this week

OPERA THERAPY p 255 • **COST OF LIVING CRISIS** p 256 • **NORTHERN IRELAND NHS** p 258

"Doctors were not protected in pandemic"

The BMA has accused the government of failing in its moral duty by not providing staff with adequate PPE, among other errors

The government failed in its duty of care to protect doctors and other healthcare staff from avoidable harm and suffering in its management of the pandemic, a major review by the BMA has concluded.

Two reports published on 19 May document the pandemic experience of thousands of doctors, drawing on real time surveys, formal testimonies, data, and evidence sessions. The reports will form part of a wider review by the BMA, with three further instalments to come.

The evidence lays bare the impact of covid-19 on doctors and the NHS, with repeated mistakes, errors of judgment, and failures of government policy amounting to a failure of a duty of care to the workforce, the BMA said. Chaand Nagpaul, its chair of council, said, "A moral duty of government is to protect its healthcare workers from harm, as they serve and protect the nation's health. Yet, in reality, doctors were desperately let down by the failure to adequately prepare for the pandemic, and subsequent flawed decision making.

"The evidence presented in our reports demonstrates, unequivocally, that the UK government failed in its duty of care to the medical profession."

Doctors' testimonies reveal fears and anxieties about shortages of personal protective equipment and a lack of risk assessments and show how seriously their mental and physical health was affected.

"Many doctors were left unprotected due to critical shortages of PPE, resulting in healthcare professionals becoming infected at a higher rate than the rest of the population," said Nagpaul. "Hundreds of healthcare workers lost their lives. And 95% of doctors who died in April 2020 were from an ethnic minority, a figure which demands the government addresses the deep race inequalities afflicting our NHS workforce."

The reports, which will form part of the BMA's public inquiry submission, also highlight the burnout, overwork, trauma, and isolation doctors endured. They make recommendations for improving pandemic preparedness, such as by addressing the "chronic underinvestment" in services, and ensuring sufficient levels of PPE, testing, public health capacity, and staffing to handle future crises.

Nagpaul said, "The lessons from this review need to be learnt and acted on now —given that new variants, new viruses, or surges of demand can happen swiftly."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2022;377:o1235

LATEST ONLINE

- Abuse from patients is harming GPs' mental health, leaders warn
- US abortion law: Scientist says his work on fetal pain has been misrepresented
- Former Isle of Man medical director wins whistleblowing case against health department

SEVEN DAYS IN

Satisfaction with Scotland's GP services fell during pandemic, survey reveals

Just two thirds of respondents to a survey of satisfaction with family doctor services in Scotland rated the care they received in 2021 positively, down from 79% in the 2020 survey and 90% in the very first survey in this series in 2009-10.

The Scottish Health and Care Experience Survey had just over 130 000 responses in 2021. It found that 37% of patients had been seen face to face, a 49% drop since 2020, and 57% had a phone appointment, a 46% rise. Just under two thirds were not given a choice on the type of appointment, and 72% complained they had not been offered the chance to see or speak to anyone within two days of first making contact.

Andrew Buist (left), chair of the BMA's General Practitioners Committee for Scotland, said the results were not a "massive surprise," given the challenges of the pandemic. "The Scottish government is expanding our community teams and has pledged to deliver an additional 800 GPs by 2027," he said. "These are the right steps. In the meantime, there must be real focus on supporting GPs and their teams—and we need that to be backed up with honesty from politicians and patience from the public."

Bryan Christie, Edinburgh Cite this as: *BMJ* 2022;377:o1190

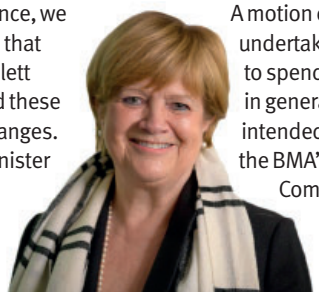
Covid-19

Inequalities persist in vaccine uptake in pregnancy

More pregnant women are coming forward for the covid vaccine, but uptake continues to differ starkly by ethnicity and by level of deprivation, showed data from the UK Health Security Agency. In January over half of pregnant women (51%) had received two doses of the vaccine, up from 43% in December 2021 and 38% in November 2021. Women of black ethnicity and those living in the most deprived areas of England remained the least likely to be vaccinated.

PM is urged to include children in public inquiry

The Royal College of Paediatrics and Child Health welcomed a letter sent to the prime minister by the chair of the covid-19 public inquiry, Heather Hallett (below), urging him to include children in the scope of the inquiry. The college's president, Camilla Kingdon, said, "While it was disappointing that children were missed off in the first instance, we are delighted that Baroness Hallett has proposed these important changes. The prime minister should now accept this request, so the review team can move into its core work and consider lessons and recommendations for the future."



LMC conference

GPs "need equivalence" on supervision time

At the annual meeting of local GP representatives in York, leaders passed a motion calling for GPs to receive the same level of protected time for professional supervision and education as their hospital colleagues. Representing Oxfordshire's local medical committees (LMCs), James McNally brought the motion, which called for recognition that it was "increasingly difficult to maintain knowledge in a working day" and that this justified protected time and adequate backfill for essential training as part of core GP funding. But a separate part of the motion was rejected, having called for lobbying to make the measures statutory.

Give specialist trainees "months in general practice"

A motion calling for all doctors undertaking specialty training to spend at least three months in general practice was passed, intended as a reference to guide the BMA's General Practitioners Committee instead of a binding instruction, owing to concerns that the practicalities may be difficult to deliver. Bringing the motion, Wendy Outwin, chair of Norfolk and Waveney LMC, said that just as GPs spend at least a year in hospitals during their training, specialty trainees should do similar in general practice so that "we truly understand each other's working lives."

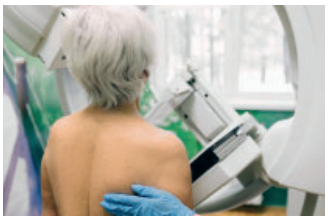
"Deprived areas should receive more funding"

GP representatives passed a motion calling for a fairer funding allocation to tackle widening health inequalities. The conference instructed national GP negotiators to review the impact of current funding models and to lobby for enhanced funding for practices serving areas with significant deprivation. It also asked for a health impact analysis to become a requirement when new houses or care homes are located in deprived areas and for fairer funding for practices with a low vaccine uptake.

Breast cancer

Assess frailty and fitness of older women, says audit

Clinical teams in England and Wales should always assess frailty and fitness in older patients with breast cancer, the National Audit

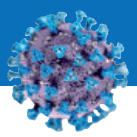


of Breast Cancer in Older Patients advised. It also encouraged clinicians to involve patients in decision making around their treatment choices. The audit compared the patterns of care for women aged over 70 with those of women aged 50-69 with a breast cancer diagnosis.

Social care

More than 500 000 adults await assessment

Hospital bosses expressed concern at a report from the Association of Directors of Adult Social Services, which showed that more than half a million adults were waiting for social care assessments. Miriam Deakin, director of policy and strategy at NHS Providers, said, "This valuable report paints a worrying picture of unmet care needs and lays bare the pressures on the social care system, which are having a serious knock-on effect on individuals' quality of life and independence, as well as the timely discharge of patients from hospital."

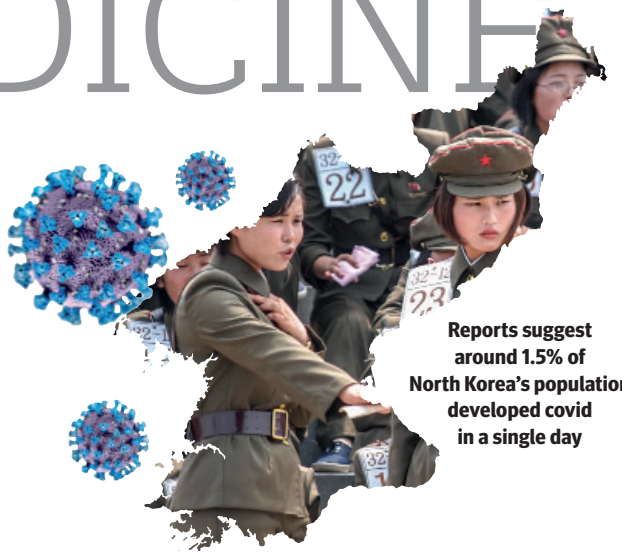


MEDICINE

Overseas

North Korea confirms first covid cases and deaths

Only three days after acknowledging its first covid case North Korea reported 393 920 new "fever" cases in a 24 hour period ending on 15 May, suggesting that more than 1.5% of the population had developed symptomatic disease in a single day. The country reported 18 000 new cases of fever over the previous 24 hours on 13 May and 178 120 on 14 May. Fifty deaths have been reported so far. North Korea's leader, Kim Jong-un, has blamed institutions of his own ruling Workers' Party for "incompetence and a lack of responsibility" in tackling a covid outbreak that he characterised as "the biggest upheaval since the nation's founding."

