victims and their families, Burnham says that he would advise the government to hand the inquiry to another department.

“To use the Hillsborough parallel, there has to be a degree of independence from the bodies being considered in terms of establishing an inquiry,” he says. “My appeal to the government at this stage would be that it needs to hand over responsibility for pulling together the inquiry, probably to the Cabinet Office.”

Abi Rimmer, The BMJ

Cite this as: BMJ 2017;358:j4113
The impact of the junior doctor contract—a year on

This October will mark 12 months since trainees began to sign up to new terms and conditions. Abi Rimmer looks at the effects on employees and employers

The implementation of the new contract for junior doctors in England marked the end of a long period of unrest. Though the BMA remained in dispute with the government, ongoing strike action over the changes brought by the contract came to an end with its introduction. Since then most junior doctors who are eligible to move onto the new contract have done so.

The process began in October 2016, with obstetrics trainees in their third year and higher. Then in November and December doctors in the two years of the foundation programme who were taking up new appointments also started. Between February and April this year trainees in psychiatry, pathology, paediatrics, and surgery began to work under the contract. Any remaining eligible trainees are expected to be working under the new terms and conditions by the end of October.

Paul Wallace, director of employment relations and reward at NHS Employers, says that the transfer has gone smoothly overall but that it has created a lot of extra work for trusts’ human resources departments. “We’ve had lots of real hard work done by medical staffing colleagues to ensure that the contract was implemented in the way that we anticipated,” he says. “And so far I think it’s going well.”

The contract’s implementation has also created an opportunity for employers to reflect on junior doctors’ working conditions, Wallace adds. “Clearly, the world of work is very different from what it was 30 or 40 years ago, and as employers we need to reflect on that. In this case we’ve got a group of staff we need to be reflecting on in terms of what that employment experience needs to look like.”

Such reflection on working conditions might help trusts meet many of the concerns raised during last year’s dispute, which often ranged beyond details in the new contract to broader issues about doctors’ working lives and careers.

Exception reporting

Steve Gill, consultant in intensive care medicine and anaesthesia at Nottingham University Hospitals NHS Trust, says, “The contract negotiation brought a lot of things to a head which are not contractual but are about working conditions, rest facilities, food out of hours, those sorts of things.”

Gill is his trust’s guardian of safe working hours, a role created by the new contract. The guardians are responsible for overseeing their trusts’ compliance with the contract’s safeguards on working hours. They are also expected to ensure that “exception reports,” another creation of the new contract, are properly dealt with.

Exception reports were designed as a mechanism for junior doctors to raise an alert when their actual hours or working varied significantly or regularly from their schedule. The work schedule, again a new concept introduced by the 2016 contract, sets out junior doctors’ rota template and the training opportunities that must be included in their placement.

Gill says that, as far as it goes, the exception reporting system is working well at his trust. But he says that he is aware of instances of trainees thinking that they are working too many hours but aren’t submitting an exception report. In some cases, Gill says, this could be because of a department’s working culture. “For some specialties that have only just come on to the new contract, and are only just getting to grips with it, I think there is a ‘you do the work however long it takes’ or ‘put up and shut up’ kind of attitude that has persisted for a long time.”

Simon Fleming, president of the British Orthopaedic Trainees Association, has also seen varying attitudes towards exception reporting.
The impact of the junior doctor contract—a year on

“I think exception reporting, if used properly, will be one of the most powerful tools for enabling trainees to get the best possible training at all stages in all situations,” says Fleming. “But it needs to be used properly, which means the guardians need to be supported to do their job properly, and trainees need to be encouraged to exception report at all levels.”

At Great Ormond Street Hospital, trainee anaesthetist Ged Manning has seen exception reporting working in practice. “There’s quite a lot of time off in lieu that has been given [as the result of exception reporting],” Manning says. “There’s been a case of financial compensation for a trainee who worked too much, and there’s one rota that is being reviewed after there was a series of exception reports for one part of it.”

Like Fleming, Manning thinks exception reporting is a good thing. “I think it’s a really powerful tool for positive change. It’s a great way of highlighting when the work that we are doing on the ward and in the department isn’t the same as the work that our supervisors, and their supervisors, think it is. It’s a way of closing that misunderstanding.”

