# this week

**NHS FUNDING BILL** page 87 • **WHISTLEBLOWERS** page 90 • **TROUBLE AT GOSH** page 90

# LMCs to debate rejected GP contract

GP leaders have rejected a new contract from NHS England and condemned the work that primary care networks (PCNs) are expected to deliver over the next four years.

The details of the proposals are confidential, but *The BMJ* understands they include minor changes to the five year GP contract agreed last February, together with the new conditions for the networks.

NHS England presented the BMA with a revised version of the network conditions on 16 January, just a day after the consultation closed. GPs strongly criticised the draft requirements, saying that the demands were unrealistic and would pile new layers of bureaucracy on overstretched practices.

The BMA's General Practitioners Committee has called for a special conference of English local medical committees to allow GP representatives from across the country to debate and consider the outcome of the contract negotiations. Richard Vautrey, the committee's chair, said the message from GPs on the PCN proposals had been clear: they were "unreasonable and completely unachievable."

"At a time when demand and workload for practices are unprecedented, GPs working on the front line felt that these draft specifications pile on more pressure and would undermine primary care networks that were only just getting off the ground," he said. "This overload would therefore put in jeopardy all of the good work and progress PCNs have made. Even in the short time GPs were given to respond to the consultation, NHS England and NHS Improvement were overwhelmed with feedback, which was unanimous in its condemnation."

Vautrey said the committee would now go back to NHS England and NHS Improvement to "seek a way forward."

The draft service specifications for the primary care network directed enhanced service, published just before Christmas, said that practices that sign up from this April would be required to provide five national services over a year. These include having to visit patients in care homes at least once a fortnight from September and, from April, initiating structured medication reviews for the patients most likely to benefit, including those in care homes.

NHS England said that it could not comment while negotiations continued.

▶ NEWS ANALYSIS page 90

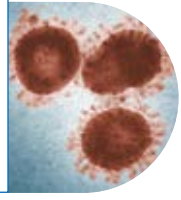
Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2020;368:m214

**Richard Vautrey, chair of the BMA's General Practitioners Committee, said the contract's network proposals were "unreasonable and completely unachieveable"**

## LATEST ONLINE

- China coronavirus: cases surge as official admits human to human transmission
- Antibiotic resistance: more companies are withdrawing sales personnel or incentives to limit use, report finds



# SEVEN DAYS IN

## RCGP cancels fossil fuel conference at headquarters after backlash


ALAMY

**The Royal College of General Practitioners has cancelled a conference run by Oil & Gas UK, due to be held this month at the college's London headquarters, after a social media petition garnered more than 1000 signatures from GPs and other medical professionals.**

**The petition demanded that the college must ensure its building was not used by organisations that "threaten public health by promoting the use of fossil fuels." Cancelling the event, the college announced that its policy on hiring rooms is being reviewed. Oil & Gas UK, which describes itself as "proud champions of the UK offshore oil and gas industry," advertised the event as a "unique opportunity for the industry to share stories on the exploration challenges in the North Sea and Atlantic Margin."**

**In 2018 the RCGP, announcing that it would no longer invest in fossil fuel firms, said it had "long recognised the impact that climate change has on the environment—and the adverse effects it can have on patients' health." The college is also a member of the UK Health Alliance on Climate Change, which advocates for climate crisis responses that protect and promote public health.**

**Martin Marshall, the RCGP's chair, said, "We deeply regret that [this] booking conflicts with our longstanding commitment to combat the impact of climate change on the health of our patients."**

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2020;368:m205

### Patient discharge

**Hospital asked doctors to discharge patients early**

Medical leaders warned that doctors and patients were being placed at risk after a hospital encouraged doctors to discharge patients early because of a lack of beds. In an internal email the Royal Cornwall Hospitals Trust said it was considering discharging patients "earlier than some clinicians would like" because of "significant pressure" on services. Chaand Nagpaul, BMA council chair, said he was writing to the trust and the GMC to express "serious concerns."

### Clinical trial reporting

**US compliance is poor and not improving, study finds**

Only 41% of clinical trials reported their results to the US registry within a year of completion as required by law, a study found. Researchers from Oxford University, who identified 2497 trials that breached the rules, called for better enforcement from the US Food and Drug Administration. The FDA Amendments Act 2007 requires trial sponsors to report results, whatever they are, directly to ClinicalTrials.gov within a year of completion.

### Gambling

**Crackdown on "loot boxes" in video games is urged**

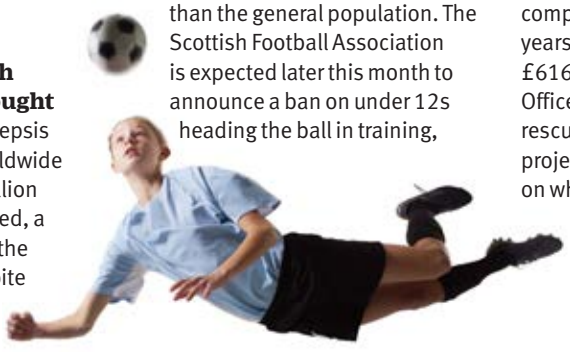
Claire Murdoch, NHS mental health director, called on video gaming companies to crack down on the risks of gambling addiction by banning "loot boxes" (below), which allow players to pick up potentially valuable items in return for in-game spending.

Murdoch said companies risked "setting kids up for addiction" by building gambling tasks into their games. She also called on companies to introduce "fair and realistic" spending limits, to make clear to users what percentage chance they have of obtaining the items before buying the loot boxes, and to increase parents' awareness of risks from in-game spending.

### Sepsis

**Deaths are much higher than thought**

Almost 50 million sepsis cases occurred worldwide in 2017, and 11 million deaths were recorded, a study published in the *Lancet* found. Despite a decreasing global trend in sepsis the study still found "substantial differences" among regions in the total number of deaths, age distribution, and case fatalities. Babies and small children in sub-Saharan Africa were particularly at risk. "These differences by location are alarming and deserve urgent attention from the global health, research, and policy communities," the authors said.



### Dementia

**Scotland to ban children from heading footballs**

A ban on children under 12 heading footballs is set to be implemented in Scotland because of links with dementia. The move comes after a recent study by the University of Glasgow, which found that former professional football players were more likely to die from neurodegenerative disease than the general population. The Scottish Football Association is expected later this month to announce a ban on under 12s heading the ball in training, which would make it the first European country to do so. The United States introduced a similar ban in 2015.

### PFI hospitals

**Projects were mismanaged, says watchdog**

The government has been criticised for its handling of growing costs from two delayed private finance initiative (PFI) hospital projects that were run by the former company Carillion. The Royal Liverpool University Hospital (above) and the Midland Metropolitan Hospital in Sandwell missed their completion deadlines by several years and were costing an extra £616m, said the National Audit Office. Its report looked at the rescue of the two PFI hospital projects Carillion was working on when it collapsed in 2018. But much of the extra cost will not be left for taxpayers to meet, the NAO said.

# MEDICINE

## Social media

**Platforms should share data, say psychiatrists**

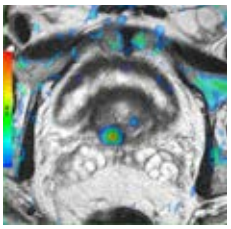
Social media companies should be forced to hand over their data to universities for use in independent research into the risks and benefits of social media use, said the Royal College of Psychiatrists. It said the government's plans to set up an online safety regulator, announced last year, should be extended to allow the regulator to compel companies to hand over anonymised data that included the nature of viewed content.

