Involve children with life limiting conditions in decisions to stop treatment, says guidance

Nigel Hawkes  LONDON

The views of children who have incurable and life limiting conditions should be actively sought and considered in decisions on whether to continue life prolonging treatment, says new guidance from the Royal College of Paediatrics and Child Health.1

Although circumstances will differ, children who have had extensive experience of disease and its treatment, such as repeated cycles of chemotherapy, will have more informed views about continuing treatment than an adult facing treatment for the first time, the document says. The presumption should be that children will be involved in decisions “at a level that reflects their ability, understanding, and experience.”

“We should increasingly allow teenagers to have a say,” Vic Larcher, coauthor of the guideline and a retired consultant from Great Ormond Street Hospital in London, told a press briefing at the Science Media Centre on 23 March. “We have to take strong notice of them.” But the document does not distinguish between children and teenagers, indicating that each case should be considered on its merits.

The shifts of emphasis from earlier versions of the guidance reflect two changes, said Joe Brierley, a consultant in intensive care at Great Ormond Street Hospital who chairs the royal college’s Ethics and Law Advisory Committee. One was the increasing emphasis on shared decision making, the second the great advances in the past decade in palliative care for children. “We can’t save every child’s life,” he said. “So how do we stop active curative attempts and move to palliative care? These are not easy decisions.”

The new document was not so much a guideline as a support framework, not designed to be followed by rote, Brierley said. While earlier versions focused on particular scenarios, such as brain stem death and persistent vegetative state, the new one stepped back and emphasised process.

It said that limiting treatment could be considered if it was no longer in the child’s best interest—because life was limited in quantity or quality—or where there was informed, competent refusal of treatment.

Such decisions should not be rushed and should be taken only after careful consideration with the child’s parents and, where relevant, the child as well. If the process is well managed, very few cases should end in the courts, said Simon Newell, a consultant neonatologist at Leeds Teaching Hospitals NHS Trust. “I think the new framework offers a better and more family friendly process that should reduce problems in communication and reduce further the very rare cases that go to law.”

Brierley said that for some families the courts could help by lifting the decision burden, so could at times be the right thing.

Reference

IN BRIEF

Morbidity obesity is a risk factor for flu: After considering the latest evidence the UK Joint Committee on Vaccination and Immunisation has confirmed that morbidly obese people are at greater risk of complications and death from flu than healthy people and respond well to vaccination. The Department of Health for England is still developing its vaccination plans for next winter’s flu season.

CQC rates most GP surgeries as good: Of 95 general practices in England inspected in the latest round of inspections, the Care Quality Commission rated 82 as good and three as outstanding. The health watchdog rated seven as requiring improvement and three as inadequate. The three outstanding practices were Upper Eden Medical Practice, Cumbria; West Road Medical Centre, Newcastle West; and Dr G M Burnett and Partners, Oxfordshire. The CQC intends to inspect all practices by April 2016.

Cost of social care predicted to be big challenge after election: Three quarters of 100 senior health and social care leaders surveyed by the health think tank the Nuffield Trust thought that finding enough money for care services would be one of the greatest challenges for the next government. The three proportion did not expect the NHS to meet its goal to find £22bn in efficiency savings over the next parliament. Of the 66 leaders who responded, 85% said that the quality of social care services had fallen over the last year, up from 56% of respondents in the same survey in June 2014.

Dementia research gets new funding: A total of £100m has been pledged to a global Dementia Discovery Fund set up by the UK government to support dementia research and find new treatments. The government had already pledged £15m, and now drug companies including GlaxoSmithKline, Johnson & Johnson, Lilly, and Pfizer and the charity Alzheimer’s Research UK have pledged to contribute as well.

Cities in England’s north to get £20m to improve healthcare: The chancellor of the exchequer announced £20m in the budget to enable the Northern Health Science Alliance, formed by the leading northern universities, teaching hospitals, and academic health science networks, to use large scale data to inform reorganisation of public sector health and social care across a 15 million strong population in the north of England. Integrated information will be analysed to identify variations in care and needs.

