

# this week

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## Anger over RCP's assisted dying poll

**EXCLUSIVE** The Royal College of Physicians has been threatened with legal action by the former chair of its ethics committee over its members and fellows poll on assisted dying.

The college currently opposes assisted dying—doctors being allowed to prescribe lethal drugs for terminally ill people to hasten their death in specific situations. It has said it will move to a neutral position unless at least 60% of the poll, sent out last week, favour or oppose a law change. It intends to announce the results in March.

But John Saunders, an RCP fellow, told *The BMJ* he had sent the college a lawyer's letter about how the poll is being conducted. In a separate letter to the *Guardian* he condemned it as a "sham poll with a rigged outcome," as the college would change its position to neutral if the poll delivered the same overall result as the last vote in 2014. Then 44% voted to oppose legal assisted dying but the majority were either neutral or supportive.

A letter to the *Times* on 1 February from 23 doctors and academics also complained of the poll's "procedural irregularities". "We contend it is wrong to demand a supra-majority simply to maintain the status quo," they wrote. "We are worried

this move represents a deliberate attempt by a minority on the RCP council to drop the college's opposition to assisted suicide even if the majority vote to maintain it."

But RCP president Andrew Goddard defended its stance in a letter to members. "It is simply not true to say the issue is tearing the RCP apart or, in the words of the *Sun*, that the RCP has been 'hijacked by assisted suicide activists,'" he wrote. "This has been completely democratic through our elected council over the past six months.

"It is important that the RCP represents fairly the views of its full membership. We will go ahead with the survey as planned."

The poll will ask the same questions as in 2014: whether members individually support a legal change to permit assisted dying, and what the RCP's stance should be.

Goddard said that by switching to neutral "the RCP could reflect the differing views of its fellows and members in discussions with government and others."

Goddard added that the college's stance was cited in legal cases and parliamentary debate, and that it has committed to repeating the survey every five years.

● **FEATURE**, p 222

Richard Hurley, *The BMJ*

Cite this as: *BMJ* 2019;364:l559

**Twenty three doctors and academics wrote to the Times to protest at the college's new assisted dying poll**

### LATEST ONLINE

- GP is suspended after failing to take proper histories and order tests for patients
- WHO proposes rescheduling cannabis to allow medical applications
- CCG hosting GP at Hand is set to cut extended hours at other practices



# SEVEN DAYS IN

## RCPCPCH pledges to review its financial links with formula milk industry



The Royal College of Paediatrics and Child Health has said it has suspended “future funding agreements” with the infant formula milk industry while it conducts a review of its ties. The decision came after growing pressure from campaigners who have said the college’s links are incompatible with the healthy promotion of breastfeeding, especially in low and middle income countries.

*The BMJ* recently reported that 12 organisations and 84 individuals, mostly clinicians, had accused the college of acting against WHO’s code on breastmilk substitutes at its Cairo conference on 29 January. Sponsors included Nutricia, Danone, and Nestlé, all of which make formula milk products. The WHO rules state that infant formula manufacturers “should not . . . sponsor meetings of health professionals and scientific meetings.”

Charlotte Wright, professor of community child health at the University of Glasgow and honorary consultant paediatrician at the Royal Hospital for Children, Glasgow, said she was concerned about the conduct of the review and called for consultation with expert organisations, including WHO and others. “These organisations have been saying for years that the college should clean up its act. The worry is that it will just have a review and conclude—what a surprise—that they are just going to carry on taking the money.”

Susan Mayor, London [Cite this as: BMJ 2019;364:l544](#)

## Statins

### GPs should consider statins “for all over 75s”

Statins should be considered for everyone over 75, said the authors of a large meta-analysis published in the *Lancet*, which found that they reduced major vascular events such as myocardial infarction and stroke in patients of all ages. Only a third of the UK’s 5.5 million over 75s take statins, and 8000 deaths a year could be prevented if they all took them, said Colin Baigent, director of the Medical Research Council Population Health Research Unit at the University of Oxford, which conducted the research.

## Emergency care

### NHS is criticised for four hour target review

The Royal College of Emergency Medicine’s lead patient representative wrote an open letter to the head of NHS England, Simon Stevens, criticising plans to review the target for 95% of emergency department patients to be admitted, transferred, or discharged in four hours. Derek Prentice urged Stevens to provide evidence that senior doctors supported the plan. “I would have thought that no one

wants to go back to the days of endless hours of waiting in [emergency] departments,” wrote Prentice. “Removing the standard will do this and hide the true scale of problems within our health service.”

## Ulcers

### NICE recommends novel wound dressing

The National Institute for Health and Care Excellence recommended UrgoStart dressings as an option for patients with non-infected diabetic foot ulcers or venous leg ulcers. The dressing contains a substance that inhibits enzymes within the wound that are linked to slower wound healing. NICE concluded that UrgoStart would speed up healing and could save the NHS £342 per patient per year on dressings and on nurse, GP, and outpatient visits. If 25% of people being treated for diabetic foot ulcers switched to UrgoStart the NHS could save £5.4m a year, NICE estimated.

## FGM

### Mother is first to be convicted in UK

A mother whose daughter

underwent female genital mutilation at age 3 became the first person in the UK to be convicted of the practice. The 37 year old woman, from Uganda, was found guilty after a trial in London. Her Ghanaian partner, the girl’s father, was acquitted by the jury. For legal reasons none of the parties can be named. Remanding the woman for sentencing on 8 March, Mrs Justice Whipple (below) warned her that she faced a lengthy jail term. FGM carries a maximum prison sentence of 14 years.

## Infertility

### Male IVF technique did not boost conception

Treating male infertility using a new IVF technique called PICSI, which some private clinics already offer, did not increase the likelihood of having a baby, a study published in the *Lancet* showed. The study involved over 2700 couples who were randomly assigned to standard

ICSI (intracytoplasmic sperm injection) treatment, where embryologists manually choose the best sperm to fertilise an egg



by sight, or to PICSI (physiological ICSI), where sperm are selected on the basis of whether they can bind to hyaluronan, a substance normally found surrounding the surface of eggs. The

researchers also found, however, that PICSI reduced the number of miscarriages by 39%.

## Brexit

### Kent is told not to cancel blood donor sessions

The government ordered NHS Blood and Transplant to reverse a decision to cancel blood donation sessions in Dover and Folkestone for two weeks before and six weeks after the 29 March Brexit deadline because of concerns that “significant traffic in Kent may prevent donation teams from reaching or leaving venues in the area.” Officials said they would hold replacement sessions elsewhere. But the Department of Health later quashed the suggestion that sessions would be cancelled.



# MEDICINE

## Falls

### Exercise in over 60s shows strong benefit

Falls in people over 60 can be prevented by exercise, concluded a Cochrane review that considered 108 randomised controlled trials with 23 407 participants with an average age of 76. It found that exercise reduced the frequency of falls by 23%. Exercise was effective in group classes or if prescribed by a health professional to do at home. Programmes involving balance and functional exercises were found to be effective. Tai chi may also prevent falls, but the review found uncertain evidence on the effectiveness of resistance exercises, including dance and walking.

## Sanitary products

### BMA: Hospitals should provide free products

Many hospital trusts and health boards do not provide free sanitary products for patients, a BMA investigation found. The association is calling for the products to be made freely available at all hospitals, as doctors consider them essential for inpatients' health and dignity. Of the 187 hospitals and health boards that responded to the survey, 25 (13%) said they did not supply sanitary products.

