this week

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HENRY NICHOLLS/REUTERS/ALAMY

"Diphtheria could have been controlled"

Seventy suspected cases of the infection have been reported among migrant families detained at Manston

The diphtheria outbreak linked to the Manston migrant processing centre in Kent "could and should have been prevented" but was made "far worse" by the Home Office, public health leaders have said.

More than 70 suspected cases have been linked to the centre in recent weeks, and with many people being moved to hotels around the country, a report in the *Times* said, suspected cases are now thought to be in West Yorkshire, London, Greater Manchester, Kent, and the south west and east of England. People were moved after the death of a man, held for almost a week at Manston, who had contracted diphtheria.

In a report the UK Health Security Agency said diphtheria was identified in 50 asylum seekers between February and 25 November, with most cases seen in males aged 14 to 25, who presented with cutaneous lesions or wounds acquired while travelling to the UK.

The agency recommended mass antibiotic prophylaxis and vaccination for people currently in, as well as those previously in, processing centres. "The Home Office is working with the NHS and other partners to operationalise this," the report says.

However, the Association of Directors of Public Health said an offer of help was ignored by the Home Office, without providing details on what the offer entailed. Jim McManus, the association's president, said, "We have had no direct engagement from the Home Office and, although we have offered our support, we have not yet received a response.

"Sadly, the current situation could and should have been prevented through joint working, and it is entirely arguable the lack of information, coordination, and engagement from the Home Office has made the situation far worse than it could have been."

The Manston centre, which was designed as a 24 hour holding facility to process up to 1600 migrants before they are moved into immigration detention centres or asylum accommodation, was recently estimated to be holding up to 4000 people. Earlier this month it was also reported to be dealing with outbreaks of diphtheria and scabies and a case of meticillin resistant *Staphylococcus aureus* (MRSA), with the Home Office being urged to "get a grip" on the overcrowding.

A Home Office spokesperson said, "We work closely with a range of partners, including local authorities and health leads, to make sure information is shared in a timely way and that everyone leaving Manston is given access to appropriate treatment."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2022;379:o2887

LATEST ONLINE

- Conceiving three months after miscarriage or abortion does not increase risks, finds study
- Health and social services staff missed chances to protect murdered 5 year old from dangers at home
- NHS must offer flexible working to staff with menopausal symptoms, says guidance

SEVEN DAYS IN

Emergency hormonal contraception in pharmacies "will cut GPs' workload"

LEWIS HOUGHTON / SPL

Offering free emergency hormonal contraception without prescription at all pharmacies in England "should have a marked impact on GP workload," authors of a study in *BMJ Open* concluded. Some pharmacies are currently commissioned by local authorities to provide emergency hormonal contraception free without prescription, but Keele University researchers noted that less than half of pharmacies had a service in place, with some local authorities commissioning the service from only a handful of pharmacies.

The study's lead author, Nick Thayer, told *The BMJ* it was a "no brainer" for the NHS to introduce a nationally commissioned service in England, similar to existing schemes in Scotland and Wales.

"You would get significant benefits to patients," he said. "It would align with the other [routine oral] contraception services that community pharmacies are introducing in 2023 as part of their contract and would have a significant impact on GP capacity. It would help GPs get other stuff done, manage the backlog, and improve patient access."

Gareth Iacobucci, *The BMJ* **Cite this as: *BMJ* 2022;379:o2832**

Workforce

Retention must be a priority, say GP leaders

Recruitment figures from Health Education England showed that 4032 doctors accepted GP training places in 2022, against a target of 4000. The Royal College of General Practitioners and the BMA welcomed the interest in GP training but urged a greater focus on retention, as the profession was losing more GPs than it was gaining every year. David Smith, chair of the BMA's GP trainees committee, said, "There is no point having record numbers coming in the front door if huge numbers are still leaving through the back."

AMR

Comments are sought for next five year plan

England's Department of Health and Social Care launched a consultation to inform the next five year plan to tackle antimicrobial resistance and is calling for input from technical experts on human health, animal and plant health, food, and the environment. It also aims to learn from the tools used to tackle the covid-19 pandemic, such as vaccines, therapeutics, and diagnostics, as well as public behaviours. The consultation closes on 20 January.