Number of non-smokers continues to rise: There were 3.9 billion non-smokers aged 15 years or over in World Health Organization member states in 2010 (78% of the 5.1 billion population of these countries), a WHO report says. This number is projected to rise to five billion (or 81% of the projected 6.1 billion population) by 2025.

UK creates £195m fund to fight drug resistance: Chancellor George Osborne has announced the creation of a £195m fund to fight drug resistant infections worldwide, with contributions from the government, the Wellcome Trust, and other international charities. The Fleming Fund will work over the next five years to build laboratory facilities, surveillance networks, and response capacity worldwide, with a particular focus on low and middle income countries.

No action is taken against anaesthetist who confessed to falsifying records

Clare Dyer THE BMJ

A UK fitness to practise tribunal has taken no action against an anaesthetist who panicked after a patient’s death during surgery and wrote a false account of her actions in the patient’s notes.

The patient required surgery for a rare complication of dialysis. Another consultant told the patient that rapid sequence induction (RSI) would be used for anaesthesia but the surgery was delayed by two days. Era Vermani, a consultant anaesthetist at Central Manchester University Hospitals NHS Foundation Trust, decided against using RSI.

Expert witnesses told the hearing that, where there was some doubt as to whether the patient’s stomach was empty, most consultant anaesthetists would opt for RSI, but not all. Vermani changed the electronic and paper record to show that she had used RSI, and changed the muscle relaxant administered from cisatracurium to rocuronium, a drug used in RSI.

Vermani later went to the clinical director for anaesthesia and confessed to changing the patient’s record.

Peter Jefferys, chair of the panel of the Medical Practitioners Tribunal Service, said that “both the public and profession generally would view prompt admission of ‘guilt’ as commendable. In the circumstances of your case, the sanction imposed might be interpreted as a discouragement to medical practitioners to promptly admit dishonesty. Such a message would clearly be contrary to the public interest.”

Cite this as: BMJ 2015;350:h1570

Politicians set out their stall at election debate

Rebecca Coombes THE BMJ

Politicians from two major UK political parties have refused to rule out yet more reorganisation of the NHS in England after May’s general election.

Speaking on 19 March at a debate about the future of the NHS at the Royal College of Surgeons in London, Andy Burnham, Labour’s shadow health secretary, said that he wanted to “reset” the NHS into a “national health and care service,” including social care. England “will need to embrace radical change in the way it delivers services,” he said, so that hospitals were no longer the “default setting for care.” He floated the idea of local integrated care organisations that would employ GPs directly.

Charlotte Leslie, a Conservative member of the House of Commons Health Committee, called for an “open debate” about the way the NHS was funded. She told the audience at the debate, organised by the Spectator magazine, that the NHS would not survive if demand for services kept rising. And she said that one reason for the increased demand was that, because services were free at the point of use, people did not know the true cost of healthcare.

Leslie praised the former health minister Norman Warner, who last year floated the idea of an “NHS club” into which people paid a £10 membership fee. She said it was a shame that funding was on the “prayer list” of things politicians were not allowed to raise about the NHS.

Cite this as: BMJ 2015;350:h1601
NHS trusts’ deficits could more than double over next year, leader predicts

Matthew Limb LONDON

NHS trusts’ deficits could more than double from around £1bn to £2.5bn in 2015-16, their highest ever level, a health leader has predicted.

Chris Hopson, chief executive of NHS Providers, said that many hospitals’ cash reserves were running out, and performance levels could plummet unless the gap was plugged. “We are in real danger of the strategic deterioration speeding up and getting out of control,” he said.

Hopson, whose organisation represents the vast majority of NHS trusts, spoke at the King’s Fund in London on 18 March in a debate on the priorities facing the next government in the first 100 days of administration.

He said that trusts had performed as well as they could in recent years, achieving around £20bn in efficiency savings, but that funding had grown by only 1% while demand rose by 4%. Trusts had also been required to accommodate an additional £1-£1.5bn of staff costs that were “never planned for” at the beginning of the current parliament, under a mandate to raise care quality.