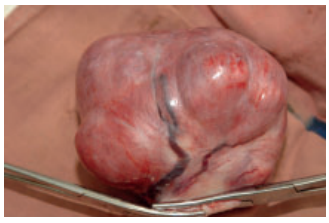


Reports suggest around 1.5% of North Korea's population developed covid in a single day

Uterine fibroids

Treat moderate to severe symptoms, NICE advises

The National Institute for Health and Care Excellence recommended a new oral treatment for uterine fibroids (below). Final draft guidance said that around 4500 women would be eligible to receive relugolix with estradiol and norethisterone acetate (also called Ryeqo and made by Gedeon Richter UK). Helen Knight, interim director of medicines evaluation at NICE's Centre for Health Technology Evaluation, said, "This treatment has the potential to improve quality of life. As well as effectively reducing symptoms, it can be taken at home and is therefore more convenient than the injectable treatment, given in a hospital setting."



Clinical trials

"Include pregnant women" to improve outcomes

Pregnant women should have the opportunity to take part in clinical trials of medicines that could be used in pregnancy unless there are specific safety concerns, a policy commission recommended. The commission—led by Birmingham Health Partners, an alliance of five organisations—said pregnant women and babies had been "completely failed" as they continued to get sick and die from largely preventable or treatable causes. The alliance gathered evidence from key stakeholders on how best to develop safe, effective, and accessible medicines for use during pregnancy.

Workforce

Care at risk from lack of respiratory professionals

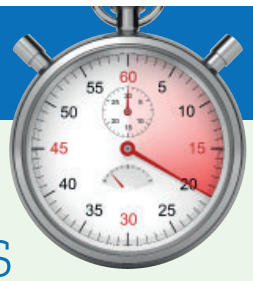
A lack of skilled staff to care for a growing number of patients who require specialist respiratory care is compromising patient outcomes and taking its toll on existing staff, the British Thoracic Society warned. In a report it said many patients were not being seen by specialists because of staff shortages. This can delay both correct diagnosis and the start of optimal treatment, leading to longer hospital stays and ultimately poorer outcomes, the report warned.

Cite this as: *BMJ* 2022;377:o1227

AIR QUALITY

Pollution was responsible for nine million deaths in 2019—**one in six** deaths worldwide—a number virtually unchanged since 2015

[LancetPlanetary Health]



SIXTY SECONDS ON . . . **OPERA THERAPY**

ROCK ME AMADEUS?

I should say so. A breathing and wellbeing programme developed by the English National Opera with Imperial College Healthcare Trust, called ENO Breathe, has been found to significantly reduce breathlessness and improve quality of life for people with long covid.

WON'T SINGING GET ME INTO TREBLE?

It might have done during lockdown, but even though choirs can meet in person again ENO Breathe is delivered online for an hour a week for six weeks.

HOW DOES THE SCHEME OPERA-TE?

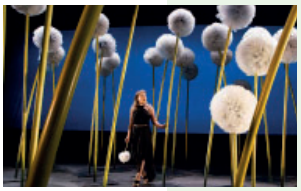
Its focus is lullabies, which the team says are familiar to most people, calming, and soothing. There are also exercises to improve posture and breath control and advice on managing anxiety and breathlessness.

WAS PLACEBO DOMINGO INVOLVED?

ENO Breathe is not a drug, but this was a parallel group, single blind, randomised controlled trial in which 150 patients who had been referred from one of the UK's 51 long covid clinics were assigned to the intervention or usual care. The results, published in *Lancet Respiratory Medicine*, showed that participants experienced a 10.48 point (out of 100) cut in breathlessness while running compared with people who had usual care. Mental health scores improved slightly, but not physical health scores.

ROCKABYE BABY ROCKS!

Focus groups also found that participants said they felt their symptoms improved, that it complemented other care, and the singing technique suited their needs. Patients who attended all the sessions were also found to have improvements in a wider range of respiratory symptoms, anxiety, and quality of life.



CAN WE END ON A HIGH NOTE?

Keir Philip, the lead author, said, "We urgently need evidence based treatments and interventions for people with long covid. Our study suggests the improvements experienced by participants resulted from practical breathing techniques learnt, but also the creative, humane, and positive way the programme is delivered."

Zosia Kmietowicz, *The BMJ*

Cite this as: *BMJ* 2022;377:o1212

Experts condemn "shocking" delay on junk food multibuy ban

Public health campaigners have accused ministers of turning their back on child health after they announced that a ban on multibuy deals for junk food would be delayed by a year in response to the cost of living crisis.

The Department of Health said the ban on "buy one get one free" deals for food and drinks that are high in fat, salt, or sugar and restrictions on free refills for soft drinks would be delayed until October 2023 so the effect on household finances can be assessed. A ban on TV advertising of such products before 9 pm will also be paused.

Jyotsna Vohra, director of policy and public affairs at the Royal Society for Public Health, said, "To say that it is disappointing to hear about these delays is an understatement. To hear that the cost of living crisis is the reason is unbelievable and frankly feels like an excuse."

Caroline Cerny, of the Obesity Health Alliance, said, "Big challenges such as child obesity need bold leadership, not a government that shirks its responsibility and continues to let unscrupulous food companies bombard us with advertising and fake bargains at the expense of our health. We urge Boris Johnson to remember the promise he made to make it easier for everyone to be healthier and reverse this abysmal decision."

Graham MacGregor, professor of cardiovascular medicine at Queen Mary University of London and chair of Action on Sugar and Action on Salt, said, "This will massively affect the NHS and the nation's health, which will suffer the consequences and escalating cost of treating obesity, type 2 diabetes, and tooth decay."

Michelle Mitchell, chief executive of Cancer Research UK, called the claim that the delays would help address the cost of living crisis "grossly misleading."

"The government's own report shows that price promotions lead us to buy 20% more than intended and cause us to impulse buy unhealthy foods," she said.

Maggie Throup, the public health minister, said, "We're committed to doing everything we can to help people live healthier lives. Pausing restrictions will allow us to understand its impact on consumers in light of an unprecedented global economic situation."

Gareth Iacobucci, *The BMJ* **Cite this as: *BMJ* 2022;377:o1220**

THE REPORT from the government shows that price promotions lead us to buy 20% more than intended and cause us to impulse buy unhealthy foods

Rising cost of living is damaging people's health, says royal college

More than half of UK people in a survey commissioned by the Royal College of Physicians have reported that their health has been negatively affected by the rising cost of living.

The poll carried out by YouGov was conducted after members of the college reported the effects they were seeing of the squeeze in living standards on people's health, and the resulting impact on health inequalities.

Doctors reported examples such as a patient being unable to afford to travel to hospital for lung cancer investigation and treatment, a woman whose ulcers on her fingertips were made worse by her house being cold, and conditions such as asthma and chronic obstructive pulmonary disease being made worse by pollution and exposure to mould because of the location and quality of council housing.

"Alarm bells"

Andrew Goddard, president of the RCP, said, "The cost of living crisis has barely begun, so the fact that one in two people is already experiencing worsening health should sound alarm bells, especially at a time when our health service is under more pressure than ever before."

In the poll of 2001 UK adults carried out online between 29 April and 2 May 2022, a quarter (275) of those who said their health had been negatively affected had also

NICE sets out steps NHS must take to implement ME/CFS guidelines

NICE has issued an unprecedented implementation statement setting out the practical steps needed for the NHS to implement its updated guideline on the diagnosis and management of myalgic encephalomyelitis/chronic fatigue syndrome.