Teething problems

Although the introduction of exception reporting has been seen as positive, there are undoubtedly ongoing problems with the new contract.

Jeeves Wijesuriya, chair of the BMA’s Junior Doctors Committee, says that the way the contract has been implemented has created problems in some places. “We know there are bits of the contract that we fought for which we think are positive and important, and we have been trying to ensure that those safety protections and limits are there and work,” he says. “But there are, because of the fact that this contract was imposed, huge teething problems.”

Wijesuriya says that some trusts have created junior doctor rotas that don’t fall within the safe working limits set by the contract, and don’t facilitate exception reporting. Other trusts have misinterpreted the contract’s rules on locum working, he says.

Wijesuriya recently wrote to University Hospitals Birmingham NHS Foundation Trust asking it to retract briefing notes sent to junior doctors suggesting that they might be referred to the General Medical Council if they didn’t take on locum work.

Two key concerns raised by trainees about the new contract during the dispute were that it would disproportionately affect trainees who work less than full time and that there would be a sex divide, as most of these trainees are women.

Wijesuriya says that the BMA is still trying to tackle the longstanding pay gap between the sexes in medicine. “We’ve done a huge amount of work to create less than full time pilots to improve access to less than full time training. We’ve also created a less than full time forum to enhance the representative voice of our less than full time trainees.”

He adds that that BMA is still calling for a review of the gender pay gap, promised by the health secretary and the Department of Health last year.

And there continue to be problems with junior doctors’ rotas, Wijesuriya says. “There are a lot of fundamental employment practices that we aren’t doing [in the NHS] that we need to,” he says. “For example, we need to build rotas that have the capacity for juniors to take annual and study leave. We need to make sure that we identify which staff should be on a particular rota and define what a rota gap is.”

Unfilled rotas

Many junior doctors are already finding that the contract’s restrictions on working hours are making it more difficult to fill junior doctor rotas. Tom Oates, a senior specialty trainee in nephrology and general medicine, says that constraints in the new contract are creating additional staffing problems.

“I know people who are trying to run rotas who are finding it very hard to staff wards under the working hours constraints of the new contract, regardless of the rota gaps that we know exist anyway,” he says. “The contract has added a layer of complexity for you in using the doctors that you have to [provide] staff 24 hours a day, seven days a week.”

Abi Rimmer, The BMJ

Cite this as: BMJ 2017;358:j4125

We need to build rotas that have the capacity for juniors to take annual and study leave

Abi Rimmer, The BMJ
This poignant display of 606 pairs of shoes, one for every person who took their own life in New Zealand last year, is at the heart of a campaign to force the government to tackle the “silent epidemic of suicide.”

The country has the highest youth suicide rate in the developed world—five times that of Britain and twice as high as Australia’s. Latest figures show the number of such deaths has risen for three years in a row to 606 in the year ending 30 June, from 579 in 2015.

This display in Rotorua, on the North Island, was one of many across the country, in a campaign that will end on the steps of Wellington’s parliament building on 10 September. “We want the government to set a suicide prevention target and hold an urgent independent mental health inquiry. They’ve refused to do both,” said a spokesperson for the campaign group, Yes We Care.

Alison Shepherd, The BMJ
That bird has flown: dangers of trying to control social media

A medical association that tried to censor what conference delegates shared online soon discovered that a blanket ban is not a workable option. Dara Mohammadi reports

In June the American Diabetes Association (ADA) banned attendees at its 77th Scientific Sessions meeting from sharing photographs of presented slides on social media. Using its Twitter account, @AmDiabetesAssn, it publicly asked each offending delegate to delete their tweets. This was met with a huge, defiant, and largely humorous reaction, with many tweets comparing the policy with Orwellian censorship. One commentator pointed to the absurdity of not being able to share a photograph from a presentation about “open innovation.” Such was the force of the delegates’ response that an analysis of the meeting’s hashtag, #ADA2017, by Graham Mackenzie, a consultant in public health medicine at NHS Lothian, showed that the Twitter ban was a more popular topic of online conversation than anything presented at the meeting.