**The data held by platforms could help research into the risks and benefits of social media**

## Complaints

**Only 38% of hospitals report responsive action**

Just over a third (38%) of NHS hospitals in England reported action taken in response to patient complaints in 2018, research showed. A review by Healthwatch found that just one in eight hospital trusts had provided all necessary information to comply with statutory regulations.



The review team searched 149 NHS acute trust websites and found that, while all hospitals had reported the number of complaints received, just 16% had published the required standalone complaint reports.

## Maternity

**Inquiry into scandal to examine 900 cases**

The independent Ockenden review into maternity care at Shrewsbury and Telford Hospital is examining 900 cases, the government said. The review was set up to investigate 23 cases but has rapidly expanded after an appeal for families to come forward. Speaking in the House of Commons, Nadine Dorries, health minister, said some of the 900 cases dated back 40 years. The review is expected to conclude at the end of this year.

## Prostate cancer

**UK sees record number of deaths from the disease**

The number of men dying from prostate cancer in the UK has exceeded 12 000 in one year for the first time, figures showed. In 2017 deaths from the cancer (below) stood at 12 031, up from 11 637 in 2016. The rise was largely attributable to more patients having the disease diagnosed: in 2017, 48 561 men were given a new diagnosis. The charity Prostate Cancer UK, which analysed figures based on the Office for National Statistics' data, said that the numbers were "unacceptable."

## Primary care

**Pledges need investment to succeed, say NHS leaders**

The NHS Confederation warned that Tory health commitments made during the election will be no more than a pipedream without greater support and investment in primary care. It said the promises, including 50 million extra GP appointments and more primary care staff, were unlikely to happen because GPs had not been given enough time, support, or funding.

Cite this as: *BMJ* 2020;368:m232

## HPV

HPV 16 and 18 infections were found in less than 2% of women aged 16-18 during 2014-18—down from 15% in 2008, when human papillomavirus vaccination was introduced

*[Public Health England]*

## SIXTY SECONDS ON . . . NHS FUNDING BILL

**THIS SOUNDS IMPORTANT**

Matt Hancock (below) would like you to think so. The government has published a bill to enshrine in law its election pledge of a "historic" £33.9bn extra a year for the NHS by the end of the parliamentary term.

**WHAT'S HISTORIC ABOUT IT?**

Ministers say it's the biggest cash boost the NHS has ever had. This is technically correct, but only because of inflation. In real terms the pledge amounts to an extra £20.5bn by 2023-24 (around 3.4% a year on average). This is higher than the almost flat funding of the past decade under Tory governments, but less than the average 6% increase under Labour.

**BUT HASN'T NO10 ALREADY PLEDGED THIS CASH?**

It has, but why rely on promises when you can publish largely ceremonial legislation to occupy valuable parliamentary time?

**WHY INDEED . . .**

The government says it's focusing on people's priorities, but a less charitable take might be that it's simply pledging to do something that it has already promised to do, so as to stop itself from not doing it.

**I'M CONFUSED**

It's the equivalent of putting a lock on the biscuit tin to stop yourself raiding it. Or a parent legally guaranteeing a child their pocket money irrespective of whether the family falls on hard times.

**IS THERE ANY PRECEDENT FOR THIS?**

This is the first time any government has placed such a commitment in legislation—pledges are usually either delivered and bragged about or quietly broken and swept under the carpet. But the Tories may see their recently enlarged majority as a chance to shift the narrative from "long waiting times" to "cash bonanza."

**IS THERE A CATCH?**

Jonathan Ashworth, shadow health secretary, argues that the bill as it reads will technically cap NHS expenditure for the next four years. So, while it places a legal duty on the government to guarantee a minimum level of spending, Labour says this isn't enough to deal with the service's current pressures.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2020;368:m223

# Figures show big increase in emergency admissions of dementia patients

England has seen a large rise in the number of people with dementia being admitted to hospital in an emergency, with many having to stay in hospital for months because of a lack of social care in the community, an analysis by the Alzheimer's Society has shown.

In 2017-18 there were 379 004 emergency admissions, up from 279 265 in 2012-13 (a rise of 35%), the charity's analysis of NHS England's hospital episode statistics found.

In 2017-18 40 083 patients with dementia stayed in hospital for between a month and a year, including 412 who were in hospital for longer than six months.

More than half (237 881) of the 435 600 people who had a diagnosis of dementia in 2017-18 were admitted to hospital as an emergency at least once that year. Between 2012-13 and 2017-18 more than half of people with dementia were admitted more than once, with 2335 admitted more than 10 times.

LIFE IN VIEW/SPL

The Alzheimer's Society estimated that the extra 99 739 emergency admissions in 2017-18 cost the NHS more than £280m, while the 40 083 patients who spent between a month and a year in hospital that year cost more than £165m.

Jeremy Hughes, chief executive of the society, said, "People with dementia are all too often being dumped in hospital and left there for long stays. Many are only admitted because there's no social care support to keep them safe at home.

"They are commonly spending more than twice as long in hospital as needed, confused and scared. This costs the NHS millions for the want of properly funded social care."

The charity urged the government to allocate an extra £8bn a year to adult social care in England in the spring budget, which is the amount the House of Lords Economic Affairs Committee recommends is needed by 2020-21.

The Conservative government has been promising a green paper on social care reform since 2017, and Boris Johnson promised to "fix the crisis in social care" in his first speech as prime minister last July.

But no plan has been forthcoming. The Conservatives' election manifesto promised an extra £1bn a year for social care and "to build a cross party consensus" on how services should be funded long term, an approach confirmed in the Queen's speech in December.

When asked what had happened to the delayed green paper, a Department of Health

THE ALZHEIMER'S SOCIETY estimated that the additional 99 739 emergency admissions of patients with dementia in 2017-18 cost the NHS more than £280m

# Obesity surgery does not ease teens' mental health problems

SPL

**Diet education class for children and teenagers in obesity care centre**

Adolescents who have bariatric surgery continue to experience mental health problems five years later despite substantial weight loss, a study has found.

The authors of a study published in the *Lancet Child and Adolescent Health* said that, while surgery can improve many aspects of health, their results indicate that alleviation of mental health problems "should not be expected."

The team, from Sweden, used records of psychiatric drug prescriptions and specialist care in combination with self-reported data to assess the long term effects of weight loss surgery in 161 adolescents aged 13-18.

At five year follow-up, despite small improvements in self-esteem and moderate improvements in binge eating, the adolescents who had undergone surgery did not see improvements in overall mental health when compared with those who received conventional obesity treatment.

### Realistic expectations

Kajsa Järvholm, coauthor of the study from Skåne University Hospital, said, "Our results provide a complex picture, but what's safe to say is that weight loss surgery does not seem to improve general mental health. We suggest that adolescents should be given realistic expectations in advance of embarking on a surgical pathway and that long term mental health follow-up and support should be a requirement."

The researchers recruited 81 adolescents with severe obesity (average body mass index of 45 before treatment) who had Roux-en-Y gastric bypass surgery between 2006 and 2009. As a control group, 80 adolescents with an average BMI of 42 received conventional treatment, including cognitive behavioural therapy and family therapy.

Gareth Iacobucci, *The BMJ*

**Cite this as: *BMJ* 2020;368:m242**

and Social Care spokesperson said, "We have given councils an extra £1.5bn next year for children and adult social care and are determined to find a long term solution so that every person is treated with dignity and offered the security they deserve."

But Nina Hemmings of the Nuffield Trust said the extra funding was "unlikely to match rising demand."

"Decisive leadership and long term funding reform will be crucial," she said.

Hugh Alderwick, deputy director of policy at the Health Foundation, said a better social care system was affordable but required much delayed reforms to be implemented.

"The current government has committed to fixing social care 'once and for all' but so far has only said that a new model will mean nobody has to sell their home to pay for care. This is a narrow view on the problems in social care," he said.