## Social media

### End self regulation, says MPs' child health report

Social media companies should be subject to a formal legal duty of care to help protect young people's health and wellbeing, said MPs on the Science and Technology Committee. They called on the government to create a regulatory framework setting out companies' responsibilities towards users and to appoint a regulator by the end of October. The regulator would provide guidance on spotting and minimising harms,

### Practising tai chi may prevent falls in older people

monitor a code of practice, and take enforcement action.

## US news

### Arctic weather forces medical testing to halt

The Mayo Clinic in Minnesota warned clinicians not to send medical samples that should not be allowed to freeze during the polar vortex. "Unfortunately, there is no specific routing at this time to get a specimen to Mayo Clinic Laboratories on time and unfrozen," it said.

### Coca-Cola tried to access public health agency

Correspondence between Coca-Cola and the US Centers for Disease Control and Prevention revealed the drink maker's interest in "gaining access to CDC employees, to lobby policymakers, and to frame the obesity debate by shifting attention and blame away from sugar-sweetened beverages." A paper published in the *Milbank Quarterly* said Coke had tried to "advance corporate objectives, rather than health, including to influence the World Health Organization." Last month a *BMJ* investigation showed how Coke had shaped obesity science and steered public health policy towards its interests in China.

Cite this as: *BMJ* 2019;364:l550

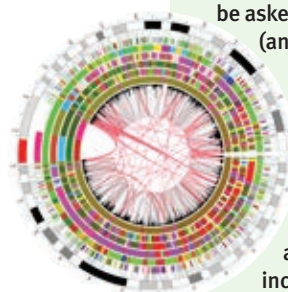


## ALCOHOL DEATHS

There were 5843 alcohol specific deaths in England

in 2017, 6% more than in 2016 and an increase of 16% on 2007

[*NHS Digital*]



## SIXTY SECONDS ON... GENOME MAPPING



### BECAUSE THE NHS IS SHORT OF WORK?

Hilarious. When the Department of Health and Social Care says that every NHS patient will have the opportunity to have their whole genome sequenced for a fee through Genomics England, it's considering the future. England's health secretary, Matt Hancock, thinks population genetic testing can save lives, prevent illness, and reduce demand on the NHS.

### CAN IT TELL ME HOW LONG I'LL LIVE?

No, it's genomics not fortune telling. And clinical geneticist Anneke Lucassen thinks it might be too early to give everyone a personal profile of their health. She said that testing large chunks of the population could take attention away from people that genetic services are able to help. And the Royal College of General Practitioners' Helen Stokes-Lampard said, "A lot of things that will be picked up by genetic testing will be of dubious value."

### SO WHAT'S THE POINT?

People found to be at high risk of some conditions could be referred for further screening and treatment. Many people with a genetic risk will never go on to develop the disease, and we need to be able to make better predictions, says Lucassen. The real benefit is that people who take the test will be asked to allow their genome to be used (anonymously) for research.

### HOW MUCH WILL IT COST?

That's a work in progress, though for healthy people a fee of "a few hundred quid" has been bandied about. Testing will be free for seriously ill children and adults with genetic conditions, including cancer.

### AND THOSE WHO CAN'T AFFORD IT?

You're right to ask. The royal colleges of physicians and pathologists, Genetic Alliance UK, and the Joint Committee on Genomics in Medicine are concerned that selling a test breaches an NHS core principle, care free at the point of delivery.

### WILL IT STYMIE MY LIFE INSURANCE?

If you are given a diagnosis you have to inform insurers. But you don't have to tell them about predictive genetic tests. The exception is testing positive for Huntington's disease and applying for life insurance over £500 000. Then you have to come clean.

Ann Robinson, London Cite this as: *BMJ* 2019;364:l527



## IT problems cause missed screening coverage targets

Screening programmes in England are missing take-up targets because of complex and outdated IT systems, concludes a report by the government's spending watchdog.

The National Audit Office investigated four programmes in England—for abdominal aortic aneurysm and bowel, breast, and cervical cancer—and found none hit its target in 2017-18.

Bowel screening came closest to hitting its 60% coverage target at 59.6%, but in eight clinical commissioning groups only 30-44% of eligible people were screened. Last year 43 220 women were found not to have received a cervical cancer screening call because of a system error, and for the past nine years 50 000 of the 350 000 women a year who should have received mammography invitations did not get them.

NHS England has admitted that omissions on this scale were unlikely to be identified through the national level performance data used to monitor the programmes, which “raised questions about the effectiveness of its governance arrangements,” the report said. Providers’ performance is delegated to regional and local teams, and where providers fail to perform their contracts can be terminated.



To identify patients eligible for screening, all four programmes rely on a national database of GP registrations, which the Department of Health and Social

Care says is not fit for purpose, as the information is held on 83 separate databases that were due to be replaced in 2017. Each programme also relies on its own IT systems—an estimated 350 systems support the cervical screening programme, for example.

Many patients also experience delays in getting results, the report said. Although 98% of women are meant to receive cervical test results within 14 days, this target has not been achieved since 2015, and in March 2018 just a third of women (33%) received their results on time.

Rebecca Fisher, a GP and Health Foundation policy fellow, said the findings were “deeply concerning.” She said, “Policy makers must consider how to most efficiently run screening programmes to ensure that these potentially lifesaving services are equally available right across the country.”

Ingrid Torjesen, London

Cite this as: *BMJ* 2019;364:l524

## Better scheduling, more operations, trusts told



**T**heatre time lost to late starts, early finishes, and delays between operations could have been used by hospitals to carry out 291 327 more elective operations a year (a 16.8% increase), according to NHS Improvement.

An agency report calls on England's trusts to consider measures to improve the scheduling of non-urgent operations such as hip replacements and cataract surgery.

The NHS performs around five million elective operations a year but has been

struggling to meet its target to treat 92% of patients within 18 weeks. The number having to wait over a year has grown, with the figure standing at 2432 at the end of November 2018, up from 1452 for the same period a year previously.

**A THIRD** of operating lists started 30 minutes or more late and **38%** finished 30 minutes or more early

## RCGP drops course on trans health in response to members' concerns

An online course on gender variance has been withdrawn by the Royal College of General Practitioners after concerns were raised about its content.

The course, provided by the Gender Identity Research and Education Society (Gires), had been hosted on the RCGP website since 2015 but was withdrawn because GPs were worried it might create “unrealistic expectations for patients regarding the role of the GP in initiating treatment” for gender reassignment.

The feedback prompted the RCGP to amend the course, but its changes were not acceptable to Gires.

Jonathan Leach, RCGP honorary secretary, said, “New presentations of

gender reassignment are exceptional in general practice. It is a specialist area, and treatment should be initiated in specialist care. Feedback from members was that this was not sufficiently clear in our e-learning module.”

Bernard Reed, a Gires trustee, denied the course was not clear. “The e-learning module described very clearly the respective responsibilities of specialist services and GPs,” he said. “The role of the GP is to refer those patients who seek medical intervention to a gender

**“The changes give GPs excuses to deny access to healthcare for transgender people”** Gires

Earlier this month NHS England and NHS Improvement published guidance which said that providers would be fined £2500 for every patient who waits more than a year for elective surgery.