Paediatrics

Comic strip aims to reduce surgery anxiety

An online *Beano* comic strip starring the character Dennis the Menace has been developed by the Royal College of Anaesthetists and the Association of Paediatric Anaesthetists of Great Britain and Ireland to help children understand how it feels to have a general anaesthetic and to help reduce anxiety about surgery. Samantha Black, consultant anaesthetist and patient information lead at the Royal College of Anaesthetists, said, "'Dennis has an anaesthetic' is a fantastic resource that can be used in preoperative assessment clinics and at home with parents to answer children's questions and to reassure them." (See www.rcoa.ac.uk/dennis-has-anaesthetic)

Measles

Disease is "imminent threat" worldwide

Falling vaccination rates and reduced surveillance during the covid pandemic have created an "imminent threat" of measles spreading in every region of the world, said the World Health Organization and the US Centers for Disease Control and Prevention. Measles vaccination coverage worldwide has fallen steadily since the beginning of the covid pandemic, with a record of nearly 40 million children missing a vaccine dose in 2021. A joint report highlighted that 25 million children missed their first dose and 14.7 million missed their second.

Professionalism

Trust in doctors and nurses remains high

Doctors and nurses remain among the most trusted professions in surveys, but their reputations have fallen slightly. The latest edition of the Ipsos Veracity Index shows that 85% of the public trust doctors to tell the truth, down from 91% in 2021. Nurses topped the index but showed a similar fall, from 94% to 89%. Politics is the least trusted profession in Britain, with just 12% of the public saying that they trusted politicians to tell the truth—an all time low and down from 19% in 2021.

Cholera

MSF: Haiti's treatment centres are overwhelmed

Treatment centres in Haiti are being overwhelmed by the continuing spread of cholera, Médecins Sans Frontières warned. The first case of a new outbreak of the bacterial disease was detected in Port-au-Prince on 29 September, and health authorities and medical non-governmental organisations have struggled to contain its spread amid spiralling gang violence. "Our centres are filling up, and we will soon be at maximum capacity," warned Mumuza Muhindo, MSF's country director in Haiti. MSF highlighted the immediate need for more financial donations, doctors, and vaccines to prevent more unnecessary deaths.

MEDICI

Nurses plan to strike on 15 and 20 December

Strikes

Nurses plan to strike twice this month

Members of the Royal College of Nursing in England, Northern Ireland, and Wales will strike on 15 and 20 December, after the UK government turned down formal pay negotiations. More dates could be announced if governments fail to enter into formal negotiations, the college said. Saffron Cordery, interim chief executive of NHS Providers, said there was still time to stop strikes. "Trusts have been planning for industrial action. Those [affected] will do everything in their power to minimise disruption for patients," she said.

Public health

Scottish footballers are advised to limit heading

New guidance from the Scottish Football Association says professional footballers should not head the ball in training the day before and after matches, and players should not train with repeated heading more than once a week. The advice follows the Field study, which found that former footballers were 3.5 times as likely as non-footballers to die from brain disease. In 2020 the Scottish FA banned children under 12 from heading balls in training.

Second monkeypox vaccine is offered

The NHS is offering all eligible people a second smallpox vaccine to protect against monkeypox. Almost 68 000 people have been vaccinated since the first cases in this outbreak were identified in England in May. The second jab can be given from two to three months after the first dose. One vaccine dose offers 78% protection after 14 days, UK Health Security Agency research has shown.

WHO to refer to monkeypox as mpox

After consultations with global experts, WHO will begin using the new preferred term "mpox" as a synonym for monkeypox. Both names will be used simultaneously for one year while "monkeypox" is phased out, it said. The move came after reports of racist and stigmatising language being used after the outbreak earlier this year.

Trial will investigate influenza treatments

A new national trial aims to use lessons from covid-19 to find effective treatments for people admitted to hospital with flu. The £2.9m Remap-Cap trial will work with the NIHCR to recruit children and adults admitted with severe flu to 150 UK hospitals over the next two years. The trial, originally set up to tackle pandemics, showed two years ago that using tocilizumab to reduce inflammation could save the lives of patients who were severely ill with covid-19.