Such statements are issued only when a guideline is expected to have a "substantial" impact on NHS resources, and this is thought to be the first. It outlines the additional infrastructure and training that will be needed in both secondary and primary care to ensure that the updated ME/CFS guideline, published last October, can be implemented.

The statement is necessary because the 2021 guideline reversed the original 2007 recommendations that people with mild or moderate ME/CFS be treated with cognitive behavioural therapy (CBT) and graded exercise therapy (GET).

Instead, the 2021 guideline says that CBT should be offered only to support patients to manage their symptoms and that any exercise programme should be overseen by an ME/CFS specialist team.

Many areas have no or very limited specialist ME/CFS services, meaning that services must be commissioned, specialist health professionals need to be trained to deliver these services, and GPs need training in how to care for their patients. "With no nationally commissioned service for ME/CFS in either primary or secondary care, it will be for local systems to determine how to structure their services to achieve the aims of the guideline," said Paul Chrisp, director of the Centre for Guidelines at NICE.

When the 2021 guideline was

The surprise is that people in above average income groups are affected
Michael Marmot

been told this by a doctor or other medical professional. Some 16% (172) of those affected said that they had been told by a doctor or health professional in the past year that stress caused by rising living costs had worsened their health, and 12% (134) were told that their health had been made worse by the money they were having to spend on their heating and cooking.

The Inequalities in Health Alliance, a group of over 200 organisations convened by the Royal College of Physicians, called for a concerted cross government effort to tackle the social determinants of health to be included in the white paper on health disparities that is due later this year.

"We can't continue to see health inequality as an issue for health directives to solve," Goddard said. "A cross government approach to tackling the underlying causes of ill health will improve lives, protect the NHS, and strengthen the economy."

Michael Marmot, director of the UCL Institute of Health Equity, said, "This survey demonstrates that the cost of living crisis is damaging the perceived health and wellbeing of poorer people. The surprise is that people in above average income groups are affected, too. More than half say that their physical and mental health is affected by the rising cost of living, in particular food, heating, and transport.

"As these figures show, the cost of living crisis is a potent cause of stress. If we require anything of government, at a minimum, it is to enable people to have the means to pursue a healthy life."

Katherine Merrifield, assistant director for Healthy Lives at the Health Foundation charity, said, "The government needs to get a hold on the crisis. Recent decisions suggest they are yet to fully grasp the pandemic's stark lesson that health and wealth are fundamentally intertwined.

"We need urgent action, on benefits to protect people in the here-and-now, but also to build greater resilience against future threats to our health by investing in areas that support health, including housing, education, and transport."

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2022;377:o1231

In the poll of 2001 UK adults carried out online between 29 April to 2 May, 55% (1110) reported a negative impact on their health from the rising cost of living. Of these, 84% (936) attributed this to increased heating costs, 78% (870) to the rising cost of food, and 46% (507) said rising transport costs had contributed

published, Charles Shepherd, honorary medical adviser of the ME Association, told *The BMJ* that the recommendations were "something that currently cannot be coped with."

"New services"

After publication of the implementation statement, he said, "I think NICE have gone as far as they can. It is now up to individual clinical services to reposition what they do in order to comply with the recommendations and for commissioners to start setting up new clinical services where none currently exist—especially in Wales and Northern Ireland.

"A lot of people with ME/CFS are clearly not getting the medical care and support that they need in both primary care and secondary care, especially those who are severely affected and do not have access to any form of domiciliary service or a dedicated inpatient facility."

He added, "It would obviously be helpful if the royal colleges could also express their support for implementation of the changes, as it's not clear whether they remain unhappy with the recommendations downgrading CBT and the removal of GET."

The BMJ asked three royal colleges for a response to the implementation statement, but none responded before publication.

Ingrid Torjesen, *The BMJ*
Cite this as: *BMJ* 2022;377:o1221

Innovative magnetic technology recommended for breast cancer

A magnetic liquid tracer and a handheld sensing probe are now recommended as an option to help surgeons establish whether breast cancer has spread.

Hospitals with limited or no access to a radiopharmacy department could particularly benefit from the Magtrace and Sentimag system, said draft guidance from NICE.

Magtrace, a non-radioactive liquid, is both a magnetic marker and a visual dye. It is injected into the tissue around a tumour, and the particles are then absorbed into the lymphatic system before becoming trapped in sentinel lymph nodes.

Sentimag, a magnetic sensing probe, emits sounds of varying pitches as it passes over the Magtrace tracer. The nodes also often appear dark brown or black, which helps with identification. The surgeon can then remove the node for biopsy. If cancer cells are detected by a pathologist the surgeon may remove additional lymph nodes, either during the same procedure or at a follow-up.

Magtrace costs £226 per unit excluding VAT, and the Sentimag probe costs £24 900. However, NHS trusts that commit to buying 100-120 units a year receive the probe free of charge. NICE has concluded the technology is likely to be cost saving, but it recommends further data collection to monitor the number of sentinel lymph node biopsies done after the technology is adopted.

The draft guidance is open to public consultation until Thursday 16 June.

Jacqui Wise, Kent
Cite this as: *BMJ* 2022;377:o1226

Magtrace costs £226 per unit excluding VAT, and the Sentimag probe costs £24900

NEWS ANALYSIS

Northern Ireland's healthcare can no longer wait for Stormont to fix crisis, say health experts

Health leaders are frustrated at the region's lack of an executive, despite last week's election of a new legislative assembly, reports **Chris Baraniuk**

JOE FOX/ALAMY

Everything's ready to change, but we are dependent on a multiyear budget—and that needs an executive
Alan Stout

The newly elected assembly could decide to pass health and social care decision making to a technocratic authority
Ciaran O'Neill

The vagaries of Northern Irish politics are not a good enough reason to fail to deliver healthcare, particularly abortion services
Leah Hoctor

While the secretary of state is preparing next steps to establish commissioned abortion services, the reality is that he has already missed his own deadline
Grainne Teggart

SINCE 2014, the number of GP practices in Northern Ireland has declined by 8%, while the average number of patients at each practice has grown by almost 14%

"We cannot keep going like we are," Alan Stout, deputy chair of the BMA's Northern Ireland council, told *The BMJ* with regard to the continuing stalemate in Northern Ireland politics.

On 5 May people in Northern Ireland elected 90 members of the legislative assembly, with Sinn Féin winning the most seats overall (27), while the Democratic Unionist Party came second with 25. This means that in Stormont, the seat of the devolved government, the largest unionist and nationalist parties must agree to share power under the terms of the Good Friday Agreement. The DUP is currently refusing to do so, however, in protest over the Northern Ireland European Union protocol.

Among many consequences is that strategies to tackle the deepening healthcare crisis are effectively on hold.

Soaring health demands

Northern Ireland has the worst waiting lists in the UK: nearly a fifth of the population is currently on a waiting list of some sort. All cancer waiting list targets have been missed. Ambulances are failing to hit response time goals for even the most urgent calls. Two and a half years after legalisation, abortion services remain largely non-existent.

In an article published last month, Ciaran O'Neill, professor of health economics at the Centre for Public Health, Queen's University Belfast, noted that demand for services was rocketing at a time when they are falling short. "Since 2014, the number of GP practices in Northern Ireland has declined by 8%, while the average number of patients at each practice has grown by almost 14%," he wrote.

Stout said GPs are dealing with 200 000 patient contacts a week, more than 10% of the population. Nursing, too, is struggling. According to official figures, there is a shortage of 2666 nurses and nursing support workers, or 10% of the nursing workforce.

Key priority

In their election manifestos all the major parties said health was one of their key priorities. Sinn Féin promised an additional £1bn by 2024-25, while the DUP also said it was committed to significant additional spending and the training of more GPs. The Alliance Party, which took 17 seats, offered to make sweeping changes to several aspects of healthcare, including mental health,

diagnostics, and cancer services. But with no functioning government, Stormont can't implement multiyear budgets to reform the health service, which experts say is "failing."

Several reviews, including the so called Bengoa report of 2016, which was cited by various political parties, including the DUP, in their manifestos, have already laid out a long list of possible improvements. Many of them are yet to be implemented. A strategy for overhauling cancer services was published in March, but it cannot come into effect without a stable government.

"Everything's ready to change, but we are dependent on a multiyear budget—and that needs an executive," added Stout.