“I don’t agree with what they did but I have sympathy for the ADA,” Mackenzie told The BMJ about the backlash. “When things start to go awry on Twitter, much like when a political party makes a bad move in an election campaign, it can be very difficult to put it back in the box.”

Intellectual property

The ADA has stood firm. In response to a request for an interview with The BMJ it emailed a statement, saying the ban was maintained to protect intellectual property which belonged to speakers and not the association.

“Upon registration,” the statement read, “all attendees agree to the meeting policies, which includes following all local and federal laws. This includes those related to the intellectual property rights of all parties.”

In its online photography and audiovisual policy for the meeting, though, the ADA says attendees must grant the association worldwide and royalty free rights and permission to use any media, webcasts, or recordings from the meeting.

“ADA isn’t the only association to have these rules [against sharing], but to my knowledge this is the first time they have been enforced so strongly,” said Michael Gibson, a professor in cardiology at Harvard Medical School, who was not at the meeting but was prominent in the Twitter response. “We were active because this type of ban could set a dangerous precedent for academic meetings.”

The Ingelfinger rule

Prohibition of the free sharing of findings presented at academic meetings may stem from the 1969 Ingelfinger rule. Franz Ingelfinger, then editor of the New England Journal of Medicine, said that the journal would not publish findings that had been published elsewhere.

This rule pre-dates social media and may be being misinterpreted. In interviews since the ADA’s June meeting, the current editors of NEJM and the Lancet confirmed that the sharing of data on social media would not jeopardise publication in their journals. The BMJ’s policy states, “We accept that reports may appear in the media after presentations at scientific meetings.”

“The whole argument around protecting the intellectual property of speakers is a weak one,” says Kevin Campbell, a cardiologist in Raleigh, North Carolina, and a media commentator. Campbell was not at the ADA meeting but was active in the ensuing Twitter discussion. He described the ADA’s policy as “the most egregious example of censorship in academia I’ve seen in my career. It felt like the ADA didn’t want people to be part of the conference unless they had paid to attend.”

He added, “If you have privileged
information, then don’t share it at a public meeting. Nobody can present their data publicly and then say, ‘Shhh, don’t tell anyone.’” He notes that if speakers would like information not to be shared, they can say so and include that information on sensitive slides.

In email correspondence with the ADA, the association confirmed that its gross income for Scientific Sessions is about $14m (£11m), just over 7% of its overall gross annual income of $190m, but it denied that financial considerations were a factor in its social media ban. It went on to say that it has asked its top speakers at the event and that the “overwhelming majority said that they would not present their research at a future meeting if we change our policy regarding photos of slides or intellectual property.” Such views from researchers are absent online, on social media, or on blogs written about the event—although that could be because of the self selecting nature of the types of practitioners who take to social media. Speakers at previous scientific meetings have complained of delegates recording video of their presentations despite being asked not to, and fear that those delegates might plagiarise their work.

**Insider trading**

As for live sharing of data from presentations, especially embargoed material, concerns are legitimate. At the ADA’s 2016 meeting, for example, tweeting of data about the drug liraglutide from one presentation led to a one day drop in the share price of Novo Nordisk, the manufacturer, of 5.6%.

“Knowing the results of a trial before they are presented publicly can allow people to buy or sell stock to their advantage, and that’s insider trading,” says Gibson. “I can understand that concern leading to an enforcement on one symposium, but not a blanket prohibition throughout an entire meeting.”

The financial ramifications of online sharing also include conference organisers’ ability to sell slides after a meeting. Associations such as the Cardiovascular Research Foundation, for instance, sell packages worth up to $1000 that include slides and webcasts of presentations at its meetings. This is a redundant business model if videos and photos of presentations are shared freely online.

The backlash against the ADA’s censorship, and the unpicking of potential financial drivers behind other organisations’ unwillingness to allow delegates to share slides, is more than media savvy doctors being difficult. Mackenzie says that social media at meetings and conferences have become an invaluable asset to the medical profession and, ultimately, to patient care.