The report analysed data from 92 trusts in England between January and December 2017 for eight surgical specialties. Dedicated emergency lists and operating lists with no scheduled cases (dropped sessions) were excluded.

A third of lists started 30 minutes or more late and 38% finished 30 minutes or more early, the report found. More than 110 000 finished at least an hour early, with day lists of three sessions of four hours most likely to finish early.

NHS Improvement wants hospitals to consider using the “6-4-2” model whereby surgical staff must agree their

annual leave six weeks in advance, agree their surgical lists four weeks in advance, and double check two weeks ahead. This has been in use at Guy’s and St Thomas’ NHS Foundation Trust since the start of 2018 and since then the trust has been able to identify and make use of more than 2700 operating hours that would not otherwise have been used.

#### Productivity programme

Another example cited in the report is Hampshire Hospitals NHS Foundation Trust, which has been running a theatre productivity programme focused on gynaecology, orthopaedics, ophthalmology, and urology. This includes clinicians taking responsibility for ensuring their lists are fully booked and posters on every theatre door showing how many minutes were lost the previous week and how much money has been wasted as a result.

The Royal College of Surgeons said it supported the report. Ian Eardley, college council member, said, “We must not, however, underestimate the wider challenges hospitals face to increase the number of operations. Recent statistics show the UK has the second lowest number of hospital beds for each 1000 people in the EU. Such shortages mean time is wasted in freeing up beds instead of treating patients. This is compounded by workforce shortages.”

Jacqui Wise, London

Cite this as: *BMJ* 2019;364:l540

#### THEATRE GUIDE

The report acknowledges that bed availability and its effect on patient flow may be a problem but says that all trusts can target areas to improve productivity. These include:

- Effective scheduling and making sure theatre lists are always fully booked
- Streamlining admission processes to ensure availability of the surgical team and the patient to allow a prompt theatre start
- Understanding the reasons for surgery cancellations to minimise cancellations on the day, and
- Minimising the gaps between cases

identity clinic. GPs then act on the recommendation, as they would for any other specialised condition.”

#### Undermined GPs’ responsibility

Gires, which paid the RCGP £7837 to host the course for two years, said the changes undermined the responsibility of GPs to follow specialist guidance and unnecessarily promoted the role of secondary care. “Gires could not agree to changes in a resource that was meant to help GPs support transgender people with confidence, when the changes give GPs excuses to deny access to healthcare for transgender people,” it said.

Leach said access to NHS specialist gender reassignment services was inadequate, which was “incredibly frustrating” for trans patients, but “GPs should not be put in a position

where they are being asked to prescribe treatment that they are not trained to prescribe or monitor safely.”

James Palmer, NHS England’s medical director for specialised services, said last June there had been a 240% rise in referrals to gender dysphoria clinics in five years, adding that in the future, he expected up to 3% of the population to want to have a discussion about their gender. Reed said such discussions would not necessarily lead to intervention, “but it does indicate that gender diversity is not rare.”

The RCGP is developing a new e-learning course, due to be launched later this year.

Harriet Pike, Cambridge

Cite this as: *BMJ* 2019;364:l573

## “Limited value” injections are still given for back pain

Patients with lower back pain still receive local anaesthetic or steroid injections with “limited clinical value” rather than the physical and psychological rehabilitation NICE recommends.

A Getting it Right First Time (GIRFT) report on spinal surgery found wide variation in NHS trusts’ management of lower back and radicular pain in England. From 2015 to 2018 an average of 5.7% of patients received three or more facet joint injections in a year despite evidence and guidance advising against them. The annual cost of repeat injections is estimated at £10.5m.

#### Longer term rehabilitation

The report said that this money should be spent on longer term rehabilitation programmes close to patients’ homes. This is in line with the 2017 National Back and Radicular Pain Pathway.

GIRFT is a national programme that works with frontline clinicians to help improve the quality of care by identifying and reducing unwarranted variation in practice. This report is the eighth since the programme was rolled out to cover more than 37 specialties.

Mike Hutton, a consultant spine surgeon at the Royal Devon and Exeter Hospital, based his report on visits to 127 spinal units. It sets out 22 recommendations, aiming for cost savings of up to £27m.

ANNUAL  
COST of  
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#### Improving care pathways

The report highlights opportunities to improve care pathways for patients with

emergency spinal conditions. Many patients admitted to specialist trusts do not require surgery, and many have long stays in acute beds with non-emergency conditions. For patients with suspected cauda equina syndrome, it recommends referral without delay to 24 hour MRI scanning. It also recommends that all major trauma centres should have 24/7 ability to stabilise and decompress the spine in patients with a fractured or dislocated spine.

Jacqui Wise, London

Cite this as: *BMJ* 2019;364:l467





# Will the new GP contract prove a game changer?

Gareth Iacobucci reports on the five year deal to boost practices' income and to encourage them to form primary care networks



**Richard Vautrey:** "This five year deal guarantees investment"



**Nigel Edwards:** "We need to hear more about where staff are coming from"



**Ian Dodge:** "Extra support staff is a pragmatic solution"

Last week the BMA's General Practitioners Committee (GPC) and NHS England announced with much fanfare that they had agreed on a contract deal for general practice in England, amounting to an extra £2.8bn over the next five years.

The deal has been described by some as the most important change to the GP contract since 2004 and a potential "game changer" for practices that have been struggling to cope with an unsustainable workload, a shortage of GPs, high demand, and a decade of constrained funding. The changes cover a number of key areas, including pay, QOF (see box), indemnity, and pensions.

The multifaceted agreement is significant for several reasons, not least because it spans five years rather than the traditional one. This longer timeframe was enabled by the commitment in the *NHS Long Term Plan*, published last month, to boost investment in primary and community services as a share of total NHS spend.

GP leaders hope the extra certainty will stabilise and support practices under pressure and improve services for patients.

## Core practice funding and pay

The new deal will increase core practice funding by almost £1bn over the next five years. In 2019-20 practices in England will receive a 1.4% increase to core funding through the global sum. In the four years after this, global sum payments will continue to rise each year until 2023-24 in line with predicted

inflation. The BMA said that this funding, when coupled with additional income to support practices' participation in primary care networks (see below), will guarantee a minimum 2% uplift for GP and staff pay and expenses this year, and uplifts to core practice pay and expenses each year.

Richard Vautrey, chair of the GPC, said, "After years of derisory pay uplifts and tightening financial pressures, we have been able to negotiate a five year deal guaranteeing investment that covers pay and expenses and at least matches predicted inflation."

The news that NHS England will also invest £20m in the global sum for practices to cover the costs of dealing with subject access requests by patients, after the ability to cover costs was removed by the General Data Protection Regulation, is likely to be warmly welcomed.

The profession may be less pleased that any GPs whose NHS earnings are more than £150 000 will have to make this public from April as part of an NHS England transparency drive. There are no exact figures on how many GPs will be affected, but Vautrey told a joint GPC and NHS England press conference that he expects it to be a "modest" number.

## Indemnity

The agreement confirms that the much anticipated state backed indemnity scheme for all GPs will begin in April. This means that all GPs (partners, salaried, and locums) and practice staff will no longer have to personally fund clinical negligence cover. Helen Stokes-Lampard, chair of the Royal College of General Practitioners, said



## QUALITY AND OUTCOMES FRAMEWORK

From April, 28 "low value" QOF indicators will be retired, worth 175 points. They include annual cholesterol checks for diabetes; dementia blood tests; annual FEV1; osteoporosis; and peripheral artery disease.