Decisions on healthcare in Northern Ireland could in theory be made by the UK government under direct rule, but politicians in Westminster have not taken this route for many years, except for particular concerns, such as the decrimnalisation of abortion in 2019.

Technocratic authority

O'Neill suggested that, in line with another review published in 2014, the assembly could decide to pass health and social care decision making to a technocratic authority. Politicians could hold any such body accountable for meeting its targets but they would no longer have to agree with one another to implement change.

Deirdre Heenan (below), professor of social policy at Ulster University, told *The BMJ*, "I'm now of the view that health will have to be taken out of the hands of local politicians." She criticised the lack of a "strategic plan" to improve efficiencies in the health service, noting that Northern Ireland already spends more per person on health than most other regions of the UK. The current situation was "shambolic," she added.

Leah Hoctor, regional director for Europe at the Centre for Reproductive Rights, said the vagaries of Northern Irish politics were "not a good enough reason to fail to deliver healthcare," referring to the continued lack of abortion services.

In a statement, Grainne Teggart, campaigns manager for Amnesty International UK, called on the secretary of state for Northern Ireland, Brandon Lewis, to put full abortion services in place as a matter of urgency. "While the secretary of state is preparing next steps to establish commissioned services, the reality is that he has already missed his own deadline and we now face further unacceptable delays," she said.

The sentiment that there is no longer any time to spare was expressed by everyone who spoke to *The BMJ*.

"We already believe the service is broken," said Rita Devlin, director of the Royal College of Nursing Northern Ireland. "If we end up in a hiatus again, the health and wellbeing of our population is going to be even more damaged."

Chris Baraniuk, Belfast
Cite this as: *BMJ* 2022;377:o1177

Continuity of care should take priority over access or targets, say GP delegates

GP representatives at the local medical committees conference on 11 May overwhelmingly backed a motion instructing the BMA's General Practitioners Committee to demand a move away from a target based GP contract to one that would reward and prioritise continuity, a move they said would not only improve clinical outcomes but be most cost effective.

Proposing the motion, Gavin Shields, representing Coventry LMC, said continuity was the "jewel in the crown for everyone involved in general practice." He said, "It's my jewel because I get to know my patients well; it makes my job a damn sight easier, actually; it's far more rewarding; and it's more likely to keep us together as stable teams."

Emma Radcliffe of Tower Hamlets LMC also described continuity of care as a win-win formula. "The system benefits, the patient benefits, but looking at this from a selfish point of view, I also benefit from continuity of care," she said. "It is the reason I love my job. It is the essence of general practice."

Diana Hunter of Cambridgeshire LMC said that evidence and GPs' experiences showed that continuity of care saved lives. Years working in general practice had taught her that "continuity is paramount," she said. "Continuity not only keeps our patients safe—it works both ways."

Farah Jameel, chair of the BMA's General Practitioners Committee in England, said it was right that policy makers valued continuity of care. She said it needed to be fairly rewarded but it would be important to find and agree on a mechanism for measuring it and use that to drive change.

Adele Waters, *The BMJ* Cite this as: *BMJ* 2022;377:o1202

CONTINUITY OF CARE IS THE JEWEL IN THE CROWN FOR EVERYONE IN GENERAL PRACTICE
GAVIN SHIELDS

"England needs 11 000 more medical students a year"

England needs to create an additional 11 000 medical school places to train the medical workforce it needs by the year 2030, the BMA told MPs on the House of Commons Health and Social Care Committee.

Latifa Patel, interim chair of the BMA's representative body, told an evidence gathering session for the committee's workforce inquiry on 11 May that England wasn't training nearly enough doctors. The BMA has calculated that England has just 2.9 doctors per 1000 population, less than Germany's ratio of 4.3 per 1000 and the EU average of 3.7 per 1000.

For the EU average to be achieved, Patel said, "We need 11 000 more medical students per year—we're at a shortage of 46 300 at the moment—and only then will we reach that sustainable number by the year 2030."

Malcolm Reed, lead co-chair of the Medical Schools Council, said the council recommended increasing medical student numbers by 5000 a year but acknowledged this wouldn't be enough to fill the workforce gap without international recruitment.

Roger Kirby, president of the Royal Society of Medicine, said one of the big problems was not retaining doctors, "so many of our best doctors qualify, and then leave." Many go to work in Australia and New Zealand, the committee was told, although 80-90% of doctors who went to these countries did return after a few years.

But Kirby added, "We're losing a lot to McKinsey and Ernst and Young, etc—losing some of our best people."

Ingrid Torjesen, *The BMJ* Cite this as: *BMJ* 2022;377:o1210

THE BIG PICTURE

Caught on film: NHS life during the pandemic

Selfless, an exhibition of the work of photographer Jessica van der Weert that captures the working lives of NHS staff during the covid pandemic, has opened in Liverpool.

The images—of staff across the health service in Northumberland and Brent, London—offer a stark landscape of the UK at the height of the covid-19 crisis.

"I wanted to capture the enormous scale of loss, tragedy, and grief. It's a vital moment in history that has to be captured, to ensure that future generations will remember, and that those who perished would never be forgotten," said van der Weert.

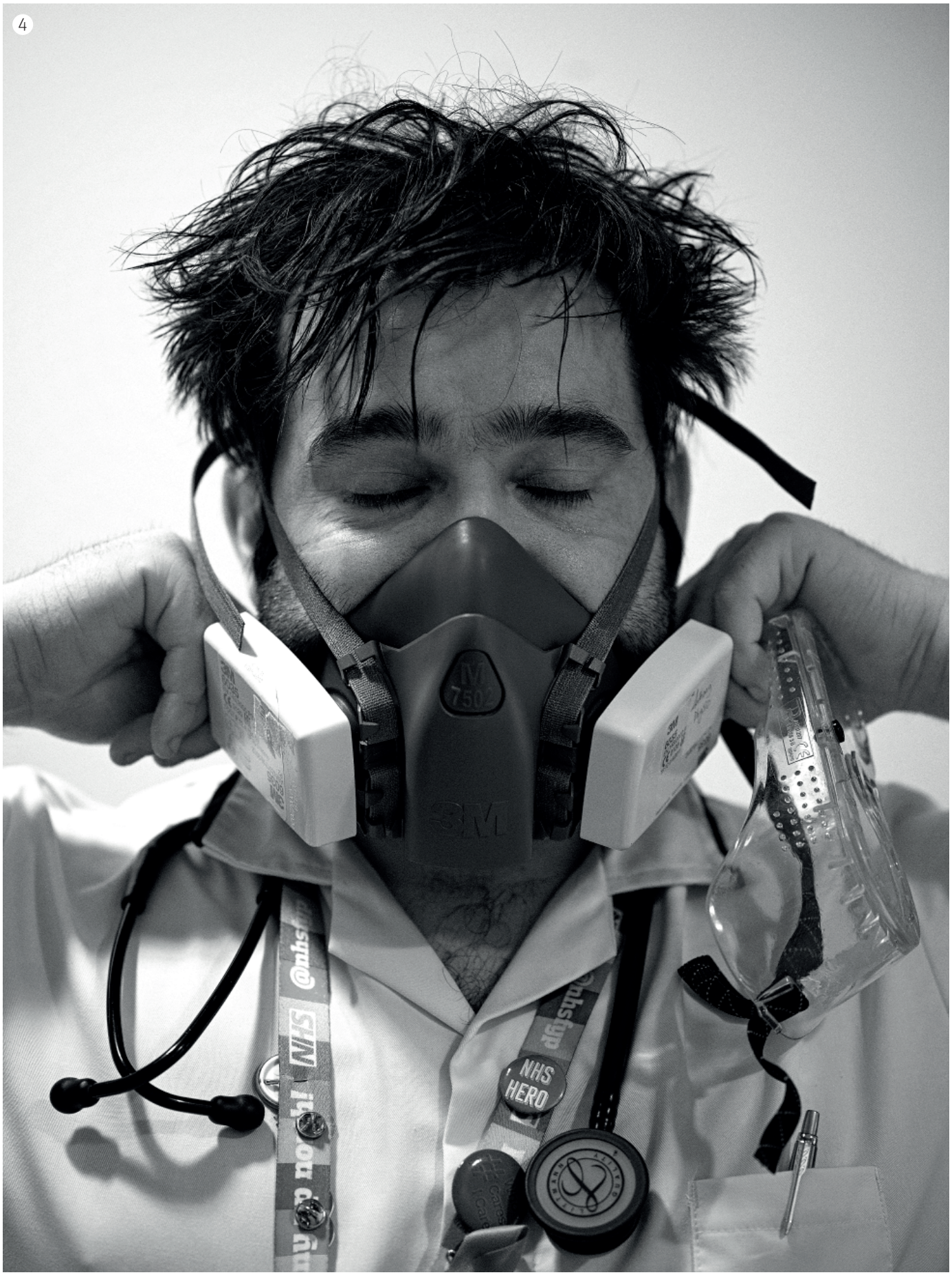
The exhibition, which is supported by the Royal College of Physicians and the Jerwood Foundation, is open to the public until 19 June at the RCP, Paddington Village, Liverpool, and then at RCP, Regent's Park, London, from 1 July