"Government action is needed to stabilise social care services, improve access to care, and reform the funding system to make it fairer and provide greater protection against social care costs."

**People with dementia are all too often being dumped in hospital and left there. Many are only admitted because there's no social care support to keep them safe at home**
Jeremy Hughes, Alzheimer's Society

Ingrid Torjesen, London

Cite this as: *BMJ* 2020;368:m249

Before treatment, the proportion of participants taking prescribed psychiatric drugs was 20% in the surgical group and 15% in the control group, compared with 2% in the general population

The proportion who received specialist mental healthcare increased in both groups after five years, but those who had undergone surgery had significantly more hospital based inpatient and outpatient care for mental health problems than those who had not—36% (29 of 81 participants) *v* 21% (17 of 80) in the control group

# Consultant is struck off for lying over girl who died from septicaemia

A consultant in emergency medicine has been struck off after a tribunal found he lied repeatedly to cover up his failure to recognise meningococcal septicaemia in a 6 year old girl who later died.

Harsha Rajanna was a specialty trainee year 6 registrar in emergency medicine in February 2017 when he failed to examine Layla-Rose Ermenekli properly at the Royal Oldham Hospital. Her mother had brought Layla in to the emergency department with a high temperature. Rajanna did not notice a rash on her hip, the tribunal found.

After a brief test of liquid tolerance, he ordered her discharge, but a concerned paediatric sister called a junior doctor, who noticed the non-blanching rash and recognised it as a classic sign of meningococcal septicaemia. The junior doctor alerted Rajanna but, she told the tribunal in a statement, "Dr Rajanna made me feel that I was worrying unnecessarily. He reassured me and was confident with his impression of Patient A's condition and the rash."

**Layla-Rose Ermenekli died after Harsha Rajanna did not notice a non-blanching rash**

## Cardiac arrest

Nevertheless, a senior paediatric doctor also examined Layla and concurred with the junior. Layla was admitted to paediatrics and given intravenous antibiotics, but she worsened rapidly and died after a cardiac arrest about four hours after first being examined.

Rajanna was not accused of causing the child's death but of failures in her care and of lying about the events, first to an inquiry by Pennine Acute Hospitals NHS Trust, and later under oath at a coroner's hearing. In both cases he claimed he had seen "a bruise-like area." At the inquest he said Layla's mother had told him it was caused by bumping into a table. He also claimed to have told this to the junior doctor when she brought the rash to his attention.

Both the mother and the junior doctor testified at his medical practitioners' tribunal hearing that this was untrue and he had not mentioned a bruise or mark.

Described as a "credible and compelling witness" by the tribunal's chairman, David Urpeth, Layla's mother was "steadfast" in rebutting his bruise claim. She also denied Rajanna's claim that the discharge had been her idea.

## "Non-credible witness"

Had this been the case, said Urpeth, Rajanna would have recorded it in his notes as being contrary to his advice. Rajanna was "an unreliable and non-credible witness," the tribunal found. "He often conflated his usual practice with his memory" in a way that the tribunal found "deliberately misleading," said Urpeth.

Rajanna's dishonesty was persistent, developed over time, and "has led to further anguish" for Layla's mother, who had been cross examined as a result, Urpeth added.

Counsel for the GMC asked for a sanction of erasure. Rajanna had been the only staff member not to apologise to the family at the coroner's court, she noted. He had apologised later, she said, but this was "cheapened" by his continued denial of some of his clinical failings and of dishonesty.

Rajanna's counsel argued that he had an otherwise unblemished 18 year record, had a young family to support, and since 2019 had been working in an area where recruitment was difficult, as a consultant in emergency medicine at Tameside Hospital. He said the trust investigation report showed failings across the board and urged the tribunal to be alive to the risk that Rajanna could be made a scapegoat for the actions of the whole emergency department.

"The tribunal determined that Rajanna's dishonesty is incompatible with continued registration," said Urpeth.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2020;368:m241

# Doctors "bullied" in search for whistleblower

A hospital trust fingerprinted staff and asked for handwriting samples after the family of a woman who died following surgery received an anonymous letter highlighting mistakes in her care.

The whistleblower's letter, which alleged that "something had gone wrong during surgery," prompted the coroner examining Susan Warby's death to instruct Sussex Police and West Suffolk NHS Foundation Trust to investigate.

### "Intimidatory tactics"

Doctors accused managers of using "bullying and intimidatory" tactics in their attempt to unmask the whistleblower. The letter alleged that glucose instead of saline had been used in a drip into one of Warby's arteries. She died, aged 57, at West Suffolk Hospital on 30 August 2018, five weeks after an operation to treat a perforated bowel.


**The hospital launched two serious incident investigations**

At the inquest on 16 January, Ipswich coroner Nigel Parsley said, "Both the Suffolk Constabulary and the West Suffolk Hospital investigations have confirmed the issue regarding the arterial line."

The inquest also heard that Warby's lung was punctured as a junior member of staff tried to insert a central line into her inner jugular vein. Cause of death was recorded as multi-organ failure, with contributory causes including septicaemia, pneumonia, and perforated diverticular disease, affecting the bowel.

The inquest was adjourned to await a report on what, if any, contribution the blunders made to her death.

In a statement the trust said, "We asked staff involved to provide handwriting and fingerprint examples to immediately rule themselves out. Staff . . . were not threatened with disciplinary action if they chose not to do so. However, we know . . . this was a very difficult and stressful situation, for which we are sorry."

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2020;368:m221

NEWS ANALYSIS

# NHS England under pressure to rein in PCN ambitions

Waves of protest and resignations of doctors signed up to lead the new primary care networks have sent the BMA and NHS England back to the negotiating table. **Gareth Iacobucci** finds out why

Mounting unrest over the proposed new terms and conditions for general practices to participate in primary care networks came to a head last week when GP leaders rejected an updated contract.

Practices that are part of a PCN are expected to agree terms for the services they will deliver from April to receive the extra funding agreed with NHS England. But draft terms and conditions published two days before Christmas caused alarm among many GPs, many of whom thought that too much was being asked of them.

The BMA's General Practitioners Committee for England will now push for changes, armed with what it called a "mandate" from GPs not to accept terms that would overload overstretched practices.

The details of the wider package of proposed contract changes for 2020-21 remain confidential, but new conditions for participating in networks form a key part of the negotiations.

### Unexpected demands

GPs were concerned about requirements in the draft direct enhanced service (DES) that they would have to visit patients in care homes at least once a fortnight from September, initiate structured medication reviews for patients most likely to benefit (including those in care homes) from April, and produce plans for providing anticipatory and personalised care services by June. They must also have a clinical lead in place to support early cancer diagnosis from April and introduce a "safety netting approach for monitoring patients referred for suspected cancer" in 2020-21.

### Diktats

These diktats, many argue, are at odds with the locally driven collaborative working GPs thought they had signed up for.

Local medical committees, the bodies that represent GPs, raised objections to the plans, with many such as Birmingham, Nottinghamshire, and Cambridgeshire advising practices not to sign up to the DES without major changes. And Berkshire, Buckinghamshire, and Oxfordshire LMCs estimated that each general practice would face a deficit of £105 000 a year on average as a result of the proposals.

Significantly, clinical directors—the enthusiasts who had put themselves forward to run primary care networks—have also opposed the plans, with some stepping down in protest and others saying that only a major shift in both the tone and substance of the contract would stop the networks stalling from the start.

# Great Ormond Street used mediators to ease urology consultants' tension

Managers at London's Great Ormond Street Hospital have said that "successful mediation," an away day, and "constructive conversations" helped deal with a "dysfunctional relationship" between consultant paediatric urology surgeons that threatened patients' safety.