He warned that 20-25 large trusts that were previously in surplus would “flip into deficits” later in the financial year, fuelling the sector’s overall deficit. Foundation trusts have relied on cash reserves but these could run out two thirds of the way through the financial year.

Chris Ham, chief executive of the King’s Fund, asked what the consequences would be if the next government declared deficits to be unacceptable and reinstated “hard budgets.” He said that trusts might have to cut staff and that would “compromise patient care and may mean the targets would be missed even more.”

Cite this as: BMJ 2015;350:h1599

Waiting times for x ray results in England are increasing, figures show

Susan Mayor LONDON

Waiting times for patients in England to receive the results of imaging examinations are increasing, latest figures have shown, as nearly 333 000 patients waited more than a month for x ray results.

The Royal College of Radiologists surveyed radiology departments at all NHS trusts in England on 26 February and asked how many imaging examinations, including x rays, CT (computed tomography) scans, and MRI (magnetic resonance imaging) scans, were unreported on their systems and had been waiting more than 30 days for a radiologist to write a report on them.

At nearly three quarters of the NHS trusts submitting data to the survey (71%; 86 of 121) some patients had waited more than 30 days for the results of their imaging tests. The response rate was 78% (121 of 155 trusts).

In total 257 158 x ray results were still waiting to be reported 30 days after images had been taken, in addition to 2883 CT scans and 3277 MRI scans. These figures suggest that almost 330 000 patients across England wait more than a month for x ray results and that nearly 8000 have a similar delay while waiting for results from CT or MRI scans. The figures showed that the number of imaging examinations with delayed reporting of results had increased slightly since a similar survey in October 2014.

“These findings are deeply concerning and back up the results of our initial survey,” said Giles Maskell, president of the Royal College of Radiologists. “Amongst the patients waiting so long for their results there will be some with cancer and other serious conditions whose future health could be put at risk by the delay.”

Huge variation was found between trusts: 35 reported that they had no patients waiting for reports from x rays or scans, while others had tens of thousands of x rays awaiting reports more than 30 days after images had been taken. Most of the unreported x rays (71%) and CT scans (67%) were from three of the 10 NHS regions—South East, London, and East of England.

Cite this as: BMJ 2015;350:h1598

GPs should urge patients to focus on physical activity not obesity

Adrian O’Dowd LONDON

Clinicians should promote physical activity regularly to their patients rather than focus on dealing with their obesity, MPs have said.

In a report from the parliamentary Health Committee, MPs said that far greater emphasis was needed on physical activity independent of issues such as obesity, as evidence showed that increasing physical activity levels could have a greater effect on reducing mortality than on reducing weight. They added that the next government should prioritise prevention, health promotion, and early intervention to tackle the health inequalities and harms that arise from poor diet and physical inactivity.

MPs said that, while diet, obesity, and physical activity all affected health, activity had for too long been seen only in terms of its benefits in tackling obesity.

“A core message from this inquiry is the compelling evidence that physical activity in its own right has huge health benefits totally independent of a person’s weight,” said the report. “The importance of this—regardless of weight, age, gender or other factors—needs to be clearly communicated.”

MPs recommended that the government, Public Health England, and health professionals—particularly GPs—should take urgent action to communicate this message to the public. Evidence given during the inquiry had shown that more needed to be done in clinical encounters to promote physical activity, as activity was sometimes given lesser importance by doctors than diet or obesity.

The report recommended that primary care take the lead, as it has done for smoking cessation, in promoting physical activity and preventing obesity.

Cite this as: BMJ 2015;350:h1629

Nearly 8000 patients in England wait more than a month for results of a CT or MRI scan

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Guidance uses side effect risk to match osteoarthritis patients to NSAIDs

Zosia Kmietowicz THE BMJ

A multidisciplinary group of clinicians has advised which non-steroidal anti-inflammatory drugs (NSAIDs) are appropriate for patients with osteoarthritis, in line with the drugs’ risk of upper and lower gastrointestinal and cardiovascular side effects.