Two new gambling addiction clinics open

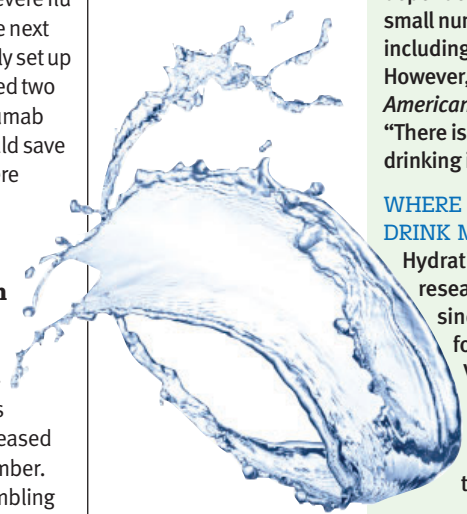
The NHS has opened two gambling addiction clinics, in Southampton and Stoke-on-Trent.Treatment referrals for gambling addiction increased by 42% from April to September. England now has seven gambling clinics, as the NHS works towards a pledge to open 15 by 2023-24.

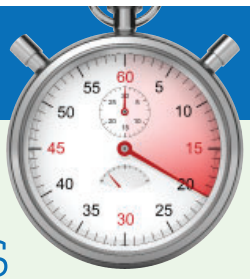
Cite this as: *BMJ* 2022;379:o2879

STAFFING

The UK would have **4000** more working specialists if the influx of doctors from the EU and European Free Trade Association had continued at the same rate as before the Brexit referendum

[Nuffield Trust]





SIXTY SECONDS ON . . . HYDRATION

I KNOW THIS ONE—EIGHT GLASSES OF WATER A DAY, RIGHT?

Not exactly. Research in *Science* shows that the recommended daily water intake of 2 L, or eight glasses, is too much for most people.

WAT-ER YOU TALKING ABOUT?

Scientists assessed the water intake of 5604 men and women aged between 8 days and 96 years old from 23 countries. The research involved people drinking a glass of water in which some of the hydrogen atoms were replaced by deuterium, a stable isotope, to show how quickly the body processes water. This was found to be higher in hot and humid environments and at high altitudes and also among athletes, pregnant and breastfeeding women, and people with high levels of physical activity.

SO MY £60 BLUETOOTH REHYDRATION SYSTEM IS A WASHOUT?

Do you mean water bottle? Not quite yet. Most people need only about 1.5 to 1.8 L a day, the study found. And for a woman in her 20s it is only around 1.3 to 1.4 L a day. John Speakman, a coauthor of the study, said, "A one-size-fits-all policy for water intake is not supported by these data." Because most foods contain water, just eating can help hydration, he added.

GOOD. WATER'S DULL BUT NOT FOOD

Without water, humans can survive only a few days, but the exact daily amount needed is difficult to measure. Previous research has depended on subjective questionnaires with small numbers of people. Many organisations, including the NHS, recommend eight glasses. However, a 2008 editorial in the *Journal of the American Society of Nephrology* concluded, "There is no clear evidence of benefit from drinking increased amounts of water."

WHERE DID THE IDEA WE SHOULD DRINK MORE WATER COME FROM?

Hydration for Health has been sponsoring research and organising conferences since 2008. It was created by the French food giant Danone, which produces Volvic, Evian, and Badoit bottled waters. And an investigation by *The BMJ* in 2012 found that sports drinks companies helped market the science of hydration.

SO HOW DO I TELL I'M DEHYDRATED?

That's easy. Are you thirsty?

Jacqui Wise, Kent

Cite this as: *BMJ* 2022;379:o2869

Complaints against GPs are up by more than a third on pre-covid level

The number of written complaints against GPs is now 37% higher than before the covid pandemic, figures from NHS Digital show. In 2021-22 a total of 99 459 complaints were made against GPs, up from 72 356 in 2018-19. No data on complaints were collected in 2019-20 during the height of the pandemic, and 72 087 complaints were recorded in 2020-21.

Primary care

Overall, more than 225 570 written complaints about the NHS were recorded in 2021-22, up from 208 924 in 2018-19. The rise in complaints was mostly accounted for by primary care (GP and dental), where the number rose from 92 677 in 2018-19 to 120 064 in 2021-22. In contrast, written complaints about hospital and community health services fell slightly: from 116 247 in 2018-19 to 105 506 in 2021-22.