The children's hospital trust asked the Royal College of Surgeons of England to review its paediatric urology surgical service after staff concerns and serious untoward incidents. A review team visited last May, and its report was published in November with the trust's board papers.

The hospital's urology service has around 3300 planned NHS admissions a year. It has six consultant

Suffolk GP Nick Rayner announced his resignation as a PCN clinical director on his Twitter page. "The level of work needed in these specs, with the speed of introduction suggested, makes me believe this is unachievable," he wrote.

Elsewhere, clinical directors representing 19 PCNs in Oxfordshire said they would have no choice but to withdraw from the DES unless it was "substantially modified." In their consultation response they wrote, "The centralised 'one size fits all' direction of these specifications is entirely contrary to the original locally led ethos of the PCN concept."

And clinical directors of four networks in the Guildford and Waverley area also advised practices not to sign up unless the DES underwent "significant alteration," because of the "overwhelming clinical and financial burdens" it would create.

The Oxfordshire clinical directors said the service specifications should be "aspirations" rather than contractual requirements at this stage. They specifically called for extra demands on GPs' time—such as stipulations on number of care home visits—to be removed, arguing that this was "not deliverable and contrary to the principle of multiprofessional team working," unless more money was attached.

### Way forward

NHS England and the BMA's General Practitioners Committee must now try to negotiate a deal that salvages some of the enthusiasm that has been lost.

Matt Neligan, NHS England's director of primary care, has conceded on Twitter that it "cannot afford to make [PCNs] over-ambitious." Just before the consultation closed, he said clinical directors and practice teams "should feel the final versions are deliverable and aimed at the right areas." But he added, "Equally we cannot afford to make them under-ambitious: the £4.5bn going into primary and community care in the NHS long term plan should create room to do more."

Martin Marshall, chair of the Royal College of General Practitioners, said in a letter to NHS England's chief executive, Simon Stevens, "Many PCNs are still in their infancy and should not be overloaded with work before they have had time to mature, or they will fail."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2020;368:m230

**The level of work needed . . . makes me believe this is unachievable**
Nick Rayner, GP

**The £4.5bn going into primary and community care in the long term plan should create room to do more**
Matt Neligan, NHS England

### TIMELINE: PRIMARY CARE NETWORKS

**2019**

**January** The plan to create small networks of neighbouring general practices working together in multidisciplinary teams is unveiled as part of the five year GP contract deal

**April** Primary care networks directed enhanced service (DES) is launched as part of the 2019-20 GP contract. The key requirement in the first year is for practices that sign up to join a network

**1 July** Nearly all practices in England (99%) meet NHS England's 30 June deadline to group together in around 1300 networks each serving 30000 to 50000 patients

**23 December** NHS England and NHS Improvement publish draft service specifications for the 2020-21 DES for consultation

**2020**

**15 January** Consultation closes

**16 January** BMA's General Practitioners Committee for England votes not to accept the contract agreement with NHS England and condemns the draft DES specifications. The committee says it will return to negotiations with NHS England

**April** The 2020-21 DES is due to start

surgeons, who the report said were widely regarded as excellent, dedicated surgeons. However, it said that a fractured relationship between two, unnamed, surgeons was causing difficulties and had the potential to affect patient care and safety if not resolved.

The report said the apparent reluctance of one consultant to collaborate with the wider team and with other services had affected multidisciplinary team working. The reviewers were also concerned about reports of inappropriate behaviour towards support staff and colleagues by another consultant, who was also unwilling to participate in cystoplasty and audit for enhanced recovery after surgery.

**THE UROLOGY service has around 3300 planned NHS admissions a year**

The report said there seemed to be significant competition between consultants for work, without clear subspecialisation being considered. This created the potential for waiting time breaches. The structures and processes in place for consultant surgeons treating private patients were not clear, the report added, and this had contributed to interpersonal difficulties.

A hospital spokeswoman said that, since the report was commissioned, a great deal of work had been done to fix the issues and repair relationships.

"We have taken the issues raised in the report and the recommendations extremely seriously and there has been good progress made," she said. "Successful mediation and the first away days have taken place, and very constructive conversations have happened between all consultants. They are now working together to shape their service to better serve the needs of their patients."

Jacqui Wise, London

Cite this as: *BMJ* 2020;368:m169

THE BIG PICTURE

# Cast in stone: university honours female pioneers

The names of Florence Nightingale, Alice Ball, and Marie Skłodowska-Curie have been added to the façade of the London School of Hygiene and Tropical Medicine's Keppel Street building.

The names join those of 23 other health innovators inscribed in the 1920s façade, all of whom are men.

As part of the celebrations for its 120th anniversary, the school gained special permission from Camden council to add the names to the frieze that wraps around the grade II listed building. The names were selected from suggestions made by the school's staff.

Nightingale (1820-1910) was a social reformer and statistician, and the founder of modern nursing. Ball (1892-1916) was an African-American chemist who developed an injectable oil extract that became the treatment for leprosy. Skłodowska-Curie (1867-1934) was the first woman to win a Nobel prize, the first person to win it twice, and the only person to win a Nobel prize in two different sciences: physics and chemistry.

Peter Piot, director of the London School of Hygiene and Tropical Medicine, said he was thrilled that these three women have been recognised.

"Attitudes were very different 90 years ago, but having only men on our frieze has always troubled me," he says. "Our frieze now better reflects the talented and diverse people who work at LSHTM and in global health around the world."

Tom Moberly, *The BMJ*

Cite this as: *BMJ* 2020;368:m246

**Sculptor Hayley Gibbs creates a model of the section of the Keppel Street frieze commemorating Alice Augusta Ball**


STONEWEST

EDITORIAL

# Divestment for health

*The BMJ*'s campaign for a better future

How do we restore hope for humanity? Many of us feel despair at a disintegrating political consensus to save our planet from fire, flood, disease, and conflict. We feel trapped in our high carbon lives and disempowered by commercial influence of companies whose products damage the planet and people's wellbeing.

Health professionals and medical organisations should not accept the world as it is. This is not a matter of playing party politics or anticorporate posturing. Taking action is a duty to the people we serve and to future generations. And we can act: by divesting from health harming industries. Divestment offers health professionals and medical organisations, for the duty is both individual and collective, an opportunity to influence politicians and industry towards behaviours that are better for the planet and people's health (box 1).

**Box 1 | What do we mean by divestment for health?**

The opposite of investment, divestment is the reduction or, as in this case, the removal of stocks, bonds, or investment funds that are unethical because of the harm to health.

## Fossil fuels

In a previous *BMJ* editorial, Law and colleagues argued that the case for divestment from fossil fuels is now clear cut.[6] Extraction of fossil fuels damages our planet. Products of the fossil fuel industry harm health, causing global conflict, driving climate change through carbon emissions, and shortening lives through air pollution. Yet politicians refuse to relinquish their political and commercial links to fossil fuels, and fossil fuel companies manipulate science to downplay the ill effects of their business. This allows us all to continue the convenient fantasy that all is well with the way we live.

Consuming our planet's fossil fuel reserves will ensure we miss carbon emission targets. Although the industry shows little sign of changing its strategy, the financial world is waking up to the threat to investments as well as to the planet. The governor of the Bank of England considers fossil fuels a risky investment because the demands of meeting the 2°C climate target will render the majority of oil, gas, and coal reserves "stranded" and "unburnable."[7]

In 2017, at the One Planet Summit in Paris, the World Bank announced its intention to end financial support for oil and gas extraction in response to the threat posed by climate change.[8] Recently, the European Investment Bank, the European Union's lending arm and the world's largest multilateral financial institution, stated its ambition to become the world's first "climate bank" by ending its multibillion euro financing of oil, gas, and coal projects after 2021.[9]

With this editorial, we launch a campaign for divestment from fossil fuels. An immediate objective of the campaign is to gain commitments from health professionals and medical organisations to divest from fossil fuel industries. Our long term ambition is that those commitments will be acted on in order to influence politicians and industry. Investment is a choice, and it is now easier to identify sustainable and ethically sound investments that will benefit rather than harm health.[10] None of this lessens the responsibility of individuals and organisations to limit their own effect on climate. You will find more on our green journey at www.bmj.com/about-bmj/how-green-is-the-bmj.