Online sharing at professional gatherings, he says, helps with learning, networking, and broadcasting. “Distilling the most salient points of a presentation helps practitioners and their followers to keep abreast of the most interesting researchers in their own and other specialties,” he says. “Online discussion can help people to disseminate their own work as widely as possible, and to find others with similar research interests.”

**Pedalling backwards**

If presentations at conferences are of a sensitive nature, he says, attendees might be asked not to share discussions online, “but when it is about research into how to care better for patients, online discussion can only help people refine their arguments and to align their research to the needs of patients.”

Open critique of a study before it is published might be a concern for a drug company. “Big national conferences may have big sponsors, which potentially keeps costs down and increases access, but can have a negative impact on the conference content and sharing.”

Campbell is similarly equivocal about the importance of free sharing. “Medicine is moving forward, and the ADA or any organisation that tries to restrict the sharing of science is pedalling backwards.”

“I think the ADA saw a backlash because they tried to turn off a flow of information that people have grown accustomed to and now expect,” added Gibson. “Many associations actively encourage social media at their conferences—it’s becoming more commonplace. The ADA would be well advised to ride the tiger rather than end up in the tiger’s belly.”

The ADA says it is reviewing its policy and will make an announcement in December when registration opens for its 2018 Scientific Sessions.

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NEGLIGENCE CLAIMS

A new settlement when things go wrong

Superseding the Litigation Authority, NHS Resolution promises to act faster, helping valuable lessons to be learnt and reducing spiralling legal costs. Clare Dyer reports

A 5 year old boy with cerebral palsy won an £11.5m settlement from the NHS in December 2015. His brain had been deprived of oxygen in the womb after midwives failed to notice his mother’s prolapsed cord. Had he been delivered 11 minutes earlier, the legal claim alleged, he would have escaped the devastating injuries that will leave him entirely dependent on other people for the rest of his life.

Last March, an 11 year old girl who was left with permanent brain damage when her blood sugar concentration fell dangerously low after her birth received a £17m settlement. Mother and baby were discharged from hospital when they should not have been; the baby’s blood sugar levels continued to fall, and she sustained brain damage so severe that she will need 24 hour care for the rest of her life.

These stories are heart wrenching yet depressingly familiar. Parents made 232 legal claims against NHS trusts in England for severe birth injuries in 2016-17, up 23% from the 188 filed the previous year. These claims are among the most expensive faced by trusts: the total value of those filed in 2016-17 hit nearly £2bn. Obstetrics accounts for only 10% of the claims made against trusts, but 50% of the overall value of claims.

Even more costly

Disasters during birth are set to get more costly for the NHS. In February, the government reduced the discount rate, the notional interest rate that gives the return on investment of compensation payments. The body that handles legal claims against trusts in England, NHS Resolution (called the NHS Litigation Authority until April this year), says that the cost of providing for the complex, lifelong needs of a child severely injured at birth could exceed £20m.

Helen Vernon, NHS Resolution’s chief executive, cites a cerebral palsy case in which a settlement was agreed at £10.4m just before the discount rate was changed in March this year. Settlements on behalf of children must be approved by the court, but the judge refused to approve the deal and told the two sides to reconsider in the light of the change in the rules. A £10.4m settlement became £25.3m.

ANOTHER OPTION AFTER BIRTH INJURIES

Families of children who sustain serious but avoidable birth injuries will have another option for pursuing compensation claims if the English Department of Health decides to go ahead with its proposed rapid resolution and redress scheme. Unveiled for consultation last October with a raft of maternity safety measures, it would provide “consistent, robust, and independent” investigations, says the department, together with support for families and clinicians, learning for the NHS, and earlier payments, totalling about 90% of a typical court award. The scheme is voluntary, and families would still be able to choose to take the case to court instead.

Why are the same sorts of errors recurring year after year? Wouldn’t the vast sums paid out to settle cases where things have gone wrong be better spent on identifying the risks and taking action to mitigate them?

Robert Francis QC, the veteran clinical negligence barrister who chaired the public inquiry into poor care at Mid Staffordshire NHS Foundation Trust, told the House of Commons health committee in 2013: “If the health service is to learn lessons, it’s no use trying to learn lessons from an obstetric disaster eight years down the line after it’s been settled for millions of pounds in court.”