The most common causes of complaints involving GPs were communication (13.5%), clinical care, including errors (13.3%), and staff attitude and behaviour (12.6%).

NHS Resolution, which deals with complaints, estimated the cost of potential claims arising from covid-19 will be £1.3bn. It predicts the main driver of these will be "in relation to the indirect impacts of delays, cancellations, and misdiagnosis."

Kamila Hawthorne, chair of the Royal College of GPs, said that though most patients were satisfied with their GP care, pressure on general practice kept growing. "We want to be able to deliver the high quality care and services we are trained to deliver, so we share our patients' frustrations when this isn't the case."

Ingrid Torjesen, *The BMJ*

Cite this as: *BMJ* 2022;379:o2891

GP leaders condemn "name and shame" appointment data

Closer scrutiny of the performance of individual general practices in England has been made possible in the form of new published data on appointments, but the information is unhelpful, lacks nuance, and unfairly punishes doctors, GPs' leaders have said.

NHS Digital's first set of Appointments in General Practice contains data about appointments from August to October, including details of the type of healthcare professional carrying out the appointment, the mode of appointment, and the time to attendance. Crucially, data are available on GP appointments at individual practice level—something that the government is keen to provide, arguing that it will allow patients to make more informed choices on the practice they choose.

DANIEL LEAL-OLIVAS/PA/ALAMY

Overall, the data show that more than a third (38.9%) of appointments in October took place on the same day that they were booked, 7.3% happened within one day, 19.9% in 2-7 days, and 14.2% in 8-14 days, with the proportion falling to just under 6% of appointments that took more than 28 days. In total, 36.1 million appointments took place in October. Almost three quarters (71.3%) of all appointments were carried out face to face, with 43.5% carried out by a GP and 23.7% by nurses.

Kieran Sharrock, deputy chair of the BMA's General Practitioners Committee for England, said, "With more than 6000 practices in England, there will obviously be some differences in the way they operate and how staff provide care for their local communities.

Ministers plan to replicate vaccine taskforce for key health priorities

The government has pledged to replicate the blueprint it used for its covid vaccine rollout to research the development of new treatments and technologies in four areas identified by the NHS as key priorities: addiction, cancer, mental health, and obesity.

Each research area will be led by an independent expert, who will be selected by a panel that includes Kate Bingham (right), the former head of the vaccine taskforce.

Improve outcomes

The government said tackling the four major challenges would improve outcomes for patients and save billions of pounds. It said obesity costs the NHS £6.1bn a year and poor mental health costs the economy £118bn a year.

The prime minister, Rishi Sunak, said, "The NHS faces real pressures, which is why we are investing over £100m in the technologies and medicines of the future to tackle some of the biggest public health challenges.

Ministers must remember that prevention is better, and indeed cheaper, than the cure David Strain

"The highly successful vaccine taskforce, which procured millions of vaccines in record time during the pandemic, will now become a blueprint for how we harness the best talent and expertise from around the world and drive investment in research and development."

The initiative aims to harness expertise in research, cut unnecessary bureaucracy, and strengthen partnerships with business. Ministers were to meet with NHS and industry leaders on 28 November to discuss the plan. The funding will see £40.2m go to research into mental health, £30.5m to addiction, £22.5m to cancer, and £20m to obesity.

Overall, the data show that more than a third (38.9%) of appointments in October took place on the same day that they were booked, 7.3% happened within one day, 19.9% in 2-7 days, and 14.2% in 8-14 days, with the proportion falling to just under 6% of appointments that took more than 28 days. In total, 36.1 million appointments took place in October. Almost three quarters (71.3%) of all appointments were carried out face to face, with 43.5% carried out by a GP and 23.7% by nurses

"None of these nuances are taken into account in today's data, and rather than this being a useful tool to aid patient choice it is really no more than a way to 'name and shame' practices when the morale of dedicated staff is at rock bottom. Ultimately, such data should be used to support, not punish practices."

Local needs

Kamila Hawthorne, chair of the Royal College of GPs, said, "It's disappointing that the hard work of GP teams, working in incredibly difficult circumstances, is being overshadowed by the publication of practice level data allowing arbitrary comparisons between practices."