*The BMJ* applauds organisations such as the Royal College of Physicians, the Royal College of General Practitioners, the Royal Australasian College of Physicians, the medical associations of America and Canada, and the BMA, our owner, for committing to divest from fossil fuels. For our part, we will not accept advertising or research funded by companies that produce fossil fuels. We will also explore how else our business might be dependent on fossil fuel companies and take steps to end any such reliance. The BMA has no direct holdings in fossil fuel companies

Our new policy towards the fossil fuel industry may seem a minor concession since we receive little or no revenue from this sector. But as our online usage grows rapidly to an increasingly diverse international audience we expect *The BMJ* will become a more attractive route to market for companies beyond our traditional pool of advertisers. We are clear that income from companies that produce fossil fuels is revenue that *The BMJ* does not want now or in the future.

**Box 2 | Possible criteria for divestment from an industry**

- Harm caused, either in product creation or use, outweighs the benefits
- Industry manipulates the science to hide harmful effects
- The industry is not essential for our existence, or an alternative industry is available or can be developed

Most importantly, we seek your commitment and invite you to sign our online declaration of intent to divest from fossil fuels [https://bmj.com/divestment]. We urge you to follow up your commitment by implementing divestment in your personal finances and in the medical organisations that you belong to. In collaboration with the UK Health Alliance on Climate Change (which the BMA and BMJ help to fund) we offer guidance to help you successfully divest (ukhealthalliance.org/divestment/).[11]

## Next steps

We will consider what else to add to the divestment list. Other industries, however, may be more complex in terms of making a case for divestment. For example, how do we tackle the food and drink industries, many of whose products are beneficial to health but others contribute to the global crisis of non-communicable diseases as well as driving climate change? Even beneficial products can be harmful in excess and damaging to the environment. Workable criteria will help decide which other industries should join tobacco and fossil fuels as targets for divestment. We propose possible criteria in box 2. We welcome your views on these criteria and on our fossil fuel divestment campaign overall

Hope is not yet abandoned in our world today; it is merely besieged. Divestment offers us an opportunity to end despair and disempowerment, to begin to reclaim our world from misguided political and commercial agendas. By divesting now we wish to restore hope for the future wellbeing of our planet and for human health.

Kamran Abbasi, executive editor
kabbasi@bmj.com
Fiona Godlee, editor in chief, *The BMJ*, London

Cite this as: *BMJ* 2020;368:m167
Find the full version with references at http://dx.doi.org/10.1136/bmj.m167

EDITORIAL

# Release arrangements for immigration detainees

Current discharge requirements are clearly unsafe

NHS England now requires that prisoners must be registered with a general practitioner before their release. It says this is because "release from custody can be a crisis situation for some and can result in the reversal of previous health improvements. Furthermore, it [pre-registration] is vital in helping to support better health outcomes and maintain continuity of care for these individuals."[1] The new policy also requires prison healthcare services to organise follow-up medical care for prisoners "up to one month" before the date of their release.

The positive commitment to aftercare for people released from prison is in marked contrast to current arrangements for the 13 992 people who were released into the community from UK immigration removal centres (IRCs) in 2018.[4] The difference arises because release dates for prisoners are well defined and predictable, unlike those for detainees in removal centres. The UK has no limit on duration of detention for people detained under immigration powers[5] and detains more than other European countries.[6 7] Discharges are ordered by the Home Office or the courts, usually without warning, making access to medical care after release more precarious than for discharged prisoners.

The contract between the Home Office and removal centre management requires that released detainees depart within four hours. Centres that breach this contract risk a substantial fine.[9]

F W Arnold, independent forensic physician, Medact, London
arnold_frank@hotmail.com

J Chisholm, chair of medical ethics committee, BMA, London

J Cohen, independent forensic physician, Oxford

C Katona, medical and research director, Helen Bamber Foundation, London

J Payne-James, consultant forensic physician, Queen Mary University of London

**Detainees leave centres without adequate medication, arrangements for GP registration, medical notes, or continuity of care provision**

We are unaware of any provision to help released detainees identify a general practice that will register them, although this patient group is known to have particular difficulty in accessing community care.[10]

### Unsafe discharge

Current discharge requirements are clearly unsafe since they can result in detainees leaving removal centres without adequate medication, arrangements for GP registration, copies of medical notes, or provision for continuity of care. These and other serious problems in the healthcare of detainees have also been documented in expert reports.[6-14] Complaints from former detainees about unduly hasty or dangerous discharge have elicited dismissive written responses insisting that clinicians must adhere to Home Office requirements for rapid discharge (personal communications, available on request from FWA).

The discharge practice is particularly concerning because many detainees need prescribed drugs such as psychotropic, anti-epileptic, or antiretroviral agents and are at risk of relapse or deterioration if treatment is discontinued. Released detainees may be vulnerable because of language difficulties, ignorance of UK healthcare systems, or traumatisation by their experiences before or during detention.

Medically unsafe discharge may be a consequence of the Home Office's desire to avoid accusations of unlawfully prolonging detention. From 2012 to 2017 over £4m (€4.7m; $5.3m) was paid each year in compensating people who were wrongfully detained in England.[14] Despite the concern to avoid such payments, the Home Office and removal centre GPs have an enduring duty of care which does not end at release.

Immigration detainees have a right to timely liberty when this is ordered but also a right to medically safe release. Similarly, the authorities should not be subject to unreasonable claims for wrongful detention. These requirements may seem conflicting but they can and should be reconciled without detriment to either party.

It is NHS England policy to audit performance indicators for immigration removal centres, and these indicators should include measures of safe discharge, as recommended by the Faculty of Forensic and Legal Medicine.[15]

New contracts for healthcare services in immigration removal centres are due from June 2020, providing an opportunity for a rethink. The Home Office, NHS England, and all providers should ensure that existing contracts do not prevent or obstruct clinicians working in these centres from complying with their professional duties as defined by the General Medical Council when discharging detainees or transferring responsibility for their ongoing care.[16]

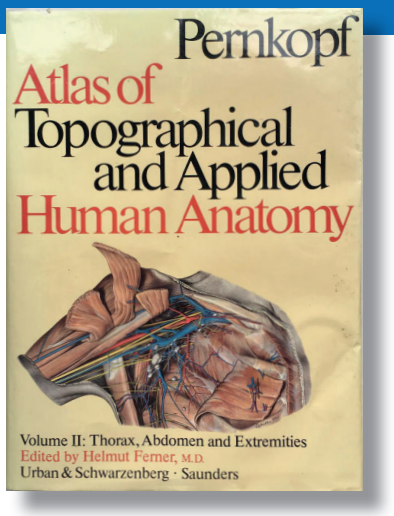
Cite this as: *BMJ* 2020;368:m15

Find the full version with references at http://dx.doi.org/10.1136/bmj.m15

ESSAY

# When medical information comes from Nazi atrocities

The nerve surgeon **Susan Mackinnon** discovered that an old but precise textbook she relied on was created by a Viennese anatomist who had dissected Hitler's victims to produce his detailed illustrations. Should we still be using the illustrations, she asks




I first encountered the *Atlas of Topographical and Applied Human Anatomy* in 1982, during my hand fellowship at the Curtis National Hand Center in Baltimore. The atlas became my dissection partner during many hours spent in the anatomy lab at Johns Hopkins Hospital.

