this week

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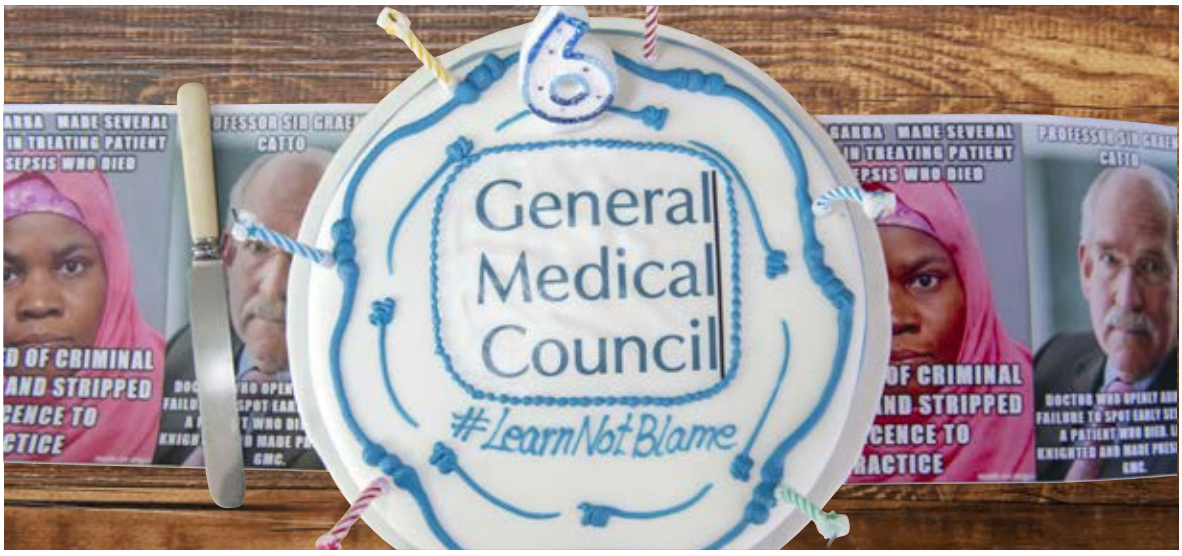


RICHARDHSMITH

GMC is stripped of right to appeal

The GMC is to lose its right to appeal to the High Court against decisions made by medical practitioners tribunals. The move by the Department of Health and Social Care for England follows a recommendation from a rapid review of gross negligence manslaughter prosecutions against health professionals, published on 11 June.

The review, chaired by Norman Williams, former president of the Royal College of Surgeons, concluded that the GMC's right to appeal, which took effect on 31 December 2015, had had "significant unwelcome and unintended consequences."

The review was set up by Jeremy Hunt, health secretary, after an outcry from the profession over the case of Hadiza Bawa-Garba, a junior paediatrician who was convicted of gross negligence manslaughter over the death of a 6 year old Jack Adcock. A medical practitioners tribunal [MPT] took into account significant systems failures and suspended Bawa-Garba rather than striking her off the medical register. But after a GMC appeal, the High Court ruled to strike her off. She is appealing the ruling.

The review panel said it was "concerned at the level of fear and mistrust of the GMC that the medical community reported." It added, "This is heightened by the right of appeal against MPT decisions, which has undermined doctors' trust in the GMC and has had a significant impact on their ability and willingness to engage with the regulator. This is deterring reflection and learning from errors to the detriment of patient safety."

Some doctors had urged the review panel to recommend that reflections be given legal privilege protecting them from disclosure in court proceedings. But the panel concluded that this would not be workable and "would rightly cause concern that healthcare professionals are above the law." It recommended, however, that the power given to the GMC in 2015 to require doctors to hand over reflections to assist in investigations should be removed.

Hunt said, "I was deeply concerned about the unintended chilling effect on clinicians' ability to learn from mistakes following recent court rulings, and the actions from this authoritative review will help us promise them that the NHS will support them to learn rather than seek to blame."

He also announced a new programme offering NHS consultants confidential data on their clinical results and how they compare nationally, "to support them to

(Continued on page 382)

Neurologist David Nicholl ordered an MPTS anniversary cake as an "ironic gesture" before the recommendation

LATEST ONLINE

- NHS England failed to disclose full amount of lost clinical correspondence, say MPs
- US suicide rate is climbing steadily, with highest prevalence in sparsely populated western states

SEVEN DAYS IN

"At least 600 general practices to close by 2022"

Between 618 and 777 practices in England will be lost between now and 2022 if funding is not increased, the BMA has warned. If the projections, which are based on data from NHS Digital, play out then millions of patients will be affected, it said.

The data show there were 166 fewer practices in 2017 (7361) than in 2016, while the total number of practices had fallen by 963 since 2010, when England had 8324.

Although the fall was partly due to practices merging, the BMA said, many had closed or were forced to merge as the result of underinvestment. It said it was urging the prime minister to end the historical underfunding of general practice.

Richard Vautrey, chair of the BMA's general practitioners committee, said that in 2016 NHS England's *General Practice Forward View* had outlined several measures aimed at improving primary care provision and the working lives of doctors, "but two years on, it's clear that it is struggling to deliver on its promises."

A Department of Health and Social Care spokesperson said, "We recognise the pressures facing GPs, and that's why we're increasing investment by £2.4bn a year by 2021 and are determined to recruit 5000 doctors to grow a strong general practice."

Abi Rimmer, *The BMJ* **Cite this as: *BMJ* 2018;361:k2546**

Abortion

Northern Irish law breaches human rights, say judges

Pressure is growing for reform of Northern Ireland's strict abortion law after a majority of the seven judges considering the issue in the UK Supreme Court decided that it breached the European Convention on Human Rights. However, a majority of the justices also held that they were unable to make a binding decision that the law needed changing because the Northern Ireland Human Rights Commission, which had brought the case to court, had no standing to bring it. Technically, therefore, they had to dismiss the appeal.

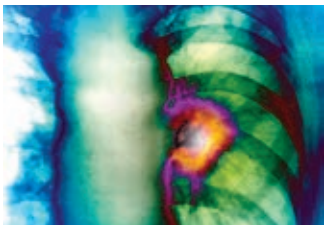
MPs push for domestic abuse bill by autumn

A cross party group of more than 30 MPs will bring forward a bill that would allow decriminalisation of abortion in Northern Ireland. On 11 June they sent the home secretary, Sajid Javid, written questions demanding that the domestic abuse bill be brought before parliament by this autumn. The bill would enable pro-choice MPs to table an amendment that would give women in Northern Ireland the right to access a termination in their own country rather than travelling to England or elsewhere for it.

New medicines

NHS strikes deal on lung cancer drug

NHS England negotiated a deal with the drug company MSD to make the lung cancer drug pembrolizumab available for routine use on the NHS. The drug, also known as Keytruda, has been endorsed by the National Institute



for Health and Care Excellence after trial results showed that it can extend life in certain adults with lung cancer for over a year. It would have cost around £84 000 per patient at full list price, but NHS England and MSD agreed a confidential arrangement for reimbursement.

Research news

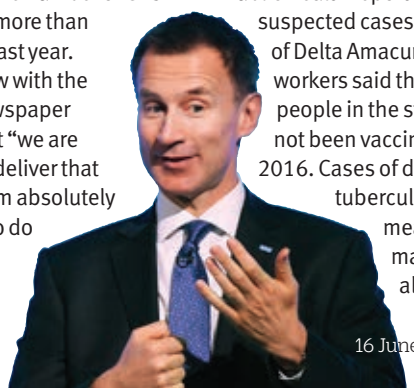
Introducing PrEP may increase risky behaviour

Although taking antiretroviral drugs as pre-exposure prophylaxis (PrEP) is highly effective for preventing HIV infection and is recommended by the World Health Organization for high risk populations, an Australian study in the *Lancet HIV* journal found that a rapid uptake of PrEP by gay and bisexual men was accompanied by an equally rapid decrease in consistent condom use, which could undermine PrEP's effectiveness. Martin Holt, study leader from the University of New South Wales, said, "PrEP has been heralded as a game changer for HIV, but declining condom use may impede its long term, population level effectiveness."