Of the retired points, 101 will be recycled into 15 more clinically appropriate indicators, including aligning blood pressure control targets with NICE guidance, improving outcomes in diabetes care, supporting age appropriate cervical screening, and offering pulmonary rehabilitation (where available) for patients with COPD.

The remaining 74 points will be allocated to a new quality improvement domain split into two modules. This year the modules will focus on safe prescribing and care at the end of life.

the college was "particularly pleased" at this announcement. "Escalating indemnity costs have become a huge burden for GPs at all stages of their careers, and some GPs have even cited this as their reason for leaving the profession," she said.

## Primary care networks

Close to two thirds of the deal's extra funding (£1.8bn over five years) will be tied to practices' participation in primary care networks. The funding is designed to help neighbouring practices develop collaborative networks across an area covering 30 000 to 50 000 patients. Trained in the long term plan, the new deal sets out the detail, taking an approach described by Nuffield Trust chief executive Nigel Edwards as "the carrot,

**FUNDING** will include **£1.8bn** over five years tied to participation in primary care networks



## CLINICAL REQUIREMENTS OF THE DIRECTED ENHANCED SERVICE

- Medicines reviews
- Enhanced support to care homes
- Anticipatory care for patients with complex comorbidities
- Personalised care
- Supporting early cancer diagnosis
- Cardiovascular disease detection
- Tackling inequalities at neighbourhood level

not the stick.” The carrot is a “network contract” that will operate alongside GPs’ existing practice contracts.

A new directed enhanced service (DES) will distribute extra funding via several avenues. These include direct payments to practices for engaging with the network, recurring annual payments of £1.50 a patient to all networks to support their work, £31m for a GP clinical lead for each network, and the moving of all current funding for extended GP access to the networks.

In line with the long term plan aims, practices will eventually have to meet the DES’s specified requirements in seven clinical areas (see box, above).

### Workforce

Through the DES, each network will be funded from 2019-20 to employ at least one social prescribing link worker and one clinical pharmacist. By 2023-24 funding will be available to employ an extra 22 000 primary care workers across England, including physician associates, practice based physiotherapists, and paramedics.

With the exception of the social prescribers (which will be 100% recurrently funded for five years), the expanded workforce will be 70% recurrently funded by NHS England, with networks funding the rest. NHS England’s Ian Dodge, who led the BMA negotiations, said that adding support staff was a “pragmatic” solution to easing the workload and workforce issues in general practice. “We know there is

**“We are particularly pleased with the state backed indemnity scheme. Escalating costs had become a huge burden”**

Helen Stokes-Lampard, RCGP (below)

supply, but there is also demand,” he said.

But as Edwards pointed out, finding extra staff won’t be easy. “We need to hear more about where these staff are coming from,” he said. “After all, many other parts of the NHS have their own serious shortages.”

### IT and digital

The GPC will work with NHS England to develop a “standard specification” for IT systems that helps to increase patients’ digital access.

From April practices will have to provide new patients with full online access to prospective data from their patient record. They will also be expected to allow NHS 111 to book patients directly into their appointments systems, at a rate of one appointment a day per 3000 patients.

By July all practices will be expected to make at least 25% of appointments available for online booking and to offer online consultations by April 2020, subject to further guidance.

After a consultation last year, the deal also confirms that core practice funding will be revised to ensure fair payments for digital first providers and avoid “unwarranted redistribution” from other practices.

### Pensions

The government has agreed to fully fund the increases in employer contributions that will arise from its plan to increase the contribution rate from 14.3% to 20.6% from April 2019. “General practice will not have to bear any additional costs,” it confirms.

Separately, the BMA and NHS England have asked the government to

explore a “partial pension” option for GPs, under which they could choose to halve the rate at which their pension builds in return for paying half rate contributions. The local government scheme has a 50% pension option and it is hoped a similar scheme could ease issues with the annual allowance cap, which creates an incentive for GPs to cut their hours or quit the NHS scheme.

### What’s the initial verdict?

In the context of the past decade of underinvestment, the deal has generally been well received. The indemnity scheme will provide a huge fillip; and while a 1.4% rise in core funding is modest, when added to the indemnity and networks money, for many it represents a better deal than GPs have seen in a long time.

Networks are trickier. The principle of collaboration is hard to argue against, but how networks will form, develop, and operate will be decided by relations between practices.

There is also scepticism about the workforce targets, given the struggle to meet the target to boost GP numbers by 5000 by 2020-21. Stokes-Lampard, while welcoming extra staff, added, “Now we need the workforce strategy to deliver viable measures to continue recruitment effort, and initiatives to keep more GPs working in it.”

King’s Fund chief executive, Richard Murray, said, “The timetable for implementing these changes looks extremely challenging. It will be important that general practice and community services are supported to put these plans into practice.”

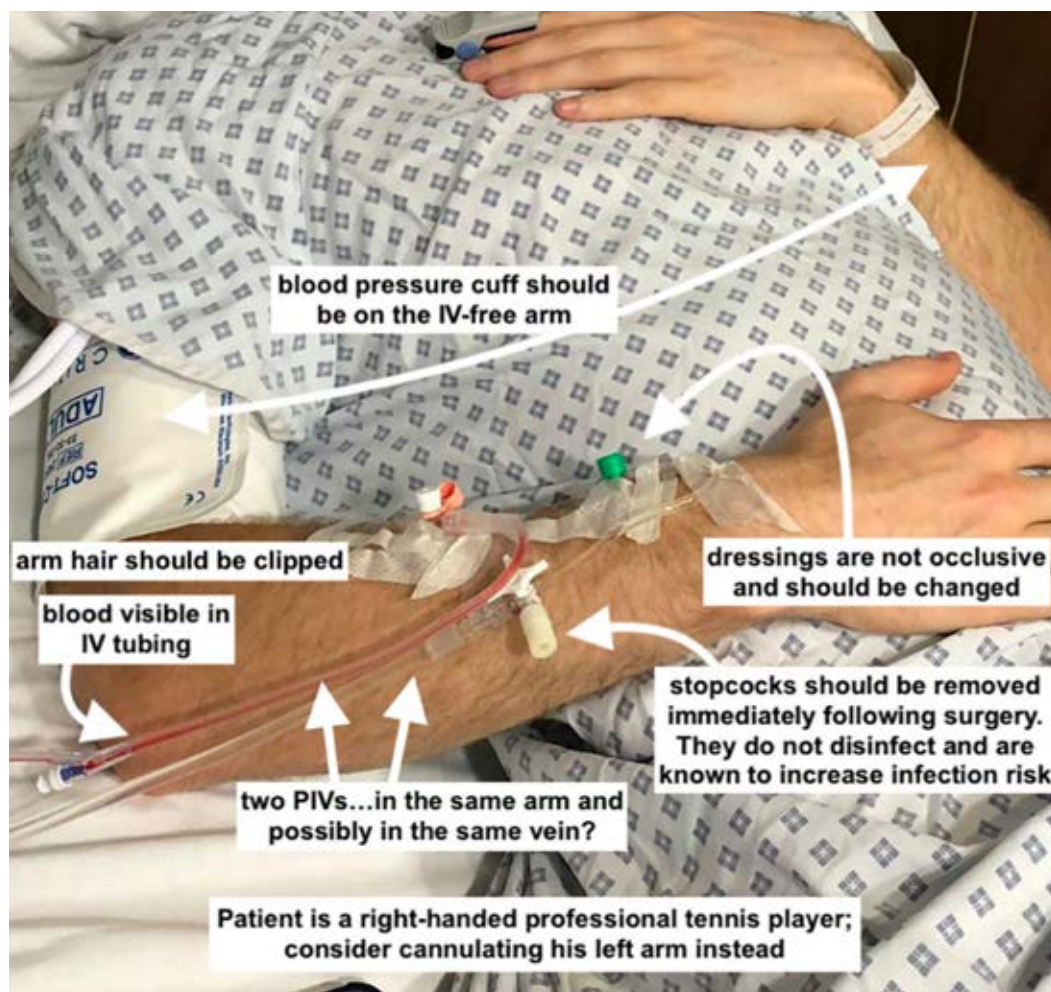
Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l531









## THE BIG PICTURE

# London volleys back transatlantic criticism

Andy Murray prompted a transatlantic debate on postoperative care after posting a picture on Instagram of his recovery from hip surgery.