For several years I knew the Pernkopf atlas (named after its author, Eduard Pernkopf, chair of anatomy and president of the University of Vienna) only as a valued piece of science and art. In the late 1980s I came across essays by Gerald Weissman, an Austrian born US physician-scientist at New York University, and David Williams, a medical illustrator of Purdue University, Indiana, exposing the origin of my dissection partner, calling it the "atlas of the Shoah," derived during the Holocaust.

Once I, a gentile, came to know the truth of its origin, my attitude changed. I stowed the atlas in my operative room locker, with copies of Weissman's and Williams's essays slipped into the atlas as a marker to anyone who might use it, and a warning to "enter with caution."

However, having already spent many years with the atlas, still the most detailed anatomy book I've ever seen, I continued to feel the need to refer to it occasionally for the sake of improving my patients' surgical outcomes. Several times a month, while operating, I would struggle with the anatomical nuances of nerve pathways. The atlas showed me the way: an exact and safe surgical approach to the nerves.

With the clarity of observation, combined with detailed artistic skill, the atlas's illustrators, under Pernkopf's guidance, had depicted the human body's great design. These anatomical plates were unique in their accuracy as a result of the cadaveric nature of the emaciated bodies, a product of torture.

For many decades I perceived the need to bring this atlas into the operating room, always with respect, gratitude, solemnity, and disclosure—and some discomfort. Once, at the request of my Jewish fellow, I promptly returned it to my locker.

**The atlas's illustrators, under Pernkopf's guidance, depicted the human body's great design**

## Second thoughts

This equilibrium regarding the use of this tool sufficed until five years ago, during a meeting with my longtime colleague, Andrew Yee, to discuss research and education that included the atlas. Serendipitously, Sabine Hildebrandt, an anatomy educator at Harvard University and Holocaust scholar, presented the 2015 Yom HaShoah (Holocaust Remembrance Day) lecture at our institution. With trepidation, at the conclusion of her lecture, Yee and I approached Hildebrandt for her thoughts. I will always remember the pause before her response: that good might come from iniquity and crime, but only with disclosure of the history and deliberation with the experts.

Over a decade, with the help of the atlas, Yee and I had built a substantial online educational programme that included a library of educational videos describing anatomically precise techniques and the accompanying clinical reasoning in nerve surgery. The Pernkopf atlas had heavily influenced the development of the surgical procedures and the accompanying video library. The open access videos have been viewed more than four million times across the world, including in regions of strife and war, to help restore function to patients injured by trauma and conflict.

On that Sunday afternoon, despite our initial reservations concerning the ethics of using data derived from the Holocaust, Yee and I had discussed the idea of including key plates from the atlas to accompany our videos. We also talked about our reservations. Would the produced materials be simply a recreation of the abuse suffered by victims of the Holocaust?

Encouraged by the thoughts of Hildebrandt and the physician ethicist William Seidelman, who supported use of the atlas to treat patients with complex nerve injuries, we moved forward with developing a sophisticated video based learning platform. We planned to include the history of the atlas and a vetted system to display the relevant anatomical plates. Within the first two years of the platform's launch, more than 1500 surgeons from all corners of the world had subscribed.

We surveyed them and the American Society for Peripheral Nerve on the question of whether or not to use the atlas in nerve surgery and education. Of those who responded, over half were aware of the atlas and 13% were currently using it in surgery. We then presented a four point proposal for the


BIOGRAPHY

Susan Mackinnon is a plastic and reconstructive surgeon at Washington University School of Medicine in St Louis, Missouri, specialising in nerve surgery. She runs a research laboratory that focuses on the basic science of nerve injury and how to repair it. She trained at the University of Toronto.

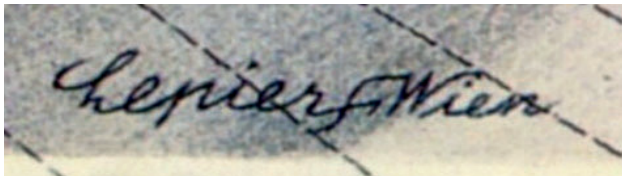

appropriate treatment of disclosure, bioethics, religious considerations, and remembrance, and the results were astounding.

Of the respondents who were initially "undecided" (17%) or "uncomfortable" (15%) using the atlas, a majority (76%) became comfortable with the inclusion of the four point proposal. Also, surgeons indicated that in all circumstances the atlas provided greater anatomical detail and surgical utility than the well known Netter atlas.

### Shared decision making

While these findings laid the groundwork, the considerations of bioethics and religious guidelines to acknowledge the atlas remained. We were aware of the framework in applied ethics created by Ira Kodner and Doug Brown to guide patients and surgeons through shared decision making and living a code of truth and trust. Also, the American College of Surgeons and the journal *Surgery* co-sponsored quarterly case studies (2008 to 2019) examining bioethical dilemmas that used a graduated framework to navigate complex ethical issues.

In 2016 and 2017 we asked the current holder of the copyright (Elsevier) if we could use the atlas's images for the advancement of education and medical ethics and received the following official response by email: "Elsevier upholds the highest ethical and business standards. For this reason, we no longer publish Pernkopf or allow license thereof," because "allegations arose that the bodies used for dissection to draw the images came from Holocaust victims."



**Pernkopf's illustrators added swastikas to their signatures when signing the plates**

### A PATIENT'S VIEW

"I recently came to see Dr Mackinnon for help with a painful nerve injury in my arm. During my appointment, Dr Mackinnon used the Pernkopf atlas to point out the nerves that might be causing my symptoms. Before opening the atlas, she respectfully disclosed its origins, and my husband and I both agreed to view the diagrams.