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2022;377:o1224

1. **Holly Hurley**
2. **Chris Biggen, emergency medicine consultant**
3. **Turning a patient in ICU**
4. **Anthony Gravell, senior respiratory physiotherapist**

4



EDITORIAL

US set to reject women's right to abortion

Sweeping restrictions would criminalise women and health workers, widen inequality, and increase deaths

On 2 May 2022, the website Politico published a leaked draft of a US Supreme Court opinion overturning the 1973 landmark case establishing a woman's constitutional right to abortion before fetal viability (Roe *v* Wade).[1] In it, the highly conservative Justice Samuel Alito said, "the Constitution makes no reference to abortion."

If it holds, the Supreme Court opinion would reverse half a century of settled precedent, including a high profile judgment in 1992 ruling that states cannot impose an "undue burden" on a woman's right to choose.[3] Nearly 60% of Americans support legal abortion, but we now face the possibility of two alternative Americas—one in which abortion is safe and lawful, and one where it is criminalised.[4]

If Roe *v* Wade is overturned, 26 states are certain or likely to ban abortions.[5] This would deny reproductive rights to 40 million women of reproductive age in the US. Some states offer no exception for rape, incest, or non-fatal health risks to the woman. States that do not completely ban abortions could impose harsh restrictions, making access difficult.

For health workers, restrictive laws will prevent open and honest counselling of patients and force decision making under threat of prosecution. In Oklahoma, for example, anyone performing an abortion faces to up to 10 years' imprisonment. Criminal penalties also often apply to individuals aiding and abetting abortions, including family members.

Pregnancy related deaths are expected to rise by 20% or more

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While abortion bans violate autonomy and bodily integrity, they also have deeply inequitable effects. Black women are three times more likely than white women to die from pregnancy related causes.[6] Abortion restrictions fall disproportionately on women of colour, young women, those on low incomes or living in rural areas, and those in abusive relationships. Women with means can travel to states that permit abortions, but those without cannot take time off from work, pay for childcare, or afford to travel.

The inequity is more acute because Medicaid, the government funded health coverage programme for people on low incomes, is prohibited from paying for abortion services. Without the constitutional protection of Roe *v* Wade, many disadvantaged women will be forced into unwanted pregnancies, and pregnancy related deaths are expected to rise by 20% or more.[7]

Self-managed abortions have become safer thanks to abortion medication that can be accessed through telehealth and be taken at home through 10 weeks' gestation.[8] Yet many states are now criminalising distribution of abortion pills or clarifying that bans also apply to medical abortions.

Wider repercussions

The repercussions would not end there. Louisiana may classify abortion from the moment of conception as homicide.[9] Women who miscarry would face greater risks too, as it can be clinically difficult to distinguish pregnancy loss from attempted abortion. Providers could be required to report suspected abortions to law enforcement agencies, deterring women from seeking much needed care.

The leaked Supreme Court opinion rejects previous precedent affirming a broad right to privacy, which could erode key human rights such as same sex marriage (Obergefell *v* Hodges, 2015), contraception (Griswold *v* Connecticut, 1965; Eisenstadt *v* Baird, 1972), and consensual same sex intimacy (Lawrence *v* Texas, 2003). A post-Roe America may be inhospitable to many rights held by marginalised communities.

Since Roe *v* Wade, the overwhelming global trend has been towards expanding access to abortion, buoyed by international human rights law that prohibits governments from impeding access to abortion services. Sexual and reproductive health are integral parts of the right to health.[10] Denial of abortion may even constitute cruel, inhuman, or degrading treatment, as the Committee against Torture concluded.[13] Likewise, the Committee on the Elimination of Discrimination against Women found that denial or delay of safe abortion and forced continuation of pregnancy are forms of gender based violence.[14]

The Supreme Court's final ruling on the Mississippi case underpinning the leaked opinion is expected in June and, if the leak is correct, is likely to trigger a swath of punitive abortion restrictions. While 16 states and DC have passed laws to codify legal abortion, including for women travelling from other states, conservative states are closing all avenues for safe and legal abortion, and they have a new ally in the Supreme Court. The US is rapidly becoming an outlier in the trend towards advancing women's reproductive rights.

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ABORTION RIGHTS

Unborn in the USA: what's next for Roe v Wade and abortion rights

The US appears poised to remove the guaranteed right of access to termination, but it was already halfway there, reports **Joanne Silberner**

Roe v Wade: the history

In January 1973, the US Supreme Court announced a decision in the case of Jane Roe (a pseudonym), who lived in Texas where, at the time, abortion was legal only to save the mother's life. Unlike today's deeply divided court, several justices appointed by Republican presidents joined in with those appointed by Democrats for a clear 7 to 2 vote favouring Roe.

Obstetrician-gynaecologist Sarah Prager lives and works in Washington state, in the far northwestern corner of the US. "I've never felt any pressure not to provide [abortion services]," she tells *The BMJ*. She feels supported not just by the clinics where she practises but by the state government as well.

Anti-abortion legislators in Washington state often introduce bills to outlaw abortion, but the bills don't progress. And it includes abortion in the joint state and federal programme for people on low incomes—even though the federal government is not allowed to finance abortions—by shouldering the full cost.

The situation in Texas is the reverse. The state has some of the most restrictive laws in the US. An obstetrician there who spoke to *The BMJ* prefers to remain anonymous because of the possibility of legal threats to their ability to practise medicine and maintain their medical licence, as well as the risk of criminal prosecution. "As long as I've been here, it's been a fraught time for abortion access," they said.

The draft plan would reduce access to abortion from a national right to one that individual states could rule on separately

Nearly 10 years ago, soon after the doctor moved to Texas, the state enacted a law that required all abortion facilities to meet the full standards of outpatient surgery centres and all providers to have hospital admitting privileges. Nearly half the abortion clinics in the state closed. State law also requires patients to wait at least a day after an ultrasound examination to consider their decision. That's tough because many of them have travelled several hundred miles to the clinic, leaving jobs and children at home.

These two states bookend the range of access to abortion services in the US—a situation that has come under the spotlight in the past six months as the Supreme Court considered a controversial case that would overturn the 1973 Roe *v* Wade ruling that made abortion legal across the US.

Roe *v* Wade now looks set to be overturned, if a draft of a US Supreme Court decision leaked to news website Politico in May is finalised. The draft plan would reduce access to abortion from a national right to one that individual states could rule on separately—and, according to the human rights organisation Center for Reproductive Rights, abortion could end up being severely limited or outlawed in more than half the states.

Mississippi and Texas

The current court case stems from a 2018 law passed in Mississippi that prohibited most abortions after the first 15 weeks of pregnancy. That was immediately blocked by the precedent set by Roe *v* Wade and never enacted. But it was enough to bring it to the attention of the Supreme Court, the highest court of law in the US.

Fast forward to September 2021 and the Texas state legislature passed what may be the most sweeping anti-abortion law in the country: the Texas Heartbeat Act. Where abortions were once allowed up to 20 weeks after fertilisation, the new law prevents doctors and clinics from providing medical or surgical abortions (except in life threatening medical emergencies) once they can detect fetal cardiac activity—generally about six weeks into a pregnancy, before many people realise they're pregnant. That has meant doing extra ultrasound examinations and often turning patients away.