Workforce

Hunt admits extra GP target will be missed

Jeremy Hunt (below), England's health secretary, admitted that the government will struggle to fulfil its pledge to increase the number of GPs in England by 5000 by 2020. The pledge was made in 2015, but the number of GPs has fallen by more than 1000 in the past year. In an interview with the *Guardian* newspaper Hunt said that "we are struggling to deliver that pledge, but I'm absolutely determined to do so. This is not a pledge that we're abandoning, it's just taking a bit longer than I had hoped."



Psychiatry trainees rise by a third

The number of trainees in psychiatry in England has risen by more than 30% from last year, the Royal College of Psychiatrists said. Data from Health Education England show that 368 doctors will start core psychiatry training in England this August, the most since 2009. Last year 277 doctors were accepted into psychiatry training. The college launched its #choosepsychiatry social media campaign last September.

Polio

First Venezuela case in nearly 30 years

Venezuela reported its first case of polio in nearly three decades amid a growing public healthcare crisis in the country. The Venezuelan Society of Public Health reported three suspected cases in the state of Delta Amacuro. Health workers said that many people in the state had not been vaccinated since 2016. Cases of diphtheria, tuberculosis, measles, and malaria have also risen.

MEDICINE

General practice

Vulnerable people were unlawfully refused GPs

A fifth of vulnerable patients in England are being wrongfully refused GP registration, research by the campaign group Doctors of the World UK showed. In 2017, 337 of 1717 attempts by the group's case workers to register patients with their local GP were refused. Two thirds of refusals were due to lack of ID or address, while 34 (10%) were based on the patient's immigration status. Pregnant women, children, victims of trafficking, and homeless people were among those turned away.

Homeopathy

High Court rejects challenge to NHS prescription ban

A legal challenge by the British Homeopathic Association to NHS England guidance stating that GPs should not prescribe homeopathic treatments was rejected by the High Court. Guidance to clinical commissioning groups last November recommended GPs should not prescribe homeopathic remedies to new patients and that doctors should be "supported in de-prescribing" such treatments.

Emergency care

More than a million 2017 admissions were avoidable

The NHS could have averted almost 1.5 million emergency admissions to hospitals last year if the service had invested in better preventive care outside hospital, a report by MPs concluded. Some 5.8 million emergency admissions were recorded in England in 2016-17, of which 24% might have been avoided if people had had more effective community healthcare and case management to stop them becoming so unwell that they needed emergency hospital care, said the House of Commons Public Accounts Committee.

Tackling loneliness may cut emergency admissions

The Local Government Association urged ministers to provide more funding for councils to expand and introduce initiatives to tackle loneliness. The LGA said work to prevent loneliness in partnership with community and voluntary organisations, had demonstrated clear improvements to people's quality of life and had reduced emergency admissions to hospitals by as much as 20%.

NHS reform

Local bodies should lead integrated care plans

Local NHS leaders, local councils, professional bodies, patient groups, and the voluntary sector should lead on legislative proposals to remove barriers to integrated care, MPs on the health and social care select committee said. They added that draft proposals driven by local leaders could be presented to them for pre-legislative scrutiny.

Cite this as: *BMJ* 2018;361:k2573

HEALTH SPEND

A poll of more than 1000 adults found that **77%** of people either support or strongly support a 4% increase in UK healthcare spending, every year over the next 15 years

[IPSOS MORI for NHS Confederation]

SIXTY SECONDS ON . . . HURRICANE MARIA

HOW BAD WAS IT?

Last year's Hurricane Maria was the worst natural disaster to ever hit Puerto Rico. The tropical cyclone made landfall on 20 September, compounding the destruction caused by Hurricane Irma two weeks earlier.

HOW MUCH DAMAGE DID IT CAUSE?

In Puerto Rico, an estimated $90bn (£67bn), making it the third costliest tropical cyclone in the US and its territories since 1900. It damaged roads and interrupted the water supply, electricity, telecommunications, and medical care.

HOW MANY PEOPLE DIED?

A difficult question, the official death toll is 64. The latest estimate, published in the *New England Journal of Medicine*, is 4645. In November, CNN surveyed 112 funeral homes across the island, about half the total, and staff identified at least 499 deaths they believed to be hurricane related.

WHY THE DISCREPANCY?

It's difficult to say with certainty whether the hurricane caused some of the deaths, especially because of the chaotic and unsafe conditions that have lingered for months.

CAN WE GET MORE ACCURATE DATA?

On Monday, a court gave the Puerto Rican government seven days to release death certificates and related data to CNN and the Center for Investigative Journalism in Puerto Rico, after they sued for access.

WHY HAVE WE HAD TO WAIT SO LONG?

The government argued that information contained in death certificates should be kept private to protect the identities of the dead, but the judge ruled the records are a matter of public information and must be released, without the deceased's social security numbers.

WHY IS THIS IMPORTANT?

An accurate figure will help to determine if the federal response was "sluggish" based on the artificially low numbers reported officially, says Democrat congresswoman Nydia Velázquez, who comes from Puerto Rico and represents New York. She has called for an independent commission to examine the death toll.

Ingrid Torjesen, London

Cite this as: *BMJ* 2018;361:k2558

(Continued from page 379)

learn and improve." And a system of medical examiners trialled in two areas will be rolled out, with experienced doctors scrutinising deaths not referred to a coroner.

Scrapping the right to appeal means the GMC will be in the same position as the other eight healthcare regulators, and leaves the Professional Standards Authority with the sole right to appeal against regulatory rulings.

Other recommendations in the Williams review include:

- A working group to set out a clear explanatory statement of the gross negligence manslaughter law, leading to a consistent understanding and guidance on where the threshold for prosecution lies
- Improving assurance and consistency in the use of experts in gross negligence manslaughter cases
- A new memorandum of understanding in relation to the investigation of deaths in healthcare settings, and
- A virtual specialist unit for police forces to ensure consistency across England.

Terence Stephenson, GMC chair, said the regulator was disappointed the review had not granted legal privilege to reflective notes. He added that removing the right to appeal would "significantly reduce our ability to protect patients."

The Medical Defence Union, which has assisted nearly 40 doctors with investigations since 2014, said it was hopeful that the review would lead to "fewer needless investigations."

The BMA welcomed an end to the GMC's right to appeal, but maintained that doctors' reflections should be given full legal protection.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2018;361:k2572

SCRAP THE CAP

Visa cap is costing NHS trusts thousands in failed applications

NHS trusts are spending thousands of pounds on recruiting overseas doctors only to have most of their visa applications refused, data obtained by *The BMJ* show.

The Dudley Group NHS Foundation Trust in the West Midlands has made four applications a month for tier 2 visas for doctors recruited from outside the European Economic Area since December 2017 and all were rejected, data released in response to a freedom of information request show. The trust estimated it spent £4500 in processing and fees.

Great Western Hospitals NHS Foundation Trust in Swindon submitted 19 applications over the same period. More than two thirds of these were rejected, and the trust estimated that it spent around £62 000.

Doctors account for a fifth of all applications to the Home Office for tier 2 visas, show figures provided in response to a freedom of information request made by the law firm Eversheds Sutherland. Of 18 517 applications made between 6 November 2017 and 5 April 2018 for restricted certificates of sponsorship, 3599 (19%) were for doctors.

PM approval

The Times reported on 12 June that the prime minister had agreed to changes to the allocation of tier 2 visas. The move came after Sajid Javid, the home secretary, said that he would review the system. The article said, "Under the compromise, which is set to be announced within days, the cap could be increased from its present allocation of 20 700 [a year] or doctors could be exempted from the quota."