A group of US healthcare workers criticised the arrangement of the tubes and dressings, while others defended the procedures used.

The debate started when the Grand Slam winning tennis player posted a picture of himself on 29 January, with the comment, "I underwent a hip resurfacing surgery in London yesterday morning . . . feeling a bit battered and bruised just now but hopefully that will be the

end of my hip pain. I now have a metal hip."

The next day an annotated copy of the picture with criticisms of the procedures that were used was tweeted by the Association for Vascular Access, a US organisation representing healthcare professionals involved in inserting catheters into blood vessels.

"Patient is a right-handed professional tennis player; consider cannulating his left arm instead," one comment read. "Blood pressure cuff should be on the IV-free arm," another said.

Anaesthetists in the UK and others pointed to problems with

these criticisms, including the fact that Murray was likely to have been lying on his left side for surgery, so it would make sense for the drip and blood pressure cuff to be on his right arm.

Commenting on Twitter, Helgi Johannsson, a consultant anaesthetist and clinical director at Imperial College Healthcare NHS Trust, London, said that the debate "highlights how protocols and policies designed for the ward often don't work when copied and pasted into an operating theatre environment."

Tom Moberly, UK editor, *The BMJ*  
Cite this as: *BMJ* 2019;364:l575

# Capnography prevents avoidable deaths

No trace=wrong place

**T**he continuously detectable presence of carbon dioxide in exhaled breath is widely accepted as the best method for confirming that a tracheal tube is correctly placed. However, more than 30 years after the introduction of capnography, patients are still dying because of unrecognised oesophageal intubation or tracheal tube displacement. These deaths are occurring either through failure to use this reliable technology or lack of education about the causes of an absent capnograph waveform.

Last year NHS Improvement updated its list of “never events” to include undetected oesophageal intubation resulting from failure to use capnography or to act on an abnormal waveform.<sup>1</sup> The addition is currently suspended for clarification<sup>2</sup> pending agreement with perinatologists on whether a lowest age or weight limit for its use should apply. We believe that this never event should be reintroduced as a matter of urgency.

The use of waveform capnography is mandatory during anaesthesia in the UK, and the World Health Organization and the World Federation of Societies of Anaesthesiologists have recently denoted its use throughout the world as “highly recommended” (their highest level of recommendation) when appropriately robust and suitably priced devices are available.<sup>4</sup>

Despite near universal use during anaesthesia in high income countries, capnography did not become widely used in adult intensive care units until relatively recently. In 2011, the fourth national audit project of the Royal College of



**Failure to use capnography or to interpret capnographs correctly should be seen as an important public health concern**

Anaesthetists (RCOA) and the Difficult Airway Society examined all serious complications of airway management in the UK over one year.<sup>5</sup> The project identified an excess of airway related deaths in intensive care units, 80% of which were associated with failure to use or correctly interpret capnography. Routine use of capnography subsequently increased to 98% of units.<sup>6</sup>

## Neonatal practice

The contrast with perinatal practice is notable. Waveform capnography is currently available in only 50% of neonatal intensive care units and is often not used even when available.<sup>7</sup> Efficacy and practicality remain controversial, but national guidance<sup>8</sup> and research<sup>9</sup> support the use of capnography in neonates. We welcome the British Association of Perinatal Medicine's development of a framework for difficult airway management in this high risk group of patients,<sup>3</sup> and hope that the guidance will be extended to all routine airway management. One quarter of neonatal intensive care units have reported cases of serious harm or death from airway management difficulties in the past five years,<sup>7</sup> and reports of infant deaths after delayed identification of tracheal tube dislodgement suggest

that there is a pressing need for guidance and risk management in this area.

Even when capnography is used, failure to interpret abnormal waveforms can be fatal. At least two patients have died in the UK in the past three years after oesophageal intubation was undetected and uncorrected despite the use of capnography. In both cases, lack of exhaled carbon dioxide was wrongly attributed to cardiac arrest.

Expired carbon dioxide is routinely detectable during management of patients with recent cardiac arrest, even in the absence of chest compressions.<sup>10</sup> However, this vital information has not been effectively communicated to all health professionals involved in resuscitation. RCOA and the Difficult Airway Society have launched a campaign to disseminate the essential information that the absence of a capnograph waveform must be interpreted as indicating incorrect placement of the tracheal tube: “No trace=wrong place.”

Capnography has many applications, but it is particularly valuable in monitoring safe tracheal intubation, as it can immediately detect tube misplacement or displacement that, if unrecognised, will be rapidly fatal. This is of interest not only to anaesthetists but to all who manage the airways of the four million patients who have surgery in the UK every year, the 340 000 patients admitted to critical care units, of whom about 100 000 are babies,<sup>11</sup> and the tens of thousands of patients intubated during cardiac arrest in or out of hospital. Failure to use capnography or to interpret capnographs correctly should be seen as an important public health concern. This is true in all countries where capnography is available.

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# Give us a break

Join *The BMJ's* campaign for adequate rest breaks for doctors

**H**ave you ever worked a whole shift without a toilet break? Or worked through your morning session into lunchtime and beyond without stopping to eat? Or got into your car at the end of a night shift and wondered how you were going to drive home safely? The chances are that you have. These are not unusual scenarios for doctors working in the NHS or any other overstretched health system.

The 2016 Royal College of Physicians' report, *Being a Junior Doctor*, found that doctors were unable to take adequate breaks and described an absence of suitable rest areas.<sup>1</sup> This was despite evidence that rest breaks contribute to the provision of safe care.<sup>1</sup>

Two years on, little has changed. Nearly 20% of hospitals do not have a common room or doctors' lounge according to data from the BMA. Doctors have repeatedly told us that these informal spaces are vital for learning and for building relationships with colleagues.<sup>2,3</sup> But with year round pressures on services demanding beds and facilities,<sup>4</sup> they are often not prioritised by trust management or when building new hospitals.