She said practices worked in different ways to reflect local needs and could not be compared like for like. "So this simply risks being used as a stick to beat those practices that are deemed not to be performing as well as others," she said. Instead, she said, "The government should focus on addressing the root cause of the unrelenting workload and workforce pressures GPs and our teams are working under and support them to deliver high quality and safe patient care."

Ruth Rankine, director of primary care at the NHS Confederation, said, "Greater transparency through this new data is an important step, providing that it is considered alongside external pressures and the fact that the number of appointments does not represent everything that primary care delivers for its local communities."

Adrian O'Dowd, London

Cite this as: *BMJ* 2022;379:o2852

Healthcare leaders welcomed the funding but said the government must also do more to tackle the root causes of ill health. David Strain, chair of the BMA board of science, welcomed the announcement but added, "Ministers must remember that prevention is better, and indeed cheaper, than the cure.

"If the government is to tackle the severe strain the health service is under, it will need to engage with public health policy to help prevent people from getting sick in the first place. This means tackling the cost of living crisis, reinstating public health budgets, and immediately recommitting itself to its planned public health policy on obesity."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2022;379:o2880

OBESITY costs the NHS £6.1bn a year, and poor mental health costs the economy £118bn a year

Heating prescribed by GPs to tackle fuel poverty

PAUL BALDESARE / ALAMY

A pilot scheme for GPs to prescribe heating to patients at increased risk of hospital admission in the cold is being extended to help ease the effects of the cost of living crisis.

The warm home prescription pilot, which trialled in Gloucestershire earlier this year, has funded home heating for 28 patients on low incomes who were deemed to be at highest risk of hospital admission. The scheme is now being extended to 150 households in Gloucestershire and an additional 1000 homes in Teesside and Aberdeen, after promising results.

The scheme, funded through the government's housing support fund, was established by the not for profit organisation Energy Systems Catapult, with support from general practices, social prescribers, and the energy charity Severn Wye. Eligible patients are prescribed a warm home, with Severn Wye following up the referral to credit people's energy accounts and arrange energy upgrades where possible.

Living in cold homes costs the NHS £860m a year and causes 10 000 deaths
Matt Lipson

The service also prescribes a heating plan to keep homes at temperatures recommended by public health guidance and supports patients with further energy efficiency information and signposting them to other services that could help.

Cost effective

Matt Lipson, consumer insight lead at Energy Systems Catapult, said the scheme's preventive approach would keep patients out of hospital and be cost effective. "Living in cold homes puts millions with health conditions at risk of harm. It costs the NHS over £860m each year and causes 10 000 deaths every winter," he said. "There must be a better solution to help the most vulnerable. If we buy the energy people need but can't afford, they can keep warm and stay out of hospital. That would target support where it's needed, save money overall, and take pressure off the health service. The scheme will also find homes we can insulate."

Hein le Roux, a GP near Gloucester, was among those to take part. "People with conditions such as emphysema or chronic bronchitis are at particular risk from complications associated with living in cold housing," he said. "The warm home prescription allows us to be more proactive in supporting some of the most vulnerable people in our county. We want to stop people from becoming unwell and help them to stay healthy at home in housing that is safe and warm."

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2022;379:o2835

GPs must prepare for industrial action as contract negotiations start, says BMA leader

As new GP contract negotiations between the BMA and government loom, GPs must "build support and understanding of industrial action" and ask colleagues what action they are "prepared to take," Kieran Sharrock. deputy chair of the BMA's GP Committee, has said.

Opening the England local medical committees conference in London on 24 November, Sharrock said that "successive governments have failed to listen to us" on the matters of workload, workforce, and wellbeing.

Successive governments have failed to listen to us
Kieran Sharrock

If the government failed to engage on these matters through the new contract, "will the profession be prepared to act?" he asked. "If we ballot the profession on industrial action, will that yes be loud enough to be heard by the government?" Sharrock added. "Together, the BMA and LMCs need to prepare the ground for action."