Despite the many guidelines on the use of NSAIDs none has looked specifically at the risks of these adverse effects, the authors wrote in BioMed Central Medicine.1 As nearly half of patients with osteoarthritis (44%) have cardiovascular disease and more than a fifth (21%) take low dose aspirin, more individualised guidance is needed, they argued.

They advised that any NSAID can be used in patients with low gastrointestinal and cardiovascular risk. However, naproxen may be the best choice for those with a low risk of gastrointestinal side effects but higher cardiovascular risk, they said, because of its lower potential heart risk than from other NSAIDs. For this group of patients low dose celecoxib is also acceptable.

For patients with high gastrointestinal and low cardiovascular risk, a COX 2 selective inhibitor alone or a non-selective NSAID with a proton pump inhibitor seem to offer similar protection from upper gastrointestinal events; however, only celecoxib will reduce mucosal damage, they said.

“Lebanon and Jordan are not allowing Syrian doctors to practise, even to treat Syrians,” said Redwan El Khayat, a UK based Syrian psychiatrist and member of the Union of Syrian Medical Relief Organizations.

Four years after the Syrian conflict began 3.8 million Syrian refugees are now living in Lebanon, Syria, and Turkey in what the United Nations High Commissioner for Refugees has described as the biggest humanitarian crisis since the second world war. Their healthcare needs are huge, most cannot afford the cost of local health services, and aid agencies are struggling to care for them.

Syrian doctors risk deportation for treating fellow refugees in Lebanon and Jordan

Sophie Arie LONDON

Syrian doctors who have fled the country’s civil war to Lebanon and Jordan are being prevented from treating fellow refugees despite their huge healthcare needs, because of laws protecting the livelihoods of local health professionals.

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Syrian doctors and Jordan have longstanding laws that prevent foreigners from practising medicine and many other professions, to protect local people’s jobs. Four years since the conflict began the presence of large numbers of refugees is increasingly straining local services and causing tension.

In Jordan in recent months, five or six unlicensed clinics set up by Syrian doctors have been raided and forced to close, Human Rights Watch has said. In one case the refugee patients who were present when an illegal clinic was raided were deported back to Syria.2

In Lebanon, where refugees now make up 25% of the total population, Wael Abou Faour, the country’s health minister, said last year that authorities had stopped Syrian doctors from opening clinics or working at hospitals “after receiving complaints from the syndicate and from (Lebanese) doctors.”3 However, he said that Syrians were volunteering at clinics treating refugees in border areas. “We cannot stop a physician from helping his compatriots,” Abou Faour said.

Sotmar Klopber, president of the World Medical Association, said that, if asked, he would advise that Syrian doctors in these countries could be given restricted licences, as has been done elsewhere in the past.

Public anatomy classes return to UK after more than 180 years

Bryan Christie EDINBURGH

Human remains are to be used in public anatomy lectures at the University of Edinburgh for the first time since the days of the 19th century murderers Burke and Hare.

Members of the public who pay £100 a day can take part in a series of workshops that the university says will “involve access to the dissecting rooms where you can see under the skin and gain an understanding of how your body works.”

Edinburgh was at the forefront of anatomy teaching in the early 19th century, and dissections were public events. However, cadavers were hard to come by, and a trade opened up in their supply. William Burke and William Hare sold 16 corpses to the medical school in 1828, but it was later discovered that they were

Tom Gillingwater, professor of neuroanatomy at the university, said, “We want people who have reason to learn more anatomy to do so legally, safely, and with access to actual human material.”

The workshops run from 4 April to 14 November.

Cite this as: BMJ 2015;350:h1574

Dr Robert Knox as depicted in the 2010 film Burke and Hare. Knox took delivery of bodies commandeered by the pair for his anatomy lessons.