Learning from failure

Has the NHS taken his message on board at last? Data held by the NHS Litigation Authority were described by a Department of Health report in 2000 as “a potentially rich source of learning from failure.” The authority’s new name heralds a new approach, with a focus on looking at incidents when they happen, trying to resolve cases early without the need for legal proceedings, and learning lessons to reduce the risk of similar harm in the future.

The move follows an initiative from the Royal College of Obstetricians and Gynaecologists—“Each Baby Counts,” which aims to halve by 2020 the number of babies in the UK who die or sustain severe injuries because something goes wrong during labour. Trusts are required to report all stillbirths, deaths within the first week of life, and severe brain injuries in term infants within five working days. The first full report in June 2017 made several recommendations to improve safety. Investigations into the cases have shown that about three quarters would have had a better outcome if management had been different.
Early notification

From April this year, reports on incidents that happen in England also go to NHS Resolution’s early notification scheme for potential legal claims. Every trust is asked to report cases within 30 days of the incident rather than waiting for a legal claim. “We’re collecting every incident whether or not we think that there has been fault,” Vernon explains.

Trusts reporting an incident will get advice and help on being candid with parents, help with preserving records and other evidence, mediation where the relationship between the parents and the trust threatens to break down, and a preliminary investigation, when indicated, of legal liability.

There are plans to provide support to traumatised healthcare staff, initially using the National Clinical Assessment Service. “What we also want to do is, when we have a clinician who has been involved in one of our claims, we ask them if they would be willing to lend support, a listening ear,” says Vernon. “It’s someone to talk to in confidence who’s been there, who understands what it’s like. If anyone would like to put themselves forward, we’d be very receptive.”

Learning points

NHS Resolution’s early notification scheme has recruited two senior clinical advisers on one year secondments to help trusts with investigations and provide an initial assessment of liability. Tim Draycott, a consultant obstetrician at North Bristol NHS Trust, and Rebecca Wilson-Crellin, a senior midwife with Birmingham Women’s NHS Foundation Trust, will also identify and analyse learning points for trusts and the wider NHS. “It’s relatively unusual for a claim to be focused on the activity of one individual rather than a series of events,” notes Vernon.

NHS Resolution’s five year strategy for clinical negligence cases generally is to move away from formal court proceedings when possible. “It’s a myth that we’re all about litigation,” says Vernon, pointing out that two thirds of all the clinical negligence cases settled in 2016-17 were resolved without the need for court proceedings.

Francis warned the health select committee in 2013 that unless the NHS adopted a new culture of openness and candour and settled cases quickly, the litigation bill would continue to grow. Moves such as early explanations for patients on what went wrong, quicker settlements, and working with other NHS bodies to learn lessons and prevent future tragedies hold out hope of stemming the relentless rise of compensation costs and conserving more funds for the NHS.

Clare Dyer is legal correspondent, The BMJ

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“The important difference is that we are working with the trust to get to the right answer and to ensure that the information is being shared with the family at a much earlier stage than we are currently,” she adds. Settling cases as early as possible cuts legal bills. Of the £1.7bn that NHS Resolution paid out in 2016-17 for all types of clinical negligence, nearly £500m went to claimants’ lawyers.

Trusts will need to improve their internal investigations. The Each Baby Counts scheme found that a quarter of investigations did not contain enough information to reach conclusions about the quality of care provided; parents were involved in only a third of cases, and an independent panel member in only 9%.

“"We are working to get the right answer and to ensure that the information is being shared with the family at a much earlier stage" — Helen Vernon

Payments for some clinical claims

<table>
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<th>Year</th>
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<th>Claimants’ legal costs (bn)</th>
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<td>2016-17</td>
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Source: NHS Resolution

Cost (£ billions)

2010-11 2012-13 2014-15 2016-17

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Farewell CCGs. Hello ACSs and ACOs

Sustainability and transformation partnerships are evolving into organisations that will be responsible for all NHS and social care, writes Tom Moberly. But critics worry about further cuts and privatisation.

What are accountable care systems and accountable care organisations?
In an accountable care system (ACS) several healthcare organisations agree to provide all health and social care for a given population.