The number of applications for tier 2 visas for doctors more than doubled between 6 November 2017 and 5 April 2018, from 480 to 1006 a month. Among the 3599 applications for doctors, 65% were for specialty registrars, 16% for foundation year 2 doctors, and 14% for specialty doctors. Success rates varied from 9% for foundation year 1 doctors to 93% for consultants (see box, right).

The data obtained by Eversheds Sutherland show that applications for tier 2 visas for doctors were less likely to be granted than those for other workers. In total, 34% of applications for doctors were granted, compared with 45% of all applications.

Spending on shortages of generics rose sevenfold

Rapid price rises of some generic drugs forced clinical commissioning groups (CCGs) to spend an extra £315m last year, placing budgets under significant pressure, the National Audit Office (NAO) has found. The price of one generic antipsychotic drug rose by a factor of 70.

The estimated net spend on concessionary drugs during 2017-18 was £315m

The report into NHS spending on generic drugs in primary care says a number of factors may have contributed to the increases, including a fall in the pound, supply problems, and wholesalers pushing up profits. This derailing of CCG's budgets was first reported in *The BMJ* in January.

DRUG DEALS : EXAMPLE PRICE RISES

- The antipsychotic drug *quetiapine*: **£1.59 → £113.10**
- The blood pressure drug *amlodipine*: **£0.67 → £3.75**
- The epilepsy drug *gabapentin*: **£3.62 → £13.95**
- The antipsychotic drug *olanzapine*: **£1.07 → £69.92**

The NHS spent an estimated £4.3bn on generic drugs in 2016-17, of which £3.5bn was spent in primary care. In primary care, pharmacies buy drugs from wholesalers or manufacturers who determine their own prices. The pharmacies are reimbursed according to prices set in the drug tariff. But if pharmacies are unable to buy at this price the Department of Health and Social Care (DHSC) can set a concessionary price to allow the NHS to reimburse pharmacies at a temporarily higher price. Requests from pharmacies for concessionary prices went from fewer than 150 a month before May 2017 to

MARTIN BENNETT / ALAMY

The BMJ launched its Scrap the Cap campaign last month calling for a review of immigration policies to allow doctors from overseas who have been offered NHS jobs to take up their posts.

To sign *The BMJ*'s petition to parliament go to https://petition.parliament.uk/petitions/220665

Tom Moberly, *The BMJ*

Cite this as: *BMJ* 2018;361:k2591

TIER 2 VISA APPLICATIONS FOR DOCTORS, NOVEMBER 2017 TO APRIL 2018

- Consultants—97 (**93%** of which were successful)
- Foundation year 1—78 (**9%**)
- Foundation year 2—587 (**25%**)
- Salaried GP—3 (**67%**)
- Specialty doctor—493 (**52%**)
- Specialty registrar—2341 (**31%**)

a peak of 3000 in November 2017, the report said.

In October 2017, NHS England began forecasting an end-of-year overspend across CCGs partly because of the generics market. This May, NHS England reported an unaudited end-of-year deficit of around £250m among CCGs.

New powers

The DHSC took steps to maintain the supply of generic drugs—for example, releasing one cancer drug from its central emergency stockpile. From next month it will also have powers to control generic drug prices, making it mandatory for manufacturers to share information on sales and supply issues. But the NAO warned that "the new powers are untested and will require sufficient resources."

A DHSC spokesperson said: "Our number one priority is to ensure patients have access to safe and effective drugs. We have some of Europe's cheapest drug prices and although the number of concessionary prices increased, the overall spend on generic drugs went down compared with last year."

The department said the concessionary prices granted were set higher than necessary above wholesalers' prices and this has been adjusted. It estimated this amounted to £86.3m of additional costs for CCGs in 2017-18, which it expects to be recouped through reimbursement mechanisms.

Richard Vautrey, BMA GP committee chair, said: "The unexplained and unjustified rapid rise in some generic drugs has led to many CCGs putting measures in place that require practices to use prescription monitoring systems that encourage change from high-cost drugs to alternatives. This is another piece of bureaucracy and a source of irritation for patients, who may find their medication repeatedly changed."

Jacqui Wise, London

Cite this as: *BMJ* 2018;361:k2581

FIVE MINUTES WITH . . .

Anna Conway Morris

The director of training programme for child psychiatry explains what the visa cap means for services

"In the East of England, we have four vacancies in child psychiatry and one applicant. She first applied for the specialty trainee year 4 (ST4) level post in February but she is from India and didn't get a visa despite having a great recruitment score. She has applied for a visa every month since, but has always been refused. She is our only candidate, so the situation is absolutely desperate.

"Not getting a visa has also meant that she has lost a house deposit and missed out on earnings. It's been an absolute disaster. She is an excellent candidate and I've been devastated that I haven't been able to hire her. If we don't get a visa for her within the next month then we won't have any new child psychiatry registrars in the whole of the East of England. That means that Cambridgeshire, Bedfordshire, Hertfordshire, Norfolk, Suffolk and Essex—a huge chunk of the country—will not have any starters in child psychiatry at ST4 level.

"I'VE BEEN DEVASTATED THAT I HAVEN'T BEEN ABLE TO HIRE HER"

"Almost all the candidates that we have now are from overseas. There are hardly any EU candidates, and while there are some UK candidates they don't want to come here. So many of our candidates are from India, other commonwealth countries, or elsewhere, but I am worried that word has got round already that it's difficult to get visas and they will stop applying.

"We need child psychiatry registrars because they see young people in emergency departments out of hours. They also work in our services in the community and help with the clinical work, but the main impact is on out-of-hours rotas.They are absolutely essential. They are committed to the NHS and are really well trained. Most of them stay on and fill consultant vacancies.

"Because of the shortage of psychiatry trainees, trusts are paying for locums and for doctors to do extra shifts. But many shifts remain uncovered and in some cases consultants are having to act down, which is causing a lot of unrest."

Anna Conway Morris is a consultant in child and adolescent psychiatry and East of England training programme director for child psychiatry

Abi Rimmer, *The BMJ* Cite this as: *BMJ* 2018;361:k2570

Obstetrician who delivered decapitated baby is not sanctioned

A consultant obstetrician whose attempt to deliver a premature baby ended in his decapitation will not face a disciplinary sanction, after a medical practitioners tribunal found that her error of judgment did not amount to serious misconduct.

Vaishnavy Vilvanathan Laxman, 43, was nearing the end of a 24 hour split shift at Ninewells Hospital in Dundee in March 2014 when she was called to a 30 year old first time mother whose membranes had broken at 25 weeks' gestation. The baby was positioned feet first, the placenta was low, and the cervix was no more than 4 cm dilated and clamped around the baby's calves. Midwives had made a "1111 call," which begins the preparation for an emergency caesarean section, as the umbilical cord had prolapsed, which can cause fetal hypoxia.

An ultrasound scan confirmed that cord compression had resulted in bradycardia, suggesting that only minutes remained to deliver the baby safely. Laxman testified: "I remember thinking, should I try to deliver this baby? I still believe we had a very good chance using other options than a C section but we had to act fast." This, the tribunal found, was a serious clinical error that ultimately contributed to the baby's decapitation, although not to his death—witnesses agreed he was already dead.

"LAXMAN MADE ONE BAD DECISION IN AN OTHERWISE EXEMPLARY CAREER"

As the baby moved forward, the cervix gripped his neck. After trying traction the team gave the mother general anaesthesia and used incisions to widen the cervix. After an "increasingly desperate attempt," the baby's body came out with the head detached, an autopsy found.

After being suspended by NHS Tayside, Laxman worked in her native India and stopped obstetric work, returning for her hearing in Manchester.