Cite this as: BMJ 2015;350:h1552
**RESEARCH NEWS**

**FALLS PREVENTION**

**Exercise is not preventive but reduces injuries**

The overall rate of falls among older women is not reduced by exercise training or vitamin D supplements, a randomised trial has found. But the study, published in *JAMA Internal Medicine*, found that strength and balance training more than halved the number of injurious falls.1

The two year Finnish study included 409 women aged 70 to 80 who lived at home. They had all fallen at least once during the previous year and were not taking vitamin D supplements. The women were randomised into four groups: vitamin D (800 IU/day) without exercise, placebo without exercise, placebo with exercise, or vitamin D with exercise. The exercise consisted of supervised group training classes twice a week for the first 12 months and once a week for the following year, focusing on balance, weights, agility, and muscle strengthening.

Results showed that neither vitamin D nor exercise reduced falls. Fall rates per 100 person years were 132.1 in the vitamin D without exercise group; 118.2 in the placebo without exercise group; 120.7 in the placebo and exercise group; and 113.1 in the vitamin D and exercise group.

But, the rate of injurious falls was more than halved among women who exercised, with or without vitamin D. Injurious falls were those where medical care was sought and included injuries such as bruises, sprains, and fractures. The hazard ratio among injured fallers was 0.38 (95% confidence interval 0.17 to 0.83) among exercisers with vitamin D and 0.47 in exercisers without vitamin D. Injurious falls were those where medical care was sought and included injuries such as bruises, sprains, and fractures.

At 30 days five patients in the medical group (9%) and 14 in the stent group (24%) had had a stroke or TIA. Most of these were ischaemic strokes. Intracranial haemorrhage occurred in five patients in the stent group and in none of the medical group.

After one year 36% of the stent group had had a stroke or TIA, compared with 15% of the medical group. The 30 day death rate was 3 in the stent group and 0 in the medical group.

The first randomised study to evaluate stenting also found a higher rate of stroke with stenting when compared with medical therapy3; however, it was criticised for the stent used. The new study is the first to use a balloon mounted intracranial stent.

**Cite this as**: BMJ 2015;350:h1592

**STROKE**

**Stents raise risk in patients with intracranial stenosis**

Intracranial stenting is associated with an increased risk of stroke and transient ischaemic attack (TIA) when compared with medical therapy in patients treated for symptomatic intracranial stenosis, show the results of a randomised study that was stopped early because of the adverse findings.1

The international VISSIT (Vitesse Intracranial Stent Study for Ischemic Therapy) trial, reported in *JAMA*, randomised 53 patients with symptomatic intracranial stenosis (narrowing ≥70%) to receive clopidogrel plus aspirin and 59 to receive a balloon expandable stent plus medical therapy.

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**Cite this as**: BMJ 2015;350:h1594

**END OF LIFE CARE**

**Terminally ill patients could benefit from stopping statins**

Discontinuing treatment with statins in patients with terminal illnesses is safe, could improve quality of life, and could reduce costs, US research published in *JAMA Internal Medicine* concludes.2

The study looked at 381 patients with a mean age of 74.1 years. Half of the patients had cancer, and all had an estimated life expectancy of between one month and one year. The patients had been taking prescribed statins for three months or more for primary or secondary prevention of cardiovascular disease but had no recent active cardiovascular disease. The researchers randomised 189 patients to discontinue and 192 to continue statin treatment.

The overall median survival time was 219 days, and the proportion of patients who died within 60 days did not differ significantly between the two groups (23.8% versus 20.3%). Quality of life, as measured by the McGill quality of life questionnaire, was better in the group of patients who discontinued statin treatment (mean total score 7.11 versus 6.85 (P=0.04)).

Few cardiovascular events occurred: 13 in the discontinuation group and 11 in the continuation group. The researchers calculated that stopping statins produced mean cost savings of $3.37 a day and $716 per patient.

The authors said that the choice to continue or stop statin treatment should be a joint decision between the doctor and patient. They said that further research was needed to explore the question of continuation of other preventive drugs among people with limited life expectancy.