Rest facilities for use at night have also disappeared. In March 2018, the Association of Anaesthetists of Great Britain and Ireland (AAGBI), the Royal College of Anaesthetists, and the Faculty of Intensive Care Medicine called for action to reduce the effect of fatigue and shift working in the NHS. These organisations found that the abolition of 24 hour resident on-calls had seen rest facilities removed from many hospitals: less than a third of anaesthetic trainees who responded to an AAGBI led survey had somewhere suitable to rest.<sup>5</sup>

## Self care

Lack of facilities is not the only problem. A recent investigation by the *Health Service Journal* found that

**We will promote a culture that encourages doctors to take a few minutes out of their day to pause and regroup**

since August 2016, 63 309 exception reports—which allow junior doctors to report concerns about their working hours—have been made by nearly 36 000 doctors.<sup>6</sup>

Although workload and a lack of designated spaces make it hard for doctors to take breaks, doctors must also shoulder some of the responsibility. In its report on what could make a difference to the mental health of UK doctors, the Society of Occupational Medicine called on employers to consider the need for doctors to take regular breaks. However, it also stressed that doctors were responsible for prioritising self care.

## Campaign for change

In response to the rising prevalence of burnout,<sup>8</sup> in support of the work done by many other organisations, and following discussions with our wellbeing advisory board, *The BMJ* is launching a campaign calling for doctors to be able to take the breaks that they need for their wellbeing and for patient safety.

In secondary care, we will campaign for doctors to have access to a lounge or staff room, and to properly equipped and maintained on-call rooms. In 2018, the BMA published its fatigue and facilities charter which, among other things, calls for the provision of appropriate rest areas.<sup>9</sup> We will monitor and report progress towards this aim in trusts across the UK.

We will seek out senior staff who have prompted members of their team to take regular breaks to eat, drink, and rest and ask them to share their expertise. In general practice we will explore how teams

have found ways to get together for a coffee break or lunch. We will promote a culture that encourages doctors to take a few minutes out of their day to pause and regroup.

This isn't a new idea. Medical organisations, trade unions, and royal colleges have campaigned on this issue in the past and continue to do so. However, the problem persists and may be getting worse. We will bring these organisations together, along with other stakeholders such as employer and patient organisations, in a united effort to change systems, working practices, and culture to ensure that doctors get the breaks they need.

You can follow our work and take part in the campaign by sharing your examples of where things are changing for the better or where more work needs to be done through social media using #giveusabreak. For more information see [bmj.com/wellbeing](http://bmj.com/wellbeing).

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● PERSONAL VIEW, p 232



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John Temple  
surgeon and past  
president, BMA

**Medical bodies should adopt more balanced policies, recognising the wide range of opinions on this matter**

For many UK patients, end of life care is good, but for some it is not how they would choose to end their days. Assisted dying would let terminally ill people access drugs to end their own lives, under strict conditions.

At present, it is the perceived rigid opposition of doctors that blocks any serious review of the law. Parliamentarians have used the opposition of the BMA and medical royal colleges to justify rejecting legislative change. Equally, testimonies from some doctors and representatives speaking for these medical organisations have been cited in legal judgments dismissing pleas for greater choice for dying patients.

Medical bodies should adopt more balanced policies, recognising the wide range of opinions on this matter, and not place doctors in direct conflict with 80% of the population who now support a review of the law. The RCP's decision to move to a position of neutrality unless

at least 60% of its members vote for a stance opposed to or in favour of assisted dying will ensure that the college takes its lead from its members, not vice versa.

Sadly, the same cannot be said of most of the other royal colleges or the BMA. Proposals to survey all 158 000 BMA members have been repeatedly denied. BMA policy was confirmed most recently when a proposal to adopt a neutral stance was rejected by just 198 of 313 doctors at the 2016 annual representative meeting.

The profession's apparent intransigence presents doctors as shying away from, rather than confronting, the matter.

We find ourselves at a crossroads. The RCP has opted for a path that gives its members a real voice. Should it consequently move to neutrality, this will facilitate constructive conversations with parliament. RCP members can then be assured that their interests and opinions will be championed, regardless of whether they themselves would object or participate should the law change.

Members of the Academy of Medical Royal Colleges, the BMA, and others must act. I hope they see the wisdom of following the RCP.

# ASSISTED DYING:

As the Royal College of Physicians surveys all its fellows and members this month for their views, *The BMJ* asked key commentators for theirs

Jeff Blackmer  
vice president, Canadian  
Medical Association

**Neutrality meant that if the law changed the CMA could support all its members**

In 2013, a legal case had the potential to change Canadian law on medical aid in dying. The CMA consulted its membership. Views diverged, but the consensus was clear: Canada needed to protect vulnerable patients. The CMA saw that its policy needed to evolve: neutrality meant that if the law changed it could support all its members, regardless of view.

This was a watershed moment, enabling it to lead

national discussions and to give evidence before Canada's Supreme Court. The CMA spent 16 months meeting legislators and regulators to help represent the diversity of doctors' views. It also advocated for members who did not want to participate in any way.

When the legislation was passed in 2016, it was entirely consistent with CMA policy.



Jane Campbell  
House of Lords and founding  
member, Not Dead Yet UK

**Abuse, neglect, cut-backs ... it is unsurprising that some disabled patients develop suicidal thoughts**

Many terminally ill and disabled people oppose assisted suicide. Not a single organisation of, or for, disabled people or people with long term health conditions has campaigned for assisted suicide to be legalised.

"But it's not about you," we hear frequently. Those seeking to change the law claim to do so only for patients deemed to be terminally ill, with strict criteria to be met before an assisted suicide can be considered.

Readers of *The BMJ* will recognise that the distinction between disability and terminal illness is a false one, however:



# THE VOTE IS ON



Read these articles in full, and many others, and find video and audio at [bmj.com/assisted-dying](http://bmj.com/assisted-dying)



Mark Pickering  
incoming chief executive,  
Christian Medical Fellowship

**Requiring a six month prognosis would be ripe for immediate legal challenge**

Concerns about legalising assisted suicide are shared by legislators, disabled people, and many doctors, regardless of any religious affiliation.

For example, protection of vulnerable patients who may feel

a burden (a reason given by 79 of the 143 patients who had assisted suicide in Oregon in 2017), and the likelihood of incremental extension. Many high profile UK patients who have requested assisted suicide were not close to death. Requiring a prognosis of six months or less to live would be ripe for immediate legal challenge.

The liberal atheist academic Kevin Yuill said that deriding opposition to assisted suicide as religious in nature is “easier than confronting hard questions.”

Treating dying patients with dignity was one of the driving visions of Cicely Saunders, the founder of the palliative care movement. Its principles include intending neither to hasten nor postpone death.

for many disabled people a chest infection is a terminal illness unless treated. I am many years over my prognosis end date, along with countless others who have a progressive condition.

Proponents of a change in the law say that a line can be drawn between terminal illness and disability to decide who can have an assisted suicide. But terminal illness and disability do not exist in a vacuum. It is hard to be positive as a disabled person, especially when the media are full of stories of abuse, neglect, cut-backs, and overstretched resources. Even when medical and social care are at their best, our fear of the future remains.

Given this context, it is unsurprising that some patients develop suicidal thoughts, which perhaps will be endorsed by family, friends, and members of the medical team. A change in the

law would thus permit the focus to switch from preserving life to ending life. It is hard to think of a more fundamental change in the doctor-patient relationship.

For disabled people this is profoundly worrying. It can take years to adjust to illness and disability. A person's outlook can be revolutionised with the right care, but this can take years to put in place and remains elusive to many. Would it be right to grant assisted suicide to someone who is tired of waiting for the right support?