Counsel for the GMC said that media attention meant that action against Laxman's registration was needed to maintain public confidence. But, Tim Bradbury, tribunal chair, said, "The magnitude of a doctor's error of judgment should not be elevated to the status of serious professional misconduct simply by reference to the ultimate outcome." Laxman had made one bad decision in an otherwise exemplary career, he said, and the decapitation had not been "reasonably foreseeable."

Clare Dyer, *The BMJ* **Cite this as: *BMJ* 2018;361:k2506**

Spinal surgeon was negligent in too early use of heparin

A college lecturer has been left with permanent neurological injury as a result of a consultant neurosurgeon's decision to give her anti-thrombotic medication too soon after spinal surgery, a High Court judge has ruled.

Mr Justice Martin Spencer concluded that Christos Tolias was negligent in giving Yvonne Lesforis low molecular weight heparin (LMWH) only three hours after her operation, and that this caused her injury.

Around £1m in damages

Tolias has applied for permission to appeal but if the judgment stands, Lesforis is expected to receive more than £1m in damages.

Lesforis, now 61, had been having intermittent lower back problems with pain radiating down her legs since 2007. In 2012 and 2013 she consulted Tolias at King's College Hospital in London.

She agreed to have decompression surgery to treat stenosis at the L3 and L4 levels in her spine. But because of delays in the NHS, she decided to have Tolias perform the surgery privately at his Harley Street clinic.

She was taken to the intensive treatment unit at 16.11 on 27 June 2013 after a three hour operation, which went smoothly and apparently successfully apart from a minor dural tear. Because of the tear, Tolias ordered that she not be mobilised for 48 hours. About three hours after the operation was over, she was given the anti-thrombotic medication. On the morning of 29 June, a Saturday, Tolias visited the ward and, after hearing that all was well, decided she could be mobilised. But later in the day, when a physiotherapist tried to mobilise her, she was unable to feel her legs or wiggle her toes.

A computed tomography (CT) scan showed no obvious acute clot. Tolias told the court, "The clinical and radiological picture did not suggest an acute, clinically significant compressive haematoma, that neuropraxia was more likely, and the best thing was to give steroids to reduce the potential oedema and to observe her closely, but to re-operate if she did not improve within a few hours."

She did not improve and he re-operated around midnight. His

NEWS ANALYSIS

Assisted dying: doctors could organise locally to change law

Even where national representative bodies oppose assisted dying, doctors could influence legal change through regional organisations, such as GPs' local medical committees, a US campaigner has said.

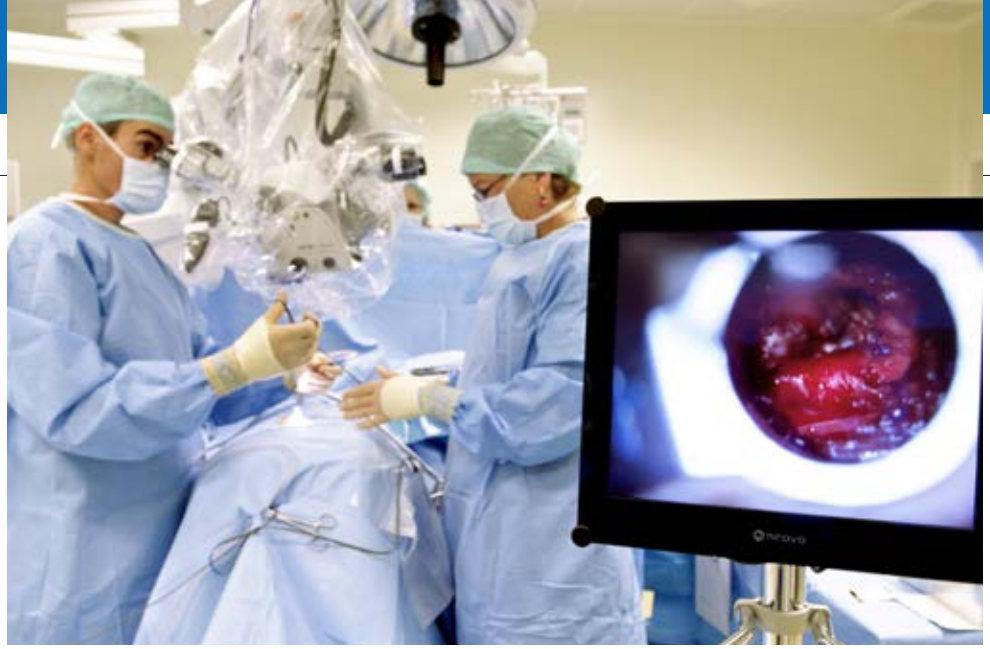
"In Colorado county medical societies began passing resolutions for neutrality or even support," Barbara Coombs Lee, president of the US campaign group Compassion and Choices, told *The BMJ*.

A position of neutrality, after careful consideration, among doctors' representatives is key to enabling law change, she said, and to her knowledge properly conducted polls of doctors have never found a majority opposing assisted dying.

Continuing opposition

The BMA has not polled members to back its continuing opposition to assisted dying, despite recent calls for it to do so, including from *The BMJ*. The BMA's policy was set in 2006 by a vote at its annual representatives meeting. A 2016 annual meeting debate upheld the policy.

A BMA spokeswoman told *The BMJ*, "What is clear is that there is a lack of consistency in the standard of palliative care throughout England, and the priority must be on providing the best quality care to patients as they reach the end of their lives, regardless



ARNO MASSEE/SPL

The judge said that no reasonable body of spinal surgeons in 2013 would have acted as did Tolias

operation note said, "There were no clots in the superficial layers. However, just epidurally there was a clot of identified solidified matter and causing compression of the dura itself, which was removed."

No sensation

Lesforis has been left with no sensation in her bladder or bowel, has severely restricted mobility because of nerve root injury affecting her knees and ankles, and is largely restricted to wheelchair use.

Lesforis's lawyers alleged that her injuries resulted from a compressive epidural haematoma, caused by a too early administration of LMWH, which was intended to prevent a deep vein thrombosis (DVT).

At the time of the operation, NICE guidelines did not give any indication about the timing of anti-thrombotic medication. Tolias said in his witness statement that it was his "normal practice to give anti-DVT chemo-prophylaxis (Clexane) very early postoperatively to all my cranial or spinal patients."

Revised NICE guidelines in 2018 advised giving the drug 24-48 hours after elective spinal surgery, but stated that it could be given earlier than 24 hours if needed, with the decision based on multidisciplinary or senior opinion, or a locally agreed protocol.

"The use of LMWH so soon after spinal surgery was cavalier, and outside the range of normal practice"
Mr Justice Martin Spencer

Having heard expert evidence from both sides, the judge concluded that "no reasonable body of spinal surgeons in 2013 would have given chemo-prophylaxis routinely within six hours of spinal surgery." He said it was "extremely unlikely" that practice in the UK in 2013 was significantly different from the 2018 guidelines. He found Tolias's use of LMWH so soon after spinal surgery was "cavalier, and outside the range of normal practice at the relevant time."

Spencer said he was surprised that "in 2013, a consultant neurosurgeon was carrying out complex spinal surgery on a patient in circumstances where there were no out-of-hours emergency MRI facilities on site." But he said this was the responsibility of the Harley Street clinic, not Tolias.

In the circumstances, Tolias acted reasonably on the basis of the CT scan and the advice from the neuroradiologist who interpreted it. Both surgeon and radiologist had been led astray by the clinical situation, which seemed to show a problem emanating from below the site of the operation, Spencer said.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2018;361:k2565

of where they live or their medical condition."

Coombs Lee drafted Oregon's law to permit assisted dying more than 20 years ago. Seven US states plus Washington, DC, and Canada allow the procedure.

In the UK the Marris-Falconer Bill, which MPs defeated in 2015, would have given similar permission in England and Wales. The bill would have allowed terminally ill adults, who ask freely, to be given lethal drugs to take themselves if two independent doctors assess them as having mental capacity and less than six months to live, and the request is scrutinised by a judge.