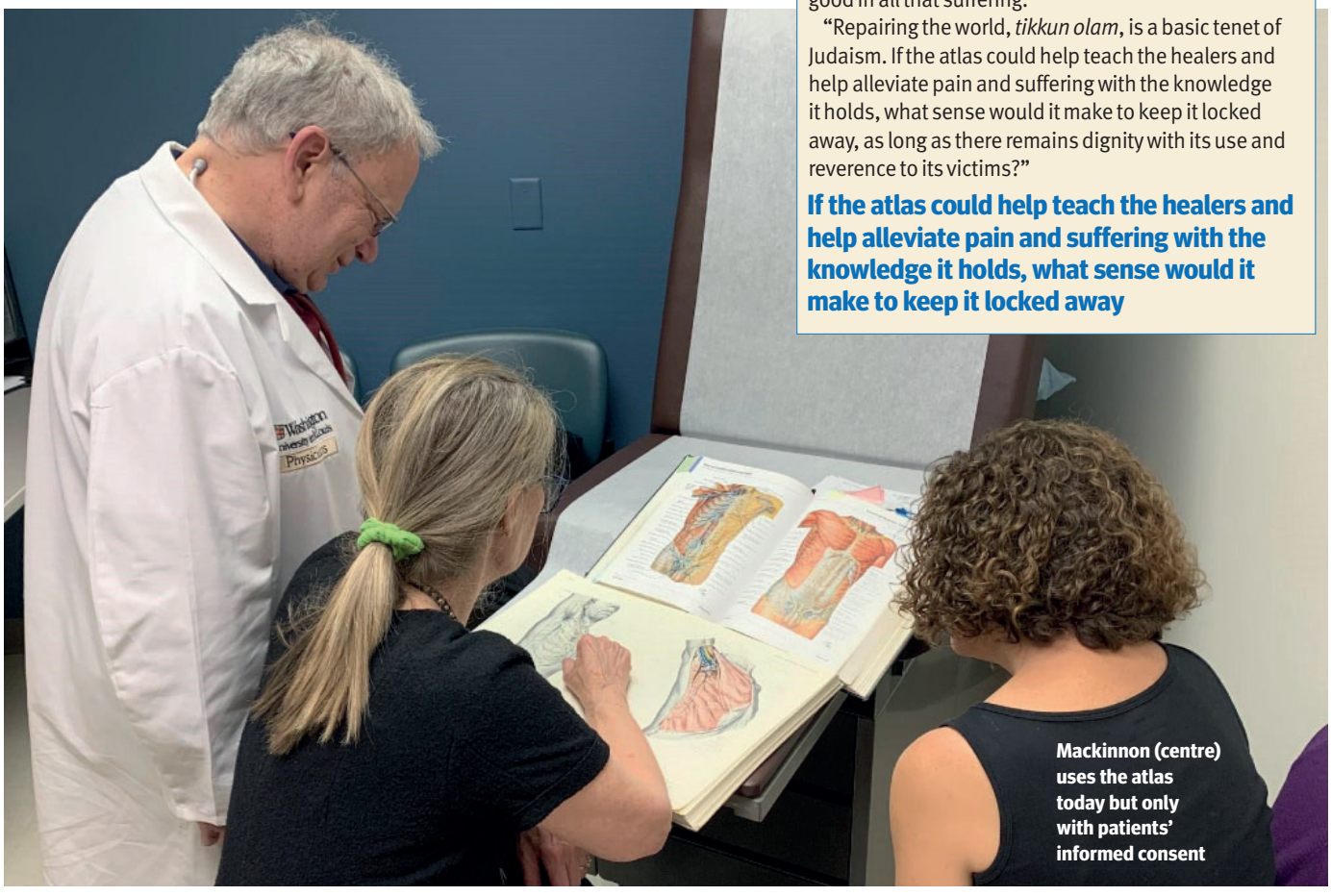
"While our Conservative [Masorti] Jewish family didn't have any known close relatives remaining in Europe during the Holocaust, my father told me of extended family that stayed behind when my great grandparents emigrated to the US at the turn of the 20th century. My son in law's maternal grandparents and great aunts and uncles survived the camps and lost their families in the Holocaust. They were too traumatised to talk about it.

"As a Jew, the Shoah affects me greatly. The Jewish people are known as 'the People of the Book.' Studying the Torah, learning, and interpreting Jewish law are very important to us. We question things and try to see things in different perspectives. We try to help others, to repair the world. I always think of how many brilliant minds, artistic minds, were lost. Would we have cures for diseases or magnificent works of art?

"Dr Mackinnon and I discussed and acknowledged the atrocities of the Holocaust. The atlas with all its detailed diagrams exists, holding valuable information that could help countless numbers of people worldwide. There is nothing that is going to bring the victims of the Shoah back. Maybe there is a tiny sliver of good in all that suffering.

"Repairing the world, *tikkun olam*, is a basic tenet of Judaism. If the atlas could help teach the healers and help alleviate pain and suffering with the knowledge it holds, what sense would it make to keep it locked away, as long as there remains dignity with its use and reverence to its victims?"

**If the atlas could help teach the healers and help alleviate pain and suffering with the knowledge it holds, what sense would it make to keep it locked away**



**Mackinnon (centre) uses the atlas today but only with patients' informed consent**

IMAGE FROM GQ ARTICLE THE MOST DANGEROUS BEAUTY

Therefore, we posed the question to Rabbi Joseph Polak, who has expertise in Jewish medical ethics and law and is a child survivor of the Holocaust, and the Holocaust scholar Michael Grodin. Was it ethical, from the victims' point of view, to use the atlas's images?

Polak's answer was framed in the form of a *responsum*—a scholarly legal and ethical response to a question posed to a rabbi—named the *Vienna Protocol*, a set of guidelines to follow when Jewish or possibly Jewish human remains are discovered, and which include a section specific to the use of the atlas.

### Medical ethics and Jewish law

Based on the *Vienna Protocol*'s authority, we published a clinical case study that lays the historical and ethical framework for questions concerning use of the atlas in managing anatomically complex and difficult surgical cases, with special attention to implications for medical ethics drawn from Jewish law.

At the centre of our work is the principle of *pikuach nefesh* ("saving of human life"), which includes the use of the atlas's images under the condition of "making it known to one and all just exactly what these drawings are [so that] the dead are accorded at least some of the dignity to which they are entitled."

Our case study presents a four step framework of applied ethics to consider the use of the atlas when it could significantly help surgeons in the care of their patients. When encountering operative difficulty, surgeons should firstly recognise a need to take time out and reassess planning. If needed, they should then call a colleague for help. Next, consult other educational resources such as textbooks. Then and only then consult the atlas, and do so with disclosure, respect, gratitude, and solemnity.

The journal *Surgery* published reviewers' questions and our responses. This extended conversation illustrated the continuing controversy over the question of how to treat scientific work from Nazi Germany that is part of the general canon of medical knowledge.

In the first commentary, the ethicist Arthur Caplan made a strong moral case for the use of "tainted" information "if, at the same time, non-maleficence can be achieved and the physician acknowledges and discloses the immoral origins of the work, in a manner that honours the victims but not its perpetrators." In the second commentary Markus Müller, president of what is now called the Medical University of Vienna, and colleagues invite readers to tour the university's Josephinum medical museum in 2021 after its renovation is completed and a new permanent exhibition for the remembrance of the medical victims of the Shoah is opened.

As Yee and I continue to assess surgeons' opinions and share these bioethical and religious considerations, we are aware of the significant need to bring humanism into healthcare and to incorporate the voice and opinions of patients in the consent and use of the atlas in their care. In the rare instances when I need to use the atlas in clinical consultations with my patients, I disclose its history and obtain their consent for its use in their presence (box, p 97). I use it to educate my patients and work through clinical examinations as I would use it in the operating room. Often, we are both learning. I have yet to encounter any hesitation but experience only deep reflection and gratitude among patients and their families when I use it to explain their complex nerve pathology.

**The Anatomy Institute at the University of Vienna in the past, as seen from the window of Pernkopf's former office. Next year the Medical University of Vienna is to open a permanent exhibition for the remembrance of medical victims of the Holocaust**

The knowledge that has accrued over my four decades of studying the atlas of the Shoah continues to influence the surgeries that we have developed and perform and teach. Our simple question to the Holocaust scholars has taken us on a journey far from our "line of expertise" in nerve surgery and education.

Since 2015, as a gentile working with Holocaust scholars and a survivor, I have personally changed. The remarkable concurrence of circumstances and connections that came together is fortuitous (*bashert*, or destiny in Yiddish). I can see a pattern of longitudinal flow that connects us all, the beautiful structure and function of the human body, and the people moving the story of the Shoah forward.

I am part of this story, as are all of us as moral humans. As physicians and educators, we have an enduring moral duty to recount history, share knowledge to generations that follow, and protect against new versions of the atrocities of the past.

**Only consult the atlas with disclosure, respect, gratitude, and solemnity**

Susan Mackinnon, professor of surgery, Washington University School of Medicine, St Louis, Missouri mackinnons@wustl.edu

Cite this as: *BMJ* 2020;368:l7075

# The struggle for GPs to get the right care for patients with gender dysphoria

Family doctors lack training and feel under pressure to prescribe, finds **Sally Howard**

Gender dysphoria can be difficult terrain for primary care doctors as it is not part of the GP curriculum. Patients face an average 18 month wait for specialist referral. And the NHS's frontline doctors may bear the brunt of some patients' distrust of a system that can't cope with the current demand for services.