We rely on the medical profession. You often see us when we are in crisis. Yet we depend on you to do all that you can for us. We want you to keep asking yourselves, “How can I improve this person's health and quality of life?” Now is not the time to give up on us to vote neutral on assisted suicide.

Anthea Mowat, chair, BMA Representative Body  
John Chisholm, chair, BMA Ethics Committee

**We are opposed, and we do not believe that the law should be changed in the UK to permit it**

The BMA has never asked its entire membership for their views on physician assisted dying. Such nuanced, complex, and potentially divisive ethical matters do not lend themselves to decision making by direct polling or surveys. Instead, we have clearly defined and longstanding deliberative and democratic processes through which we typically make policy

The BMA is often asked why we are not neutral on assisted dying. The answer is that the annual representative meeting (ARM) has rejected that position. In fact, we once were neutral for one year after the ARM passed a motion to this effect in 2005.

It made it difficult for us to lobby on or engage with the issue and risked the BMA and the profession being excluded from the debate altogether. If legislation were to be introduced, a position of neutrality could make it difficult for us to advocate on behalf of doctors about their role and the safeguards they would like to see.

Members' opinions on assisted dying vary greatly, and the BMA's democratic process allows for this. The matter was most recently debated at the 2016 ARM where, informed by our research on end of life care, representatives rejected a call for the BMA to change its stance to neutral, reaffirming our opposition.

Until we hear differently from members, our focus will be to support the current legal framework and to promote investment and improvement in palliative care so that high quality end of life care services are available to all who need them.

Our position on assisted dying is often quoted in public, parliamentary, and judicial discourse. We are opposed, and we do not believe that the law should be changed in the UK to permit it.

We have huge sympathy for people facing the effects of terminal illnesses and other incurable conditions, but we are concerned that giving them a legal right to end their lives with doctors' help, even where that assistance is limited to assessment, verification, or prescribing, could alter the ethos underpinning medical care.

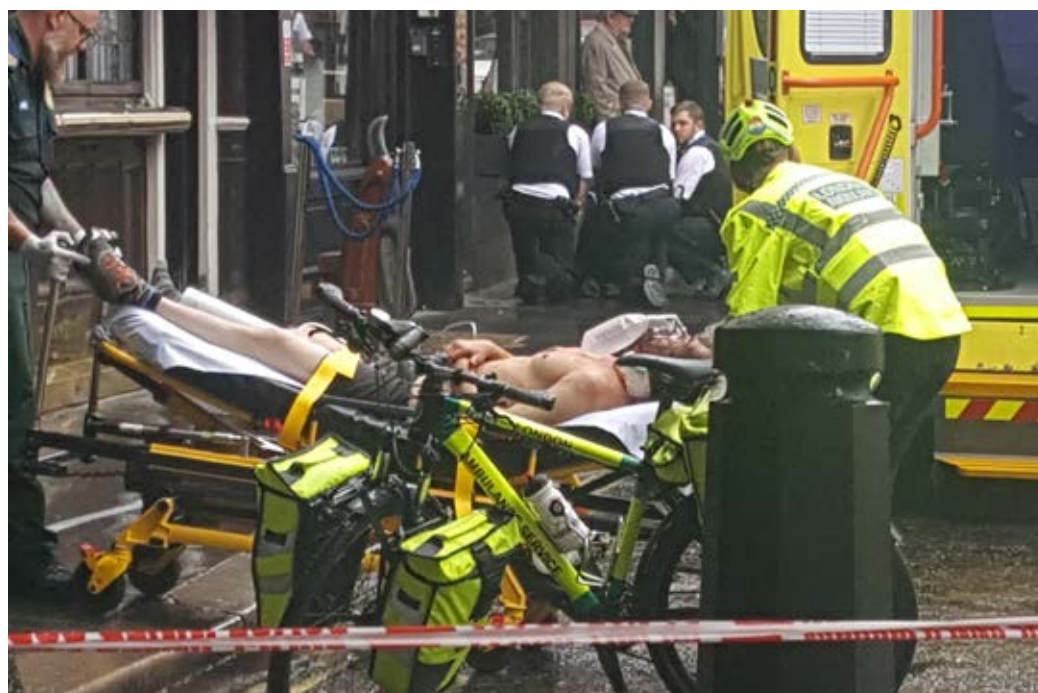
Legalising assisted dying could weaken society's prohibition on killing and undermine the safeguards against non-voluntary euthanasia. For most patients, quality palliative care can alleviate distressing symptoms associated with dying and allay their fears.

Surveys have their place, but in-depth consideration, reflection, and debate will always yield a better return. This is not a binary question. It is complex and emotive and does not lend itself easily to simple yes or no questions including rudimentary polling.



# How medical teams are coping with rising knife crime

From staffing to technical advances, doctors around the UK are responding to escalating stab injuries. But the emotional burden and meeting rehabilitation needs can be far tougher, reports **Emma Wilkinson**



Stabbing-related hospital admissions in England have risen 39% in three years

**W**ednesday lunchtime, and a man drives his car to the front of a Liverpool hospital having been stabbed multiple times, including in the chest.

Rob Jackson, a nurse clinician, was mid-shift when the man pulled up with serious stab wounds. He tells the story not because it is unusual but to underpin how stabbing has become routine, even in a hospital that is not one of England's major trauma centres.

He says the hospital has seen about a 20% increase in stabbing injuries over the past few years and that its teams have to be prepared for it happening at all times of day and night.

"Our last eight fatalities have been single stab wounds," he says. "People are not being butchered; we are losing people from single stab wounds."

Adrian Boyle, chair of the Royal College of Emergency Medicine and based in Cambridge, says that Addenbrooke's Hospital has also seen a 20% increase—albeit from a very low baseline. It is, he stresses, a complex issue with "many moving parts," but it is clear that emergency and other hospital teams are having to treat victims of knife crime with increasing regularity.

Hospital data on those admitted in England after "assault by a sharp object" show a 39% rise between 2014-15 and 2017-18. And those figures do not capture people who are treated and discharged from emergency departments without admission. The trend has implications for hospital staffing, training, and the wellbeing of clinical teams.

## Family management

The teams at Royal Liverpool and Broadgreen University Hospitals NHS Trust have the clinical side of things down to a fine art. All staff are well trained in trauma procedures and they have finessed the process, Jackson says, so that in the event of a trauma all specialties are called on immediately and stood down if not needed once the patient is assessed. A patient can be in a CT scanner within 10 minutes.

However, dealing with families of young, healthy men who have lost their lives from a knife attack or have been left with severe injuries never gets easier, Jackson says. "The part with the family, that is by far the hardest part. You can generally predict how someone will react clinically and how their injuries will pan out, but you can never predict how someone's family will react."

Andreas Crede, a consultant in emergency medicine at the Northern General Hospital in Sheffield—a major trauma centre covering South Yorkshire—says the shock when traumatised family members realise their loved one is involved in gang or criminal activity adds to an already fraught emotional situation and can be hard to manage. South Yorkshire has seen the biggest rise in knife crime outside London. The number of serious cases—those resulting in death or severe injury—has increased by more than 50% in the past five years, to an average of around three a month.

"Five years ago we would see maybe two or three a week; we're now seeing one a day, if not more," Crede says. "There has been a very noticeable increase in the number of stabbings, and in the past six months there has been a spate of fatal stabbings in young people."