Coombs Lee was speaking on 5 June at a meeting of the All Party Parliamentary Group on Choice at the End of Life, which aims to help ensure that dying adults have more control over where, when, and how they die.

In control

The group's chair, Nick Boles, a Conservative MP and a "recent convert" to supporting legal assisted dying as defined by Marris-Falconer, said, "The thing that matters to me is that I should be in control in my final moments. Assisted dying is a complement to good palliative care, not an alternative."

Karin Smyth, a Labour MP and former NHS manager, told the meeting, "It's wrong that people with money can make this choice [by travelling to the Swiss clinic Dignitas, for example]. This is also an equality issue."

Speculation about the consequences of assisted dying laws was no longer necessary, said Coombs Lee, because a robust evidence base now existed. There was no evidence of abuse or coercion, she said.

Many dying people who request lethal drugs never take them, but knowing that they have the option gives them a psychological boost, which she described as "a palliative modality."

Coombs Lee added, "Passing the law is just the start. It takes a lot of stewardship. Some people will always oppose assisted dying." California's 2015 law is being challenged in court.

Responsibility

She said that religious belief was rarely given as a reason for opposition and that the root of most objections concerned power. "There's something about relinquishing responsibility to the individual that rubs a lot of people the wrong way."

Several speakers at the meeting argued that assisted dying should not be considered a binary issue and emphasised the importance of discussing the concerns of opponents.

"Passing the law is just the start. It takes a lot of stewardship"
Barbara Coombs Lee

Richard Hurley, *The BMJ*

Cite this as: *BMJ* 2018;361:k2553

THE BIG PICTURE

Creating a debate on air pollution

British artist Luke Jerram inspects his latest installation *Inhale*, which represents a diesel soot particle, created three million times larger than real size and using coal and various chemical substances. The 3 metre tall sculpture was commissioned by UWE Bristol's Our City Our Health project.

"The artwork was in part inspired by the recent VW diesel scandal and a friend whose young child suffers from asthma," said Jerram.

A World Health Organization report published in May stated that more than 80% of people living in urban areas are exposed to air quality levels that exceed its limits. While all regions of the world are affected, populations in low income cities are affected the most.

As urban air quality declines, the risk of stroke, heart disease, lung cancer, and chronic and acute respiratory diseases, including asthma, all increase, the report said.

https://www.lukejerram.com/inhale/

Alison Shepherd, *The BMJ*

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BEN BIRCHALL/PA

EDITORIAL

Food for thought

The BMJ launches a series of articles examining the science and politics behind our understanding of nutrition and health

What should we eat in order to stay healthy and avoid disease? Nutrition is one of the biggest drivers of chronic diseases, including obesity and diabetes, yet the answer to this seemingly simple question remains a subject of heated debate. A new series of articles in *The BMJ* aims to cut through the confusion and controversy to bring the latest evidence on nutrition to clinicians.[1]

The number of studies exploring the link between food and health has grown substantially over the past 50 years,[2] but the extent to which the growth in information has been matched by greater understanding is questionable.

Navigating the vast evidence base is challenging, even more so when concerns about weak science, vested interests, and conflicting or distorted media messages also muddy the waters. Nor do people eat for purely utilitarian ends. Food is central to culture and identity, which leads to strongly held preferences, beliefs, and biases.

Food is central to culture and identity, which leads to strongly held preferences, beliefs, and biases

More light, less heat

Our goal at *The BMJ* is to advance understanding through research and debate, but we recognise that sometimes additions to the literature can generate more heat than light. This series is our attempt to take a different approach. We have brought together some of the world's most thoughtful and influential voices in the field of nutrition and health, representing a range of backgrounds and perspectives, to help make sense of the state of current knowledge, the quality of the evidence on key issues, the extent and implications of potential disagreements between experts, and the agenda for further research.

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Guided by our series advisers, Dariush Mozaffarian and Nita Forouhi, we have chosen topics covering priority areas of clinical interest and unresolved controversy. The articles consider questions that will help doctors offer clarity and sensible advice to patients and guide policy makers towards effective actions. Is there a link between saturated fat and heart disease? What are the best diets for weight loss, and how good is the evidence to support them? Can a particular dietary pattern help prevent or reverse type 2 diabetes? Will interventions focused on personalised nutrition and the gut microbiome be beneficial for health? How can we address the urgent global problems of hunger and malnutrition? And what is the role of government and the food industry in tackling ill health related to food?

The articles lay out what we know and what we've yet to learn in these areas and more. After the initial launch, more articles are planned in the coming months covering topics ranging from the relation between food and cancer to the quality of dietary guidelines.

In a field notable for strong opinions and, often, polarised debate, a key ambition of the series is to bring together authors with a range of viewpoints and ensure a balanced approach to the evidence as far as possible. Authors have been tasked with outlining areas of consensus and uncertainty, and have been encouraged to discuss their disagreements in the text rather than come to forced compromise.

Open access publication

To bring the series to as wide an audience as possible we have partnered with the Swiss Re Institute to fund open access publication for the articles. The series launches this week at a meeting co-hosted by *The BMJ* and the Swiss Re Institute in Zurich, bringing together nutritional researchers, clinicians, and policy makers to discuss themes such as dietary fats and health, the role of bias in nutritional research, and the role of commercial food systems in promoting health.

Of course these articles won't be the last word on nutrition and health. When the science is so contested and opinions so deeply held, debates will continue, new research will be done, and knowledge will evolve. But we hope they achieve a new approach in bringing together different perspectives, establishing consensus where possible, spelling out uncertainty where necessary, and moving the field forward.

They set out a credible future research agenda, meaningful evidence based policy actions, and clearer messages for clinicians to help improve the health of their patients and the public.

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ANALYSIS, p 402

EDITORIAL

SCRAP THE CAP

International rescue

The UK urgently needs a coherent approach to the recruitment of overseas doctors

The rapid agreement by the government to a review of the visa regime for international doctors is a rare glimmer of common sense in a matter that has been more usually characterised by national policy incoherence.

What remains of concern is that it required a media campaign from *The BMJ* to achieve a response from government, and that the underlying problems of the UK approach to international recruitment of health professionals remain to be acknowledged and tackled.

These problems owe much to a debilitating mix of conflicting policy goals and inadequate health workforce planning and funding. This has led to a long term "stop-go" approach to international recruitment, which has often been misaligned with domestic health workforce and immigration policies.

Please sign *The BMJ*'s petition at **http://bitly/2JffJd2**

"Disastrous failure"

Ten years ago, the Health Select Committee report on NHS workforce concluded that there had been a "disastrous failure" of planning, in part because of a "clear lack of alignment" between domestic training and active international recruitment. It recommended that the Department of Health "needs to work more effectively with other departments, notably the Home Office, to ensure that international recruitment is fair and consistent."[1]

Since 2007, little appears to have changed—except NHS funding is tighter, and staff shortages are now more pronounced. While there have been glib statements about the UK achieving "self sufficiency" in doctors and nurses, if this means ending reliance on international recruits then it is unlikely to happen in the foreseeable future, given current high vacancy rates, the ageing of the NHS domestic workforce, and retention indicators showing no substantial improvement.[2] For example, despite government announcements on expanding primary care and staffing growth targets, the numbers of GPs working for the NHS in England has fallen from 34 025 in September 2015 to 32 748 in March 2018. An international recruitment drive is struggling to fill the gap.

The backdrop to policy is that the UK continues to be heavily reliant on international doctors. Data published by the Organisation for Economic Cooperation and Development[3] (OECD) show that 28% of UK based doctors were trained internationally, which sits comfortably in the cluster of high income, English speaking countries of Australia, Canada, Ireland, New Zealand, and the US, all of which are in the 24-41% range of dependency on internationally trained doctors. Data on annual inflow, however, show the UK, with 5649 doctors reported inbound in 2016, is the second highest OECD destination country for international doctors, beaten only by the much larger US.