Specialist gender identity clinics (GICs) have seen referrals at least double between 2013 and 2018, said James Palmer, medical director for specialised services at NHS England. As of 2019, about 7839 adults and 4000 young people were waiting for a first appointment.

Chris Preece, a GP in North Yorkshire, told *The BMJ* that the two year wait for patients to be seen by his local GIC puts pressure on GPs to provide bridging prescriptions for hormone treatment, even though they lack formal training.

### "Perverse incentives"

GMC guidance recommends GPs consider prescribing hormone treatment to adult transgender patients who try to self medicate while awaiting specialist care. Preece says that the waits can create "perverse incentives" for patients to buy hormones on the internet or elsewhere.

Without training, and given the media controversies about trans care, Preece adds, many GPs "actively choose not to prescribe [hormone treatments]—which protects us, but is unhelpful to the patient."

Last year the Royal College of General Practitioners published a statement on caring for gender questioning and transgender patients. This says that long waits for patients to see a specialist are putting pressure on GPs to provide services beyond their remit and with limited access to specialist support if they do so. The college adds, "GPs should not be expected to fill the gaps in commissioned gender identity specialists and clinics."

The college launched an e-learning course on gender variance this month.

### Direct discrimination

A recent study by Anna Carlile, a sociologist at Goldsmiths University of London, investigated the experience of trans children and their parents in English healthcare. She told *The BMJ* that participants reported direct discrimination and being referred to by a previous name in GP surgeries and other clinical settings. They also thought that GPs "lack clinical and therapeutic knowledge," particularly concerning the prescribing of drugs to delay puberty.

GPs are wary of prescribing without robust research into the outcomes and side effects of puberty blockers and cross sex hormones, and the co-occurrence of gender dysphoria and autism can complicate diagnosis and treatment. The UK has no nationally recognised training programme for gender identity healthcare, although there are apprenticeship training models in specialist clinics and international professional body guidelines.

Nearly two in five adult trans respondents to a large government survey reported dissatisfaction with NHS services related to their gender identity. Jane Fae of the charity Trans Media Watch, which campaigns for better media coverage of trans issues, says that many trans people now view GPs as "an obstruction to overcome."

Some trans groups, including Non Binary London and Trans Forum UK, circulate lists of GPs they deem to be sympathetic or unsympathetic to requests for referrals to GICs or to prescribe treatments that patients have asked for.

Some areas in the UK are showing signs of service reconfiguration. Cardiff's new GIC has GPs on site. A model is being trialled in Manchester in which GPs work with GICs to improve their diagnostic skills.

The Royal College of Physicians intends to introduce a professional development programme for GPs about gender identity this year.

### Decentralised service

NHS England, meanwhile, is considering a decentralised service for adults in which GPs can prescribe cross sex hormones without specialist involvement if they have sufficient expertise.

The royal college recommends that the GP curriculum should cover gender dysphoria and trans issues, that expanding specialist gender services be a priority, and that NHS IT systems be updated to record patients' gender identity and trans status.

Preece would welcome such changes. "The hardest thing about being a GP is when you know that the service being offered to patients falls short of what you believe they need and deserve," he says.

"That chasm is at its greatest when dealing with patients with gender dysphoria."

Sally Howard, freelance journalist, London
sal@sallyhoward.net

Cite this as: *BMJ* 2020;368:m215

**Not prescribing hormone treatments protects us but is not helpful to the patient**
Chris Preece, GP

**Trans children and their parents think GPs lack clinical knowledge**
Anna Carlile, Goldsmiths University

**Many trans people view GPs as an obstruction to overcome**
Jane Fae, Trans Media Watch

# Bad press prompts changes to US medical centres' payment policies

Six Shkreli award recipients have altered the way they treat poorer patients who struggle to pay bills


Several US medical centres that were named as "Shkreli award" winners last week have taken action to correct their criticised policies.

The awards were named after Martin Shkreli, who is serving a seven year prison sentence for securities fraud. Previously, he was widely criticised when he gained rights to pyrimethamine, which is used to treat toxoplasmosis, and raised its price from $13.50 (£10.40) to $750 a pill.

The Shkrelis are given by the Lown Institute, a nonprofit organisation that aims to replace the profit driven US healthcare system with "a just and caring system." Vikas Saini, the institute's president, told *The BMJ* that market forces led to the explosion of "money minded and [money] driven outrage of immoral practices and abuses" in healthcare.

The institute invites nominations, and the winners are selected by a panel of patient activists, clinicians, health policy experts, and journalists.

### Named and shamed

Leading the 2019 awards were six medical centres that, the institute said, "claim to care about community health but sue patients [for unpaid medical bills], garnish wages, and seize houses." They were the University of Virginia Medical Center and the Mary Washington Hospital in Virginia; Carlsbad Medical Center in New Mexico; Methodist Le Bonheur Healthcare and Ballad Health in Tennessee, and Poplar Bluff Regional Medical Center, Missouri.

However, at least four of the six—the University of Virginia, Mary Washington Hospital, Carlsbad, and Ballad Health—have changed their policies and are no longer suing poor patients for unpaid bills or are greatly discounting their bills. The other two centres did not respond to inquiries, although the news story submitted with the nomination of Methodist Le Bonheur suggested it might take a more lenient approach to unpaid bills.

The patients who were sued did not have health insurance, or if they did, their bills were not covered. Some had "high deductible" insurance, meaning they had to pay the first several thousand dollars before their insurance took over. Some received a "surprise" bill when treated at a hospital in their insurance network but by a doctor who was not included—known as out-of-network care.

Most of the patients worked in low wage jobs, were unemployed or retired, and were unable to pay the bills or the hundreds of thousands of dollars of interest charges. Medical debt causes about two thirds of US personal bankruptcies.

**The awards are named after a convicted fraudster who bought the rights to pyrimethamine and then increased the price of a pill by 5450%**

Rural hospitals, such as some of those named, are at risk of closure. More than 100 have closed since 2010, and more than 400 are at risk. Rural populations are declining, and those left behind tend to be older, sicker, and more likely to rely on government health insurance, which pays less than commercial insurers.

### Other award winners

- Two medical staffing companies, for opposing legislation to regulate "surprise" bills by out-of-network doctors. One company, Envision, said it had all but eliminated out-of-network billing;
- Dignity Health, for charging nearly a million dollars for a premature baby's care. The bill was cancelled after a media investigation;
- ManorCare nursing home chain, owned by a private equity firm, the Carlyle Group, for "exposing its roughly 25 000 patients to increasing health risks";
- The Sackler family, owners of Purdue Pharma, and Richard Sackler, for "atrocious marketing techniques of Oxycontin";
- Paediatric cardiologists at the University of North Carolina Medical Center, for "high mortality rates among paediatric heart surgery patients" and unwillingness "to show their mortality statistics";
- Acadia psychiatric hospitals, for "holding patients unnecessarily to make more money," using "drug injections as punishments for children," and "sexual abuse of young patients."
- Thirty five people, including nine doctors, who were charged with fraud for billing Medicare $21bn for "unnecessary and expensive cancer DNA tests";
- Mark Zucker and the heart and lung transplant programme at Newark Medical Center, New Jersey, for keeping a patient who was in a vegetative state on life support to improve the hospital's survival rates for its transplant programme; and
- José Baselga, who resigned as chief medical officer of Memorial Sloan Kettering Cancer Center in New York after violating "conflict of interest policies by not disclosing millions of dollars he received from drug companies" and then accepting a job at AstraZeneca, one of the companies that paid him.

Janice Hopkins Tanne, New York

Cite this as: *BMJ* 2020;368:m166