The Texas law was specifically written to make it "judge proof." Rather than rely on state officials to prosecute abortion providers, which would make it subject to a constitutional challenge in a federal court, it calls for private citizens to sue anyone who helps a prohibited abortion to occur.

Just as crucially, Texas's law exposes to prosecution not just doctors but insurers that pay for abortions and taxi drivers who bring women to clinics. "It's basically creating a vigilante system," says Carol Sanger, a law professor at Columbia University and author of *About Abortion: Terminating Pregnancy in the 21st Century*. For the Texas obstetrician, the "aiding and abetting" provision "has been really complicating in terms of what I can and cannot inform patients about their options."

In December 2021, the Supreme Court finally heard the case of the Mississippi law, with a majority of the justices backing Mississippi in a private vote. A decision could have just applied to Mississippi, but the draft goes further.

In February 2022, Samuel Alito, associate justice of the Supreme Court, drafted a decision (called an opinion) to represent the majority decision. This is a

TIMELINE OF RECENT EVENTS

19 March 2018
Mississippi signs into law a measure banning almost all abortions after 15 weeks of pregnancy, although the law is never enacted

21 September 2021
Texas passes the Texas Heartbeat Act

2 December 2021
Supreme Court hears the case of the Mississippi law

10 February 2022
Samuel Alito, associate justice of the Supreme Court, drafts an opinion to represent the majority decision

2 May 2022
Leaked Alito draft opinion is published by Politico

3 May 2022
Oklahoma signs into law abortion measures modelled on the Texas Heartbeat Act

5 May 2022
Connecticut signs legislation protecting people travelling to the state for abortions, those who aid them, and in-state providers

June 2022
Expected Supreme Court decision on Mississippi case

normal court process—a justice representing the majority circulates a draft, works on it after comments, and may circulate it some more until a final version is reached. What wasn't normal was that the full 98 page draft was leaked to Politico, which published it on 2 May.

It detailed just how the law would be overturned, with the key being privacy. The 1973 Roe *v* Wade decision was based on the concept that the US constitution protects people's liberty and privacy, and thus their right to choose an abortion without excessive government restrictions. (It followed another Supreme Court ruling a decade earlier against the state of Connecticut, which tried to outlaw contraceptive use even among married couples. The court decided that contraception was a private issue and government shouldn't intervene.) In the draft opinion, Alito, a conservative Catholic and longtime critic of Roe *v* Wade, discarded the privacy concept that was its basis.

Repercussions

Back in Texas, the number of abortions in clinics dropped drastically in the months after its rule passed. But the number of Texans getting abortions dropped only about 10%, according to the *New York Times*—people were going to other states or getting medical abortions. The Texas obstetrician provides abortions in another state for one week a month, but that state may be tightening up its access rules as well. In May 2022, just a day after the Supreme Court draft opinion was leaked, the governor of Oklahoma signed legislation modelled on Texas into law. And the state of Louisiana considered (and then dropped) a bill that would have allowed murder charges against women in the state who found ways to have abortions.

On the other hand, 16 states plus the capital, Washington, DC, have laws protecting the right to abortion, and the leaked opinion has only bolstered their stance. On 2 May, the governor of New York state tweeted an invitation to anyone who needs access to care to come to her state; the governor of New Jersey assured every New Jerseyan that abortion remains available there. The governor of the state of Washington said at a rally the day after the draft opinion was leaked, "Washington state is a pro-choice state, and we are going to fight like hell to keep Washington a pro-choice state." He too promised "sanctuary" to people from other states.

Sixteen states have laws protecting the right to abortion, and the leaked opinion has bolstered their stance

Prager says she's seen patients from Idaho—a drive of 300 miles or more to her clinic—and that she and others are considering setting up clinics on the Idaho-Washington state border. Clinics in states near Texas have also reported a large rise in business. Medication abortions have also been rising—as of February more than half of all abortions in the US rely on pills that can be taken at home, sometimes obtained by mail order, and as a result of the pandemic the Food and Drug Administration allowed providers to arrange to send pills by post. (Nineteen states, however, require the provider to be physically present, and some states are now considering further restrictions.)

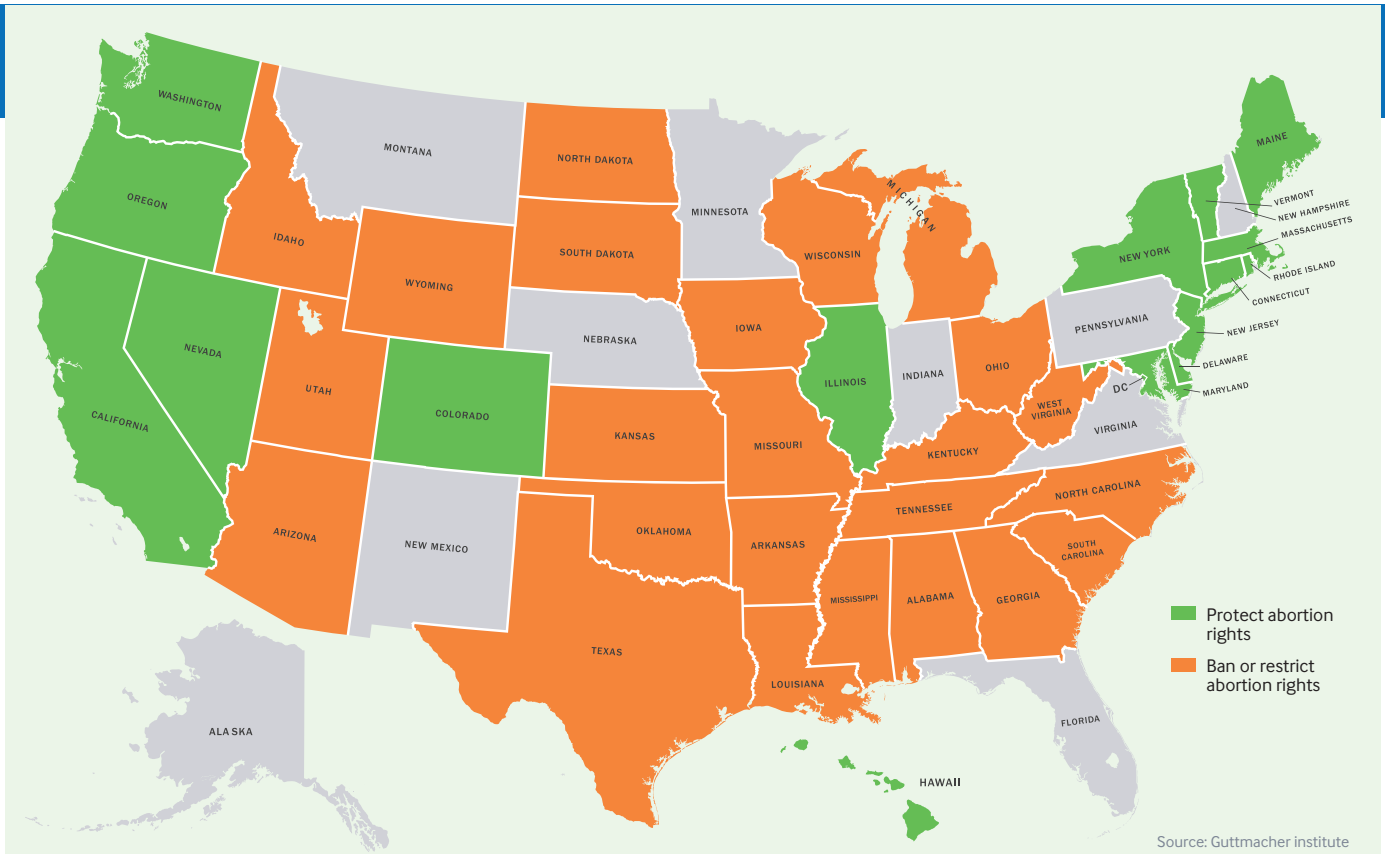
Within a few days of Politico publishing the draft opinion, the state of Connecticut enacted legislation that prevents its state agencies from cooperating with states seeking to prosecute abortion providers and patients in Connecticut and protects the medical records of people from other states who seek care within its borders.

Support has also come from over the border, with government officials in Canada and women's rights groups in Mexico indicating that they would help patients who came from the US seeking abortion services.