A more detailed consideration of data related only to the NHS in England exposes its vulnerability to changes in flows of international doctors and the extent to which this reliance has switched in recent years to doctors moving from the EU.

NHS England data show that only two thirds of hospital doctors gained their primary medical qualification in the UK (64%), while 20% of doctors qualified in Asia, 6% in Africa, and 9% in another EU country.[4]

There is no immediate likelihood of UK self sufficiency in doctors or nurses

Compared with 2009, however, there is now less reliance on Indian doctors and number of doctors from other non-EU countries such as Iran, South Africa, Syria, Zambia, and Zimbabwe have fallen. By contrast, the number of doctors from EU countries such as Greece, Ireland, and Romania has increased significantly.[4]

Hostile environment

In short, when compared with other anglophone OECD countries, the UK is not unusual in its level of reliance on international doctors. Where it does stand out is in its high level of numerical inflow of doctors, notably from EU countries, combined with its hardening stance on immigration. This makes it vulnerable to Brexit related volatility in health labour markets, while not having the option to easily "switch" back to non-EU immigration pathways because of the tough visa regime.

It is too early to be certain how Brexit will influence flows of health professionals to and from the UK, but it is likely to amplify the focus on international recruitment from non-EU countries. An unintended consequence of the pro Brexit vote is that it may force the NHS to try to replace German doctors with Indian doctors, and Spanish nurses with those from the Philippines.

The simple truth is that there is no overall government policy, published plan, or immediate likelihood of UK self sufficiency in doctors or nurses. What we need is a joined up and strategic approach to the international recruitment of health professionals, involving government health departments, the Home Office, regulators, and employers, which is embedded in overall national health workforce planning.

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CHILD HEALTH

Could a Dutch approach to obesity work in UK cities?

Is Amsterdam's much lauded policy really making a difference to child health, and could British agencies work together do the same, asks **Tony Sheldon**

Amsterdam's claims of a "12% drop" over three years in the proportion of overweight and obese children in the city have sparked international interest, glowing headlines, and calls for cities such as London to copy the Dutch approach.

Two fifths of London's 10 and 11 year olds are overweight or obese. London's adults have higher rates of obesity than New York, Sydney, Paris, and Madrid. A UK government strategy on childhood obesity is expected imminently, and London's mayor is currently consulting on banning advertising "unhealthy" food on public transport.

The UK's Centre for Social Justice think tank, the International Panel of Experts on Sustainable Food Systems, and, most recently, the UK's public health minister Steve Brine have highlighted Amsterdam's citywide Healthy Weight Programme as a beacon of good practice.

The approach puts child and adolescent health at the heart of all municipal policies and involves collaboration among many sectors. Many Dutch cities work similarly, encouraged by the national Young People at Healthy Weight (JOGG) programme. However, Amsterdam's data have also aroused scepticism because they have not been published in any peer reviewed journal and their observational nature means that causality cannot be inferred. The programme arrives at a 12% drop using approximate rates for overweight children of 21% in 2012 and 18.5% in 2015, which is an absolute decrease of only 2.5 percentage points (box).

Eric Van der Burg, the councillor responsible for the programme, accepts that some of the numbers are small and indicate only "a trend" but says, "We know the proportion overweight is declining. We know the proportion obese is declining."

In 2013, shocked that Amsterdam was home to 9300 obese children, Van der Burg was determined to do something.

"If they had had tuberculosis we would have needed a disaster plan, but these children are ill too. We needed a programme to treat this as an illness, to take all sorts of approaches." It's about changing lives, he says. And Van der Burg is in an ideal position, with responsibility not just for the city's health but also for sport and urban planning. He argues that Amsterdam's success with young people aged under 19 stems from trying to change the whole culture and lifestyle of the city to promote achieving and sustaining healthy weight.

This "whole system" or "health in all policies" approach includes collaborating with health and other professionals to design policies to create a healthier food environment—from promoting healthier options in school canteens to banning advertisements for fast food aimed at children.

What Amsterdam's data show

The latest report for the Amsterdam Healthy Weight Programme compares data from 2012-13 with those from 2015-16.[3-5] Municipal youth health services' parent and child teams and school nurses make up to 19 voluntary checks of height and weight from birth to age 16. The parents of primary schoolchildren and pupils from secondary school are asked to complete questionnaires on health and lifestyle

- Between 2012 and 2015, the total population of 2 to 18 year olds rose from 130 363 to 135 341; the number overweight or obese dropped from 27 000 (21%) to 24 500 (18.1%)
- Among 10 year olds, prevalence of overweight fell from 19.2% to 16.8% and obesity from 5.9% to 4.7%
- Among 5-10 year olds from poorer families, prevalence of obesity fell from 7.1% to 5.1%
- Prevalence of overweight among ethnic Moroccan 5-10 year olds fell from 23.2% to 19.7%
- Among girls of primary school age, prevalence of overweight fell from 16.3% to 14.2% and obesity from 6.0% to 4.2%

Healthier products

Karen den Hertog, the acting programme manager, tells *The BMJ*, "We are using different policy instruments to nudge individual entrepreneurs to offer healthier products, or to help parents to make healthier choices" (box).

In addition to this "activism," as Van der Burg describes the aim to increase awareness of childhood obesity, the programme includes interventions targeted at individual schools and families. The most overweight children are identified by voluntary routine health checks of primary schoolchildren carried out at least annually by community care nurses. The council's public health service reports that checks reach 94.7% of 5 year olds and 86.7% of 10 year olds.

The Healthy Weight Programme staff can then target the schools and neighbourhoods with the heaviest children. The programme reports identifying more than 1500 children with obesity, of whom two thirds are receiving some form of intervention. More than half of primary schools are signed up to the Healthy Weight Programme. The council also supports school sports through the Jump-In programme, in which 25 000 children

"I'm busy with the diabetes, high blood pressure. You have to work on prevention as well as treatment"
Saskia Bouma-de Jongh, paediatrician

Some fast food advertisements are banned in Amsterdam's metro system

are estimated to take part but which is aimed especially at those schools where pupils' body mass index is above the national average. Meanwhile 11 neighbourhoods, identified through school checks as having a problem with childhood obesity, have signed a "pact" bringing together health and welfare professionals, volunteers, and community organisations around a "whole system" approach towards families with overweight children. Each has access to one of five neighbourhood managers, who implement the programme in conjunction with local partners. For example, the programme identifies volunteers from minority ethnic communities who organise cookery classes in community centres to teach parents and children how to make healthier versions of family dishes.

Pregnant women

The programme also works through the public health service's parent and child teams' "1000 days approach" to support pregnant women and young mothers, who receive regular home visits from conception until their child's second birthday. This means advice on diet, weight, and exercise is given in addition to that on breast feeding, smoking, alcohol, and folate supplementation.

Van der Burg is proud that the programme seems to be reaching lower socioeconomic classes, in particular the minority ethnic groups that have higher rates of child obesity: "What normally happens in these campaigns is just that the healthy get healthier, but the reports from the municipal health staff are that people who took no exercise are now getting involved."

Saskia Bouma-de Jongh is a paediatrician at Amsterdam's Free University Hospital. She is part of a Healthy Weight Programme team, linking her with several primary care professionals. She has close contact with the "central care provider" assigned to each overweight child in her outpatient clinics. These trained youth healthcare nurses have an overview of the care available, linking nurses, dietitians, social workers, and youth workers in a particular neighbourhood. When they identify overweight children they organise follow-up programmes, talking to the children about diet and healthy sleeping, visiting their homes, and meeting their parents. "As a specialist I can't do that," says Bouma-de Jongh. "I'm busy with the diabetes, high blood pressure, but if you really want to help you have to work on prevention as well as treatment."

Amsterdam has a population of about 850 000, including 135 000 children aged 2 to 18. The programme has an overall annual budget of €5.3m (£4.7m). The programme has 65 full time equivalent staff. The central care providers are employed separately.