**“A lot of patients need two years rehab”** Shehan Hettiarachy

**“The severity of attacks has gone up”** Andreas Crede

The severity of the attacks has also gone up, he adds, with more chest and abdomen wounds and more patients having to be admitted. The Northern General Hospital has expanded its interventional radiology service in response to these trends and the consequent need for non-surgical interventional procedures to stop bleeding.

“We have seen paralysed patients or patients who have lost the function of an arm. The stuff that is often overlooked are those long term physical and emotional scars, and from an A&E point of view that is difficult for us to intervene in.”

#### Beyond the emergency

Shehan Hettiarachy, lead surgeon and major trauma director at Imperial College Healthcare NHS Trust, says that treating stabbing victims is now routine and the trust has increased the number of trauma surgeons on its team to manage the demand. Like Crede, he worries about the long term effects and care for patients.

“We are seeing people stabbed in the backs of legs and we think that is deliberate—trying to get the nerve in the back of legs so you end up with that person being disabled, or rectum so they end up with a stoma. What that has meant is that we have a lot of patients who need two years of rehab.

“There is a need for long term ongoing care and [patients are] often carrying a long term disability.”

Duncan Bew, clinical director for trauma and acute surgery at King’s College Hospital in London, agrees that rehabilitation needs, both physical and emotional, are rising. “We have seen a 70% increase in patients with complex rehab needs, and that is massive in terms of our ability to provide adequate rehab for these patients.



**“We lose people from single stab wounds”**

Rob Jackson



**“It is complex with many moving parts”**

Adrian Boyle

“There are patients who need neurological rehab [and] patients with hypoxic brain injuries, and there’s no place for them in the system.” He adds: “Mental health support to acute services is woefully inadequate.”

#### Difficult jobs

Hettiarachy points out that clinicians will always have a stronger emotional response to a teenager or young adult who has been deliberately harmed than to, say, someone who was unintentionally knocked off a bike. Combine that with fearful, vulnerable victims and traumatised families, and it makes the job especially hard for frontline teams.

“It translates into high levels of stress and high turnover of staff. These are difficult jobs that people find difficult to do,” says Hettiarachy.

The Imperial team has even treated patients who turn out to be children of members of staff at the hospital. “We are trying to support staff where we can,” he adds. “Last year with all the major incidents going on [the terror attacks in London], we had quite an exposure to more trauma events and we did quite a lot of debriefing.”

That led to the setting up of a team ethos—a set of values to keep staff on track, based on doing the best for patients but also looking after colleagues and displaying compassion and humility.

#### Prevention and safeguarding

With new challenges, new techniques are adopted. Hettiarachy recently published a study on selective non-operative management of stab wounds to hands, arms, or legs, showing it was safe in lower limb injuries.

Surgical and medical teams are also increasingly realising that their role needs to include prevention. Bew says that those who were once hesitant that prevention was part of their job have now changed their mind. “Even last year colleagues were saying to me, ‘If you wanted to be a social worker, why didn’t you choose to do that?’ They didn’t really see that prevention could be part of the surgical portfolio. That has been the really big change.”

He points out that key training for staff is not only about clinical skills. “We have to be aware of our responsibility for safeguarding in a much wider way. We are trained to look out for signs and look at someone and not think, ‘What is wrong with you?’ but, ‘What have you been through and in what way have you been harmed?’

“That’s the same for victims and perpetrators, and that awareness is important for staff.”

Bew, who goes into schools and talks to pupils as part of his prevention role, believes much of the rise in knife crime is avoidable, citing Glasgow as the perfect example of a city that has turned things around. A well funded, multiagency approach that includes work from Medics Against Violence—a charity set up by three surgeons to talk to schoolchildren about the consequences of knife crime—has led to a 62% reduction in hospital admissions for assault with a sharp object in a decade.

### Soul destroying

Christine Goodall, a maxillofacial surgeon and academic in Glasgow and one of the founders of Medics Against Violence, says it was the sheer number of life changing injuries she was treating that prompted her to want to do something about it. “It is a really soul destroying thing when a teenage patient comes in with these injuries.”

One standout case for her was a young man who had been stitched up across his face after a serious laceration. His relaxed attitude made sense only when his friends came to visit and they all had similar scars. “I just thought, ‘How terrible is that?’—his expectation of the future is one where he was going to end up with a facial scar and it was normal for him, and that is going to affect him for the rest of his life.”

Royal college chair, Boyle, says the experience of Glasgow shows it is possible to help turn things around and that there are simple things that hospitals can do to help. These include following the Cardiff model of anonymised information sharing—recording the time, date, and location of an assault—which has been shown to drive down knife crime in some places.

Boyle says, “[Knife injuries] will still only be a small part of the workload, but when the emergency department is full the ability to deal with a crisis is limited, and it puts more pressure on already stretched services.”

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**COMMENTARY** Adam Brooks, John-Joe Reilly, Carla Hope

## “For too long we have ignored victims of major trauma and violence”

Although much of the media focus on knife crime has been on London, the epidemic of violence is occurring across the UK, as Emma Wilkinson’s article makes clear.

Queen’s Medical Centre in Nottingham provides care to a population of four million across the East Midlands and has the UK’s largest major trauma centre. A patient with severe, life threatening knife injuries now presents here every week, a fourfold increase over the past five years. Of most concern is that in 2018 we resuscitated 28 children with serious knife wounds, 50% more than in the previous year. Our data show that these young victims of violent crime are more likely than their peers to present to us again, with escalating episodes of violence.

For years, the victims of major trauma and especially violence have gone unnoticed in our society. This must change. The major trauma centres need to use our collective voice to counter the increase in violence in our communities and to engage in work to tackle the cause and the results of this violence. Our approach should be multifaceted and must include advocacy; prevention; bystander life saving intervention; training surgeons and surgical teams; and working with victims to break the cycle of violence.

### Learning from the US

Such an approach should take much from colleagues in the US. For many years, leading figures in the field of trauma care there have spoken out and advocated against violence. The Eastern Association for the Surgery of Trauma in the US recently released its updated firearm injury prevention statement, confirming its position that firearm violence in the US is a public health crisis.

Initiatives such as Stop the Bleed from the American College of Surgeons aim to teach basic life saving interventions that the public can deliver with minimal training, using a kit containing gloves, tourniquet, and haemostatic dressings. Such an approach in the UK would provide life saving support until the

emergency services arrived.

In our hospitals and the major trauma centres we need to ensure that the surgeons and surgical teams have the necessary training to manage these complex, challenging, and resource intensive patients. In 2017, a Royal College of Surgeons of England report recognised the need to train the next generation of surgeons to manage unstable trauma patients and, through Health Education England, major trauma training interface group fellowships have been developed. These fellowships provide training on the resuscitative surgical skills to improve the survival of this cohort of patients.

Last January we started working with Redthread, a charity dedicated to helping young people break the cycle of violence, with specific focus on ages 14 to 24 years. Through the charity’s funding we now have youth workers available in our emergency department to provide support for young victims of violent crime.

In 2007 the late John Pryor, a trauma surgeon in west Philadelphia, wrote about his experience managing multiple trauma patients during an epidemic of violence: “They die without honor, without purpose, for no country, for no one.”

More than 10 years later, Pryor’s emotion about the senseless loss of life of our young people resonates with us. Working in a major trauma centre in the UK, we know that we too will have to have those conversations with families, speaking words they never want to hear and words we never again want to say: “I’m sorry, your child has died.”

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