Alito's draft is not likely to be the final version of the Supreme Court ruling—occasionally some justices change their votes in the process and change the ultimate outcome. But court watchers are not expecting a change in the final decision to reverse Roe, which is expected in late June. If the opinion holds, "we'll have 50 little countries deciding whether abortion will be legal or not, or how legal it will be," said Sanger. In Alito's words, "It is time to heed the Constitution and return the issue of abortion to the people's elected representatives."

Some think restrictions could go farther. Mary Ziegler is a visiting professor at Harvard Law School and author of *Abortion and the Law in America: Roe* v *Wade to the Present*. "If Roe is overturned," she said, "a lot of conservative states are counting on criminally punishing doctors, not just allowing lawsuits against them." And there's already concern among some physicians that aiding the completion of a miscarriage will be seen and prosecuted as abortion care.

Ziegler and others also think some reproductive technologies could be banned,



Source: Guttmacher institute

State of play

The Guttmacher Institute, a pro-choice research organisation, says that as of 1 May, 23 states are primed to restrict or further restrict access to abortion. Thirteen of them have so called "trigger laws" already on the books, which would go into effect if the Supreme Court overturns Roe *v* Wade. Texas has one, signed in June 2021, that would put doctors performing an abortion at risk of life in prison. Other states have restrictions that have been blocked in the courts but would become active with the demise of Roe. And there are states with laws expressing intent to add restrictions, which would be likely to be pursued in the wake of the Supreme Court's decision. Restrictions and rules exist in some states already. While Roe guarantees access through fetal viability—about 24 to 28 weeks after a last menstrual period—22 states ban abortion between 13 and 24 weeks after a last menstrual period, according to Guttmacher. The Institute also identifies five states (Alaska, Kansas, Mississippi, Oklahoma, and Texas) that require doctors to discuss a possible link between breast cancer and abortion, even though the American Cancer Society explicitly states that no causal relation has been found.

In eight states doctors are required to discuss long term mental health consequences of abortion. In five states patients must be told that personhood begins at conception. Doctors in Texas must provide a booklet that refers to the fetus as "your baby" and includes graphic representations of fetal development.

The state of Missouri has considered allowing private citizens to sue anyone who helps a Missourian get an abortion, even in another state. "This is going to be the new thing, trying to put your criminal law on people in other states," says Colombia University law professor Carol Sanger. She thinks that it will ultimately be unsuccessful because Americans have a right to travel across state lines.

most notably the creation of embryos for implantation. "It's not clear how states that ban abortion are going to view the disposal of embryos or storage of embryos," says Ziegler.

And Sanger says that, if the reasoning in the draft opinion turns out to be close to the final ruling, states could go after other privacy rights, including same-sex relationships and marriage equality. It's something Justice Sonia Sotomayor warned about when she and her fellow justices heard the case last year. The legal counsel for anti-abortion group Alliance Defending Freedom told the *New York Times* that claims that the movement wants to go beyond abortion is "hysteria and scaremongering," but another legal expert pointed out to *The BMJ* that few people in the American mainstream thought the anti-abortion movement would get as far as it has.

The American College of Obstetricians and Gynecologists, which represents 60 000 doctors, has vowed to continue support "in defense of comprehensive reproductive medical care and against legislative interference in the patient-physician relationship," and promised continued education and training in abortion care and referrals, as well as efforts in state legislatures to preserve access.

The head of the 6000 member American Association of Pro-Life Obstetricians and Gynecologists told an internet newsletter that she "hopes the final court decision matches the leaked draft." Meanwhile other anti-abortion groups noted that the decision doesn't make abortion illegal, it just turns the option back to the states, and they say that much work needs to be done on the state level.

The Texas obstetrician sees increasing restrictions on abortions as a reflection of how their state is failing a certain segment of the population—those who don't receive education about contraception, can't afford it, or don't want to bear a child because they can't afford another mouth to feed.

"Many of my patients have experienced sexual assault, have restricted choices because of intimate partner violence, are adolescents who cannot talk to their parents about reproductive health and contraception. I think that's lost in this conversation," they say. "It's hard not to get emotional about it. These are the people who need the most help."

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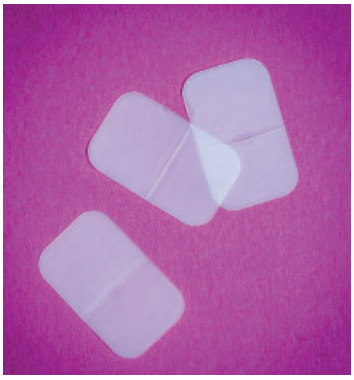
BRIEFING

Why are there shortages of HRT and other drugs in the UK?

A lack of supplies has again hit the headlines, highlighting wider problems associated with complex global supply chains. **Jacqui Wise** reports



How big is the problem in the UK?

Shortages of drugs are "becoming an increasingly frequent matter," says the Pharmaceutical Services Negotiating Committee (PSNC). Over recent years there have been supply problems with medicines including antibiotics, anti-inflammatories, antidepressants, anti-epileptic drugs, anti-psychotics, statins, and oral contraceptives.

A *Chemist and Druggist* survey in 2019 found shortages across all 36 categories of medicines. A more recent survey by the pharmacy magazine reported shortages across all 30 brands of hormone replacement therapy (HRT) between October 2019 and March 2020. Pharmacies have this month run out of some hay fever drugs because of an industry wide shortage of chlorphenamine maleate.

Shortages are not confined to the UK—the latest survey from the Pharmaceutical Group of the EU says there is a continued high incidence of drug shortages in most European countries.

Why is the HRT shortage prominent?

Some HRT products, particularly gels, are in short supply. The causes are "complex and multifactorial," according to the British Menopause Society, Faculty of Sexual Reproductive Healthcare, Royal College of Obstetricians and Gynaecologists, and the Royal College of General Practitioners (RCGP). In a joint statement they say, "HRT supply has not always been reliable in recent years, with multiple factors including manufacturing capacity, understanding current and future demand, and disruption of global supply chains all contributing."

The organisations also point to a "sea change in the public conversation around menopause." Increased awareness of the menopause and HRT has been called the "Davina effect" after a Channel 4 documentary presented by Davina McCall in May 2021.

The Department of Health and Social Care (DHSC) says demand for HRT has risen 38% in the past seven years, as access has been extended. Prescriptions for HRT have more than doubled in England over the past five years, from 238 000 in January 2017 to almost 538 000 in December 2021. PSNC analysis of data published by the NHS Business Services Authority shows significant increases in prescribing of some HRT drugs. For example, between February 2021 and February 2022 Oestrogel prescribing increased by 76%, Estradot by 74%, Lenzetto by 1106%, and Sandrena by 146%. Besins Healthcare, the manufacturer of Oestrogel, says that from January to April they delivered to wholesalers double the amount supplied in the same period last year. It says they are working to increase production capabilities.

A survey found that 67% of UK pharmacies are having to deal with drug supply problems every day

How are patients, pharmacists, and doctors being affected?

A survey for PSNC found that 67% of pharmacies are having to deal with drug supply problems every day. Shortages are also leaving primary care staff exposed to rising levels of abuse from patients who are frustrated at not being able to access their medication. The PSNC survey also found that 75% of pharmacies reported experiencing aggression from patients because of drug supply problems.

Martin Marshall, chair of the RCGP, says, "The college is concerned about the current supply problems around the provision of some preparations of HRT. We understand the distress this is causing to many women, and it is frustrating for GPs and pharmacists when we face difficulty providing patients with the treatment they need."

What are the causes?

Supply problems are driven by a number of factors, ranging from problems at the manufacturing stage—such as a lack of raw ingredients, many of which come from India and China—through to distribution and varying levels of demand. These disruptions can fluctuate rapidly and locally.

They are "enormously complex," says a spokesperson for the National Pharmacy Association. "Many of the drugs supplied to UK pharmacies are manufactured overseas and, in fact, outside Europe. This move to manufacture away from the UK is in line with other industries, but it means that drugs need to be transported along complex supply chains. If part of the supply chain fails, the UK can rapidly run out of a medicine."

Covid has also had an impact on manufacturing capability. During the pandemic's early stages there were shortages of paracetamol. This was partly because of increased customer demand and panic buying but also because India withheld stock for their use.

Is Brexit a factor?