An accountable care organisation (ACO) is a body that manages the agreements to establish such a system and is accountable for all care. Distinctions between the two terms are often overlooked, and they are sometimes used interchangeably.

How did the terms originate?
Accountable care organisations have been developed in the US, with groups of healthcare providers coming together to provide care for a given population. Examples include the Group Health Cooperative of Puget Sound, Washington State; the Geisinger Health System, western Pennsylvania; and Intermountain Healthcare in Salt Lake City.

ACOs are accountable to patients and funders for care that meets particular quality metrics within set costs, often based on a capitation funding model. For some time, ACOs have been suggested as a way to help the UK improve integration of health and social care providers.

How are they likely to function in the NHS?
In the English NHS, ACSs are being established as a new phase in the development of sustainability and transformation partnerships (STPs). In June, Simon Stevens, NHS England’s chief executive, told delegates at the NHS Confederation conference that eight of the most advanced STPs in England would be the first to evolve into ACSs.

One of these is Greater Manchester, which last year took control of its £6bn health and social care budget in a historic devolution of power. These ACSs will integrate funding for, and be responsible for delivering, all health and social care within a geographical area.

All STPs should become ACSs over the next few years, but it is expected to be several years before the ACSs formally become ACOs.

How do they relate to existing NHS structures?
The 2012 Health and Social Care Act established clinical commissioning groups (CCGs), which replaced primary care trusts in England.

In 2014, Stevens published the Five Year Forward View, a plan to save the NHS in England £22bn a year. He argued that these savings were necessary to help close the widening gap between funding and demand for services.

In 2015, 44 STPs (partnerships between CCGs, trusts, and local authorities) were announced to develop local plans to implement the Five Year Forward View. These STPs are expected to evolve into ACSs to deliver the envisaged savings.

Will they supersede other structures?
An ACS will ultimately supersede the STP from which it is formed. It is also likely that, to increase efficiency and reduce costs, they will subsume the functions of some other NHS bodies, such as CCGs.

Many of the organisations founded by the 2012 act, including CCGs, were established on a statutory basis, so legislation would therefore be needed for ACSs to replace them. However, with the government focused on Brexit negotiations, there is unlikely to be parliamentary time over the next 18 months to develop such legislation.

Who are their proponents?
Stevens says that transforming STPs into ACSs will integrate funding and delivery, and that they will effectively dissolve the boundaries between commissioners and providers that have existed since an NHS internal market was introduced in 1990.

“We are now embarked on the biggest national move to integrating care of any major Western country,” Stevens said in June. “For patients this means better joined up services in place of what has often been a fragmented system that passes people from pillar to post.”

What do critics say?
Critics, such as east London GP Youssef El-Gingihy, worry, especially because ACSs will be responsible for the £22bn a year savings for the NHS in England. “Accountable care cuts healthcare costs by restricting access to hospital care and specialists as these are both expensive,” he has said.

In a statement on ACSs, the BMA said it “has repeatedly called for government and NHS leaders to ensure proper governance structures are in place before changing structures.” The BMA thinks that the necessary legislative changes “are unlikely to happen” under a minority Conservative government and that this leaves “serious governance issues.”

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EDITORIAL

The real, harmful effects of television suicides

Survivors, families, and producers all need to be involved in minimising the risk to vulnerable viewers

On 31 March 2017 Netflix released its original series *13 Reasons Why*, portraying the fictional and graphic suicide of 17 year old Hannah Baker, who records her reasons on 13 tapes before her death. The tapes emphasise Hannah’s social environment as a causal factor.

The programme sparked immediate criticism from mental health organisations. The depiction of Hannah’s death was deemed to violate media guidelines for suicide reporting, and concerns were raised that the series could trigger self harm among vulnerable viewers by romanticising suicide and portraying it as the only option to cope with negative experiences.

News media, including the *New York Times*, reported anecdotal evidence of “imitative” behaviours among high school students—for example, girls cutting their hair, painting their nails blue, or recording similar tapes. A recent study found that Google searches for suicide—a potential marker of suicidal ideation—increased after the series’ release.