**Cite this as**: BMJ 2015;350:h1620

**HODGKIN’S LYMPHOMA**

**New treatment approach shows promise after relapse**

Adults with hard to treat Hodgkin’s lymphoma who were given brentuximab vedotin immediately after stem cell transplantation survived without the disease progressing for twice as long as those given placebo, a phase III randomised controlled trial published in the *Lancet* shows.1

Brentuximab vedotin, the first new drug for Hodgkin’s lymphoma in over 30 years, is an antibody attached to a powerful chemotherapy drug that targets the CD30 protein on Hodgkin’s lymphoma cells. It has recently been approved for relapsed or refractory Hodgkin’s lymphoma in 50 countries.

Overall survival of patients with Hodgkin’s lymphoma is 80-90%. Patients who relapse or do not respond are usually given high dose chemotherapy followed by autologous stem cell transplantation but fewer than half survive long term.

The AETHERA study randomised 329 Hodgkin’s lymphoma patients who had stem cell transplantation to receiving 16 cycles of brentuximab vedotin infusions once every three weeks or placebo. At two years the cancer had not progressed at all in 65% of patients (95% confidence interval 57% to 72%) who received active treatment, compared with 45% (37% to 52%) in the placebo group. Median progression-free survival was 42.9 months in the treatment group and 24.1 months in the placebo group.

**Cite this as**: BMJ 2015;350:h1533
Alastair Henderson
Charming theatre enthusiast

ALASTAIR HENDERSON is chief executive of the Academy of Royal Medical Colleges, a body that sees itself as the “professional conscience” of doctors and has tentacles in advisory groups, standing committees, and policy forums too numerous to mention. Rare in the higher reaches of the advisory class, he started as a Unison official, moving on to the NHS Confederation, NHS Employers, and then the Academy. In 2012 he told the Financial Times that consultants in the future might not be as well paid as today’s, a rare excursion into jungle country. Henderson is 57.

What was your earliest ambition?
I never could have been a train driver, as I am colour blind. Aside from running the National Theatre (which is unlikely), I’ve been a lot more about serendipity than planned ambition.

Who has been your biggest inspiration?
My parents, partner, children, and Bob Dylan.

What was your best career move?
I’m not sure that I’ve ever really had a career as such, but my collection of theatre programmes from the past three years or so.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
There is a case for Alan Milburn in both categories—content good, culture bad.

Who is the person you would most like to thank and why?
Probably my dad again (although I wasn’t particularly awful, I don’t think). The boy I bit on the arm at my preschool. And my children, for whatever it is this time.

What was the worst mistake in your career?
Career: ditto. Mistakes: lots, but nothing too horrendous that I can think of.

Do you support doctor assisted suicide?
Yes.

What book should every doctor read?

What, if anything, are you doing to reduce your carbon footprint?
Witty, insightful, charming; but my daughter suggests grumpy, old, git.

What is your guiltiest pleasure?
Cheese and onion crisps.

Where does alcohol fit into your life?
Not as much as I would like.

What is your most treasured possession?
My collection of theatre programmes from the past 30 years or so.

What, if anything, are you doing to reduce your carbon footprint?
Oh, dear; not enough, I am sure. I do try to switch the lights off and walk wherever I can.

What personal ambition do you still have?
To carry on interesting work and travel a lot more—specifically, to Argentina and Namibia.

What was the unheralded change that made the most difference in your field in your lifetime?
“It’s not exactly unheralded, but I suppose electronic communication in all of its forms—email, internet, mobiles, social media, etc. It has entirely changed what we do, how we do it, and the pace at which we do it.”

Where are or were you happiest?
Various times on holidays, in the UK and abroad with my family over the years.

What single unheralded change has made the most difference in your field in your lifetime?
It’s not exactly unheralded, but I suppose electronic communication in all of its forms—email, internet, mobiles, social media, etc. It has entirely changed what we do, how we do it, and the pace at which we do it.

If you were given £1m what would you spend it on?
My children, I imagine—it seems to be what happens to any money I do have—but particularly on lots of expensive holidays.

Do you have any regrets about becoming a health policy expert?
No. Working in healthcare has always been, and continues to be, fascinating and motivating.

Cite this as: BMJ 2015;350:h1568