Would it work in the UK?

Paul Gately, professor of exercise and obesity at the Carnegie School of Sport at Leeds Beckett University, is a UK exponents of a whole systems approach to obesity. He says that Amsterdam is achieving a political consensus that allows a "coherence, which is absolutely critical."

"The biggest potential lesson is about consistency and systems change but at scale"
Russell Viner, RCPCH

He argues that the complexity of obesity requires collaboration among political parties in areas such as food, transport, and sport that is often lacking in the UK, where the political right may view obesity as the responsibility of the individual and the left the responsibility of the state. By contrast, "Amsterdam offers a more nuanced approach, where government can address environmental factors and support individuals too." Whereas Amsterdam enjoys collegiate action, Gately speaks of "pitched battles in the UK between clinical commissioning groups and local authorities" over who is responsible—and who pays.

"Watch and wait" is the advice from Russell Viner, president of the Royal College of Paediatrics and Child Health. He says the Amsterdam programme is "promising" but warns against "jumping to conclusions" about what specifically has been effective, calling for independent evaluation "to get under the bonnet" of the data. Gentrification, and shifts in deprivation and ethnicity, may explain some changes, and the approach might not transfer to the UK, he says.

"It's not that there is a new unique intervention which we are not doing in Britain," says Viner. "The biggest potential lesson is about consistency and systems change but at scale. The size of Amsterdam and the centralisation of political power behind a programme like this makes it effective."

AMSTERDAM'S DIVERSE POLICIES TO ENCOURAGE HEALTHY WEIGHT

- Staff and trained volunteers visit schools, community centres, and homes to spread messages such as to drink water rather than sugary drinks
- Asking canteens in the 120 (out of 210) primary schools that have signed up to the programme to swap apple juice for tap water and to offer fresh fruit during breaks
- Banning adverts in metro stations for foods deemed to be unhealthy and aimed at children
- Giving advice to housing developers on creating an "exercise friendly city"
- Funding programmes to link schools to sports foundations and to promote sport among poorer communities
- Urging private business to promote healthier products, which has led, for example, to bakers discounting wholemeal bread

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CLINICIAN ADDICTION

Julien Warshafsky: why did this doctor die?

The story of the trainee anaesthetist lays bare the tensions between the treatment and regulation of unwell doctors—and could prompt changes in the system. **Clare Dyer** reports

A STORY OF ADDICTION

May 2013 Julien Warshafsky refers himself to the GMC after being discovered taking fentanyl from open ampoules while working as a CT2 in anaesthetics at Maidstone and Tunbridge Wells NHS Trust

August 2013 He undergoes GMC health assessment and is restricted to practising under GMC supervision. Drug testing is directed by GMC case examiners

February 2014 He informs the GMC he has been suspended from work on suspicion of misappropriating controlled drugs

July 2014 He agrees undertakings with the GMC—including drug testing, which is recommended to take place at least every four months. GMC intends to test for fentanyl but does not ask for it specifically. None of the tests include fentanyl, which the GMC does not realise

January 2015 A colleague tells the GMC Julien has been taking drugs from work again. GMC takes no action because colleague insists on anonymity

June 2015 GMC case examiners agree to vary Julien's undertakings so he can possess and prescribe controlled drugs to progress in his training

June 2015 He has a respiratory arrest five minutes after anaesthetising a patient at 2am at Medway Maritime Hospital

August 2015 He begins a new job as an ST3 registrar in anaesthetics at Royal Surrey County Hospital in Guildford

December 2015 He has a hypoxic grand mal seizure at work secondary to a respiratory arrest. Urine test is positive for fentanyl and he goes on sick leave

March 2016 Royal Surrey County Hospital tells GMC it has started a disciplinary investigation

March-May 2016 He has respiratory arrests on four occasions after injecting himself with fentanyl and is resuscitated by either his fiancée or father

28 June 2016 He collapses at home and cannot be resuscitated

At 14.03 on 28 June 2016, Julien Warshafsky sent an email to the Medical Defence Union (MDU), which was representing him in an investigation by the General Medical Council into suspected drug abuse. The email was the last he would ever send.

The MDU replied at 16.34, but he never opened the message. At 17.55 his wife of 10 days, Mariana, returned from work as an intensive care nurse to find him on his knees, slumped over a bed in the spare room. He had stopped breathing.

Julien, a trainee anaesthetist, was 31. He was on sick leave after collapsing at work from a suspected overdose of fentanyl in December 2015. After an earlier incident involving the theft of fentanyl, he was subject to regular testing for illicit drugs by the GMC.

His father, Robin Warshafsky, a general practitioner, spoke to him the night before he died. He recalls that his son was "upset and agitated" after receiving an email that day from the MDU, which wanted to discuss the GMC process. "He was in great turmoil about whether to resign or try to hold on to his registration. Julien spent his last 24 hours preoccupied with the GMC investigation and scrutiny."

Why did Julien die and what could have been done to save him? His father has used his own medical training and experience and spent thousands of hours searching for answers. He has spoken to many of the people involved in Julien's training, care, supervision, and monitoring, and describes the way clinician addiction is handled in the NHS as "amateurish."

An inquest due to reconvene from 18 June will look into what caused Julien's death. His story raises important questions about the tension between the treatment and regulation of unwell doctors and could prompt changes in the system. How should the need to regulate doctors be balanced against the need for treatment, keeping sight of the fact that a doctor has also become a vulnerable patient?

"We must allow doctors to become patients without the fear of sanctions or blame, and afford them the same compassion as they are expected to give to their own patients," Clare Gerada, a GP and head of the Practitioner Health Programme for doctors with mental health problems, has written.

Struggling to cope

Julien's use of fentanyl first came to light in May 2013, when he was caught taking the drug from open ampoules while working for Maidstone and Tunbridge Wells NHS Trust. He reported himself to the GMC, explaining that he had been struggling to cope with the demands of his training. He had a GMC health assessment by two psychiatrists, and the regulator imposed conditions—

GMC STATEMENT

"Dr Warshafsky referred himself to the GMC in 2013. He agreed to work with undertakings and was under medical supervision. That supervision included testing, but it is clear that the programme carried out was not adequate.

"Following Julien's tragic death in 2016 we have revised testing arrangements. We have also carried out a significant programme of work to support vulnerable doctors who are referred to us.

"We now have a dedicated team who work with doctors with health concerns and we have made a number of other changes to support vulnerable doctors following recommendations by leading mental health expert Professor Louis Appleby."

including regular drug testing and restrictions on prescribing—from July 2013. Julien went on sick leave but returned to work in September 2013.

"Julien returned to the anaesthesia training programme after a three month absence with no substantial treatment, risk assessment, or risk management plan," says his father.

In February 2014, Julien reported to the GMC that he had been suspended from work on suspicion of misappropriating controlled drugs. A test for fentanyl commissioned by his GP gave negative results, and he returned to work in March. In July 2014 he signed new undertakings allowing him to prescribe controlled drugs, after the GMC was told he would need the restrictions on prescribing lifted to continue with his training.

In January 2015, the GMC received an anonymous tip-off from a work colleague that Julien had been taking drugs from work again. The colleague refused consent for the allegation to be put to Julien. "In the absence of evidence, this allegation was therefore closed with no further formal action," wrote the GMC in a report after Julien's death. It did not test Julien for drugs after July 2015.

Drug tests ordered by the GMC were negative for fentanyl because they were not testing for fentanyl

Addiction missed

One startling fact Robin's investigations unearthed after his son's death was that the drug tests ordered by the GMC were negative for fentanyl because they were not testing for fentanyl. Intending to test for fentanyl, the GMC asked the lab to test for opiates. But the test for opiates did not cover fentanyl, which is a synthetic opioid. Fentanyl requires a specific test, but the GMC never made that request, although it knew that fentanyl was the drug Julien had misused.