Mark Dayan, Brexit programme lead at the Nuffield Trust, tells *The BMJ*, "Brexit is a contributory factor to drug shortages in general

terms but it is incredibly difficult to demonstrate that any one shortage is because of Brexit."

The gloomiest predictions about drug shortages following Brexit have not come to pass, because of measures the government put in place (see below). But Dayan says the number of drug shortages has risen since the EU referendum. This, he says, is because of three possible factors: logistics such as haulier problems, more customs checks, and the competitiveness of the UK as a marketplace.

He points to the shortages of blood tubes last year that forced NHS England to suspend their use in training and space their use further apart where safe. This shortage was partly because of global supply problems but the manufacturer Becton Dickinson also pointed to UK border challenges as a contributory factor.

What are the solutions?

In preparation for Brexit the UK government introduced stockpiling and set up new routes into the UK specifically for medicines.

In October 2019 changes were made to regulations to introduce serious shortage protocols (SSPs). These give pharmacies the ability to dispense less, or give a different strength, or pharmaceutical form, or provide an alternative product, depending on the wording of the specific SSP for the drug in short supply. In April this year SSPs were given to limit dispensing to three months' supply of three HRT products—Oestrogel, Ovestin cream, and Premique Low Dose. An SSP is currently in place for the antidepressant fluoxetine 10 mg.

Another government measure is restrictions to stop parallel exporting of drugs that are in short supply. In October 2019 19 HRT products as well as a further five drugs, including all adrenaline auto-injectors and hepatitis B vaccines, were subject to parallel export restrictions.

The University of Bradford held a medicines availability stakeholder event in September 2019 that had attendees from across the pharmaceutical supply chain including patients. One of their recommendations, which was shared with the DHSC, was for a dedicated information portal. The online Medicines Supply tool, launched on 5 May, provides up to date information about drug supply problems to healthcare professionals.

The latest government move is to appoint Madelaine McTernan as "HRT tsar." She has been part of the taskforce involved in the nationwide covid vaccine rollout and will work with HRT suppliers and professional bodies to tackle supply constraints and help cope with increased demand. On 6 May England's health and care secretary Sajid Javid also held crisis talks with key suppliers to find a way to boost HRT supply.

What else could be done?

Medical organisations including RCGP and the Royal College of Obstetricians and Gynaecologists are backing calls for pharmacists to be allowed to provide women with substitutions for out-of-stock HRT products.

Asha Kasliwal, president of the Faculty of Sexual and Reproductive Healthcare, says, "We are aware that women are sent away with prescriptions for unavailable products and end up lost in a system that is frustrating to navigate. We support authorising pharmacists to support women to substitute out-of-stock products where there are set protocols on safe equivalents agreed centrally, following the relevant guidance."

Liz Breen, professor of health service operations at Bradford University School of Pharmacy and Medical Sciences, says there should be much better use of data to indicate demand and more effective planning. "It's not rocket science. We have a wealth of data in our health and social care systems which logs sales, consultations, and prescribing regarding HRT products, so why suppliers haven't recognised the increase in demand for HRT and projected accordingly is surprising."

How are drug shortages monitored?

There is a mandatory requirement for pharmaceutical manufacturers to report to the government any current or impending supply issues. DHSC then sends out regular bulletins to pharmacies, CCGs, and other relevant NHS bodies. However, follow up is not always successful, Breen says. "Monitoring of shortages has improved in recent years. But there are problems with the information going out to pharmacists, such as how long the shortage will last and what should be done about it," she says. Information about supply problems can be found on the websites of the Specialist Pharmacy Service, PSNC, the British Generic Manufacturers Association, and, for HRT products, the British Menopause Society.

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CAUSES OF DRUG SHORTAGES

Supply problems may be down to a combination of factors including:

1. Manufacturing problems
2. Capacity problems
3. Commercial withdrawal
4. Drug recalls and quality problems
5. Availability of raw ingredients
6. Increased demand
7. Distribution and logistics
8. Excessive parallel exporting because of currency fluctuations
9. Stockpiling and panic buying
10. Supply quotas

Sajid Javid has held crisis talks with key suppliers to find a way to boost HRT supply

EDITORIAL

UK response to the Ukrainian migrant crisis

Must prioritise reform of its inhumane, unsafe, and ineffective system for refugees

As more than five million people flee the fighting in Ukraine, aid agencies are providing lifesaving assistance and medical supplies in Ukraine and neighbouring countries. But how should the UK respond to the health needs of people seeking refuge?

We must first ensure safe and legal ways for Ukrainian refugees to reach the UK. The current approach to Ukrainian refugees, which limits visas to those with a family member or named sponsor in the UK and requires people to acquire a visa before arriving, is too restrictive, slow, and bureaucratic.[4] Of the estimated 5.7 million people who have fled Ukraine, just 27 100 have arrived in the UK through this route,[5] and reports are increasing of Ukrainian refugees travelling to the UK without a visa.[6]

Once Ukrainians arrive in the UK, they need a fair, humane, timely, and effective refugee system. People who secure a visa in advance can stay in the UK for up to three years, but those without will face an asylum system that is notoriously slow and inefficient, with substantial effects on health. The average waiting time for a claim to be decided is between one and three years.[8]

Evidence shows that asylum seekers and people with temporary immigration status experience particularly poor physical and mental health. This is often attributed to spending long periods of time in a state of uncertainty and the constant fear of being returned to an unsafe country as well as poor access to health services.[9-12]

While asylum claims are considered, people are accommodated in communal sites that are inappropriate for longer term living and often in remote locations, leaving people socially isolated. A recent report from Doctors of the World found that asylum accommodation does not meet basic humanitarian standards.[13] Problems included poor food, lack of access to basic sanitary products, and inability to store medication or have professionals visit to provide care. Residents were unable to obtain prescriptions, medical care for pregnancy and children, referrals to specialists, and ongoing support for medical conditions, and they reported serious mental health effects from the loneliness, isolation, and feelings of being imprisoned.

SEAN GALLUP/GETTY IMAGES

Ukrainians in the UK—largely children, women, and elderly people—need meaningful access to healthcare services

Anna Miller, head of policy and advocacy, Doctors of the World UK, London AMiller@doctorsoftheworld.org.uk

Rachel Burns, research fellow, University College London

Sally Hargreaves, associate professor in global health, University of London

Kerrie Stevenson, public health doctor, London School of Hygiene and Tropical Medicine

Punitive measures

Despite this, the Home Office is introducing a raft of measures that have been described by the UN Refugee Agency as "a recipe for mental and physical ill health" and inconsistent with the 1951 Refugee Convention.[14] Measures include legislation to make refugee protection temporary, warehouse style reception centres, and plans to expel asylum seekers to Rwanda.[15] Ukrainians who arrive without paperwork could be subjected to any or all of these measures. Instead, reforms should focus on building a humane refugee system that resolves claims quickly and fairly, strengthens long term protection, and recognises the critical importance of security, safe accommodation, community, and access to medical care.

Ukrainians in the UK—largely children, women, and elderly people—need meaningful access to healthcare services, including preventive healthcare, mental healthcare, screening, and maternity services.[1] The government, NHS bodies, and frontline services need to reform the policies and practices known to prevent refugees and asylum seekers from accessing care. Currently, Ukrainians without formal immigration status will be charged for hospital services and could face barriers to registering with a general practitioner.[16]

Achieving meaningful progress will require the Department of Health and Social Care to abandon its NHS charging policy,[17] the Home Office to reform GP registration for asylum seekers, and general practices to overhaul their policies and practices in line with the seven steps set out in the safe surgeries initiative.[18] The NHS in all devolved nations could use this opportunity to clarify entitlement to primary care services and deal with the culture of bureaucracy and gatekeeping that so often prevents refugees and migrants from accessing medical care.[19]

Many of the policies outlined above contribute to the government's policy agenda known as the hostile environment,[20] which aims to discourage people from entering the UK without immigration documents and encourage those here to leave. This powerful and pervasive agenda has seeped into (and is enforced by) public services, including the NHS.[21 22] Only through recognising the intention of this harmful policy agenda, and tackling it head on, can we ensure that Ukrainians and others in need of protection will be able to build a safe and healthy life in the UK.

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Find the full version with references at http://dx.doi.org/10.1136/bmj.o1191