Concerns have been expressed about similarities with a German television programme, *Tod eines Schüler* (*Death of a Student*), broadcast in the 1980s. This series showed the fictional railway suicide of a 19 year old man.

Similar to the Netflix series, it focused on the protagonist’s social environment as the main causal factor. The broadcast was followed by a statistically significant increase in railway suicides among males aged 15-29 in Germany. A re-run of the series a year later was followed by a weaker, statistically non-significant increase.

Although we cannot infer causality from this study, the identified associations are consistent with a potential Werther effect, which describes media induced increases...
How to improve psychotropic prescribing for people with intellectual disability

An effective national strategy depends on aligning evidence, practice, and policy

Safe and appropriate use of psychotropic drugs has become a priority for people with intellectual disability, their carers, and services after revelations of shocking abuse of patient trust and safety, prompting the UK government to review care for this group of patients with complex needs. The serious and systemic failings identified by the review galvanised clinicians across primary and secondary care, and an NHS policy drive, “Stopping over-medication of people with learning disabilities” (STOMP), now entering its second year, aims to ensure the best use of psychotropic drugs. Although STOMP has kept the issue alive, it is yet to effect real change and there remains much scope for improving prescribing of psychotropic drugs for people with intellectual disability.

**Barriers to withdrawal**

It is often possible to reduce or discontinue antipsychotic drugs in people who have been prescribed them long term, but there are associated risks, including unmasking symptoms of mental disorder, withdrawal reactions, and deteriorations in behaviour. Barriers to psychotropic withdrawal include infrequent or ineffective drug reviews, lack of confidence or motivation among general and specialist practitioners, and poor access to specialist psychiatrists or pharmacists to advise on and oversee medication changes. Other important factors are the lack of supporting evidence for interventions to treat challenging behaviour and the inconsistent and patchy implementation of alternatives to medication.

A deprescribing algorithm might be one way of changing practice, but any algorithm must be sufficiently flexible to accommodate the considerable heterogeneity in this patient group. Excessive focus on reducing medication might be discriminatory, for example, if it denies people with intellectual disability appropriate treatment for mental illness.

A pragmatic approach is needed, within which medication is not viewed as inherently good or bad, but its advantages and disadvantages are considered in relation to an individual’s clinical needs, preferences, and life circumstances.

Shared decision making is central to optimising medication. This principle has been little explored in people with intellectual disability but has value in guiding decisions about psychotropic drugs in other people. We should ensure that people with intellectual disability act as partners in their care by enabling access to relevant information and by developing tools that support collaboration, such as tailored patient decision aids.

We must combine new approaches with generalisable knowledge drawn from other populations and initiatives. For example, STOMP has parallels with the national dementia strategy, which substantially reduced prescribing of antipsychotic drugs for adults with dementia over a relatively short period, although people living in care homes seem to have benefited less.

Monitoring the effect of STOMP will therefore be essential and is already part of the Royal College of Psychiatrists Centre for Quality Improvement audit programme.

We need to invest in more research to clarify the role of pharmacotherapy in the management of challenging behaviour, with a focus on understanding the causes and mediators of these behaviours and identifying subgroups of people most likely to benefit from psychotropic drugs. Qualitative investigation of the attitudes of patients, carers, and clinicians to drug reductions will help to identify the complex non-clinical and systems factors that influence use of psychotropic drugs.

Changes in prescribing can be difficult to achieve, and the effect of one-off policy interventions should not be overestimated. Meaningful and sustained change requires a cultural shift in the way that people with intellectual disability are supported by healthcare professionals and broader society.

**Right care**

Other essential elements include commissioning the right care in the right place, providing suitable educational and vocational opportunities, and investing in early intervention and training programmes for families and care staff.

If we are serious about improving use of psychotropic medication and valuing people with intellectual disability we must ensure that a clear national strategy combining policy drivers and much needed research investment is prioritised to stop further disadvantage to this patient group.

**Meaningful change requires a cultural shift in the way that people are supported by healthcare professionals and broader society**

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Elsavet Pappa, graduate student

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Find the full version with references at http://dx.doi.org/10.1136/bmj.j3896