"The fact that no fentanyl testing was conducted under the GMC's direction was not identified by anyone involved with the GMC case," the regulator admits in its significant event review of the case. Robin Warshafsky realised when he saw the lab reports on Julien's phone after his death that there was no testing for fentanyl—something he believes that he would never have spotted but for his medical training.

The GMC initially required Julien to engage regularly with the Practitioner Health Programme (PHP) and to attend any programmes recommended by the PHP, his GP, occupational health doctor, and psychiatrist. He was required to be under the care of a psychiatrist and to allow the GMC to exchange information with the psychiatrist about his health and treatment.

But none of the many people involved with Julien's case realised that he was addicted to fentanyl, so he was never treated for addiction.

No doubt reassured by the negative drug test results, everyone thought he was not addicted to fentanyl but simply misusing it, as he claimed, to self medicate for his depression, first diagnosed at the age of 18. Robin believes Julien was never accurately diagnosed with addiction because those responsible for his care and supervision never saw the full picture.

Before the inquest adjourned to allow the GMC to obtain legal representation, the regulator admitted that it was an "error" that the psychiatrist it appointed to supervise Julien on its behalf was not a specialist in substance misuse. The occupational health physician dealing with Julien's case at his employing trust wrote in February 2015 that he was "progressing well." Everyone thought he was complying with the GMC's requirements because the drug tests kept coming back clear. It is unclear how many drug tests the GMC ordered, but none tested for fentanyl and no drug testing was carried out by the GMC after July 2015.

Shunning treatment

Julien's depression and dislike of his job were the background to his use of fentanyl, to which the job gave him easy access. Anaesthetists are especially exposed and vulnerable to the risks of addiction. "He felt keenly the difficulties of life as a junior doctor," notes his father. "He constantly vocalised to his family his very low sense of self worth. He felt an existential void."

A community psychiatric nurse who assessed Julien in the emergency department in April 2016 after a second respiratory arrest within 24 hours wrote, "States that he hates his job, but unsure of what else he would do. Julien states that he does not want to commit suicide, although there is frequent ideation. When he takes the overdoses he knows exactly what he is doing, does not want to die but cannot stop himself."

This "hallmark of addiction," should have been picked up, argues Robin. A report of the trust investigation into the events of May 2013 when Julien's misuse of fentanyl first came to light, which his GP saw only after Julien's death, "suggests that he was actively looking for fentanyl when not in theatre," the GP wrote, "which is a much more worrying addictive behavioural

pattern than someone self medicating for depression."

Robin believes that Julien was loath to admit he was addicted and shunned treatment because every doctor he engaged with was obliged to tell the GMC. "Julien found it very difficult to believe therapy would help because every time he had it he was reminded that the therapist would have to report back to the GMC.

"One of his undertakings required him to attend a support group. He didn't go, and it wasn't monitored."

He did get in touch with the PHP, which was commissioned by Health Education England to give him cognitive behavioural therapy (CBT). "But Julien was not strictly a PHP patient," says PHP head Gerada. "He was a patient of a Health Education England commissioned service for Kent, Surrey, and Sussex trainees, which allowed only for assessment and CBT. This is very different from what PHP normally offers."

Let down

In August 2015, Julien started as a registrar in anaesthetics at the Royal County Surrey Hospital in Guildford, where only a few colleagues, mainly consultant anaesthetists, knew of his history.

On 13 December 2015, he was in the anaesthetic coffee room when he suddenly stopped breathing, turned blue, and started fitting. A drug test found fentanyl, and a consultant noticed many needle track marks of varying ages on both his arms, but Julien denied that he was using opioids. He was suspended from work and reported himself to the GMC for "alcohol misuse and depression."

After going on sick leave again in December 2015, Julien no longer had access to fentanyl at work. But it emerged after his death that he had been buying it over the internet using bitcoin. Between March and May 2016 he collapsed four times with respiratory arrests. Each time his fiancée or his father was on hand to bring him round. On the day he died, in June 2016, he happened to be alone.

Robin believes both the regulatory and the healthcare system let Julien down. Failures in communication meant that health professionals who knew him variously as a patient, trainee, employee, and doctor in regulatory trouble each saw only a part of the picture. The report of the trust investigation that showed Julien's trawling for drugs was not widely shared and, as his GP wrote, "The lack of information sharing can surely only have been detrimental to overall care."

Failures in communication meant health professionals who knew Julien as patient, trainee, and employee, saw only a part of the picture

Concerns about confidentiality seem to have prevented those involved in Julien's care and supervision from sharing information, including speaking to family members who could have provided much needed background information and support. Robin, who trained as a Caldicott guardian himself, points out that the second Caldicott review of the use of patient data allows and indeed mandates information sharing when this is in the best interests of the patient.

The GMC acknowledges in a report on Julien's case, "A protected confidential route of communication from the various parties to one individual with oversight might have enabled a clearer picture to be gained of Dr Warshafsky's risk profile at any one time."

System change

The PHP has seen more than 300 addicted doctors over a decade and has achieved 80% abstinence rates, Gerada says. "PHP has had patients who have died. Quite often, what marks out the deaths of our patients is not too few people (for example, psychiatrists, GP, therapists, educational supervisors, trainers, and so on) involved—but too many."

The PHP has changed its practice in the light of Julien's case. "We now ask for consent to involve a 'significant other'—a family member or close friend," explains Gerada. "We won't see doctors with addiction problems without that consent. It is safer."

She suggests that the whole system for dealing with doctors like Julien needs to change. "My sense is that across the world most addicted doctors are not managed in an adversarial system. They're managed in a treatment situation." She told the inquest into Julien's death before it adjourned, "I do not think they [the GMC] have any place in treating or managing very seriously ill people."

There is no evidence that Julien harmed any patients, but Robin adds, "I would like the confidence to know that in the UK the anaesthetist putting me or my remaining loved ones to sleep has not injected an opioid or used any other drug while doing so. I can tell you that from my investigations there can be no such assurance."

Robin is convinced that what Julien needed was a safe space to heal, where he could focus exclusively on recovery. He wants the NHS to adopt the Julien principle of staff wellbeing: "Take good care of the carers and then the carers can and will take good care of patients."

Clare Dyer, legal correspondent, *The BMJ*

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BMA members experiencing distress or difficulty can contact BMA Counselling (24 hours a day, seven days a week) and the Doctors Advisor Service on 0330 123 1245

RETHINKING FITNESS TO PRACTISE AND HEALTH PROBLEMS

The GMC is piloting a system to try to reduce the number of fitness to practise cases relating to a doctor's health that are investigated.

Previously trialled in cases where the concern related to a doctor's clinical skills, the "provisional inquiries" process allows the regulator to look for additional information about the case that might show it is not a fitness to practise issue, allowing the case to be closed.

In the clinical skills cases, it has prevented about 400 being investigated over the past two years. "So it may well be, if that pilot is successful, that we will be able to reduce the number of health cases that come in," says GMC assistant director for case examiners John Smyth.

This is important, he says, because cases that relate to a doctor's ill health often don't need to be referred to the GMC at all. Speaking to *The BMJ* in May 2018, in an interview not directly discussing the Julien Warshafsky case, he said, "If a doctor has an alcohol problem and they engage locally with treatment, and seek help, and have maybe withdrawn from work when they're particularly unwell, then in those kinds of circumstances the GMC may not need to be involved at all."

It is trickier in cases where there are conduct issues or performance concerns as well as health problems, Smyth says. "It gets more difficult when a doctor with addiction problem lacks insight into the nature of the problem or the severity of the problem and tries to continue to work, particularly if a doctor were to try to work while under the influence of alcohol or drugs. That would be something that the GMC ought to be involved with."

The GMC is now working on how it can lessen the effect that the investigation process has on all doctors, especially those with health problems.

Additional reporting by Abi Rimmer, The BMJ