The current five year GP contract was negotiated between the BMA and NHS England in 2019-20, with provision for negotiated changes every year. But negotiations came to a standstill in February 2022 when the BMA said it was clear that NHS England would not be offering sufficient measures to ease the pressure on practices. NHS England

Call for better gender dysphoria services

Current care pathways for gender dysphoria are putting patients at risk by forcing GPs to prescribe outside their competency, stated a motion passed in full.

Representatives said the BMA must ensure that NHS England commissions appropriate services at a local level that "provide ongoing prescribing and support for patients."

Catherine Chapman, a North Yorkshire GP, said, "Gender dysphoria is a very specialist area and is not well taught in GP training. It certainly hasn't been in the past. As GPs we should only be prescribing within our competences, and this is supported by GMC guidance."

Chapman said her local referral pathway stated that if GPs did not think they were capable of taking on prescribing this could cause challenges with the referral. "Statements like this are driving a wedge between GPs and our patients who we want to support," she said. "But we can only do this if we have the backing of the specialist service, with a robust shared care agreement. Without clear guidance, we are putting our patients at risk by prescribing, if it is outside our competencies."

The motion said NHS England and NHS Improvement must formally acknowledge that "it is not appropriate for general practice to prescribe medication without specialist initiation and only then when supported by a shared care agreement and if a GP believes they are competent to prescribe."

Sarah Matthews, a member of the BMA's General Practitioners Committee for England, shared her experience of the system. She said, that when her "wonderful transgender boy" came out his GP referred him promptly. But the wait, thought to be 24 months, increased with covid and he was seen at 37 months for an initial virtual appointment. "Every appointment so far has been virtual. Now he's just at the threshold of definitive treatment he was committed to at 16. This week he is 22. We need a service that sees children and provides compassionate care."

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2022;379:o2866

Soaring energy costs "will force practices to close"

GP leaders must push for extra financial support to protect practices from the "catastrophic impact" of rising energy prices, representatives urged.

The conference passed a motion warning that the financial viability of practices was threatened, amid warnings many were at risk of closure. The motion called for the BMA's GP Committee to negotiate with NHS England for "in-year intervention" in the shape of extra funding to tackle pressures that were "unforeseen at the introduction of the current GP core contract."

Waiting until a planned renegotiation of the contract in 2024 to boost funding would be too late for many practices, GP leaders warned.

WE DON'T HAVE THE LUXURY OF AWAITING THE RENEGOTIATION OF GP CONTRACTS IN 2024
Simon Hodson

Simon Hodson, a GP from Shropshire LMC, who proposed the motion, said practices in his area were spending an extra "tens of thousands of pounds a year" on energy and warned that failing to act now would condemn more practices to closure. He said, "Over several years UK GP practice closures have run at about two a week, but in recent weeks we've seen some large practices unexpectedly collapse, citing rising cost pressures as the main issue."

He added that failure to get extra support "may well prove to be another nail in the coffin of the partnership model."

"We don't have the luxury of awaiting the renegotiation of GP contracts due to come into place in 2024," he said. "An immediate central response is vital to protect the bedrock of the NHS, the family GP practice. If this is not forthcoming, that would be a catastrophic surge in practices forced to hand back their contracts due to becoming non-viable."

Girish Chawla, from Cleveland LMC, said the government should offer the same financial support it had offered to other sectors. He said, "They can spend billions to support financial services and hospitality. Would it not be nice if they had a system to support primary care funding so our staff can have a decent pay rise and services are maintained?"

Gareth Iacobucci, *The BMJ*
Cite this as: *BMJ* 2022;379:o2850

MARK THOMAS

then imposed changes to the 2022-23 contract, which included that primary care networks would have to provide a full range of services from 9 am to 5 pm on Saturdays from 1 October.

Earlier this year GPs at the BMA's annual representative meeting passed a motion saying that the union must organise the withdrawal of general practices from England's PCNs by 2023 and lobby for that funding to be moved into the core contract. It also said the BMA must organise opposition to the new contract, including with "industrial action if necessary."

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2022;379:o2851

GPs express "deep concern" over BMA's suspension of Farah Jameel

GPs have "no confidence" in the BMA's complaint resolution process and said the association's lack of transparency in its suspension of Farah Jameel (below), the chair of its General Practitioners Committee, was "unacceptable and at odds with the BMA's own values."

In an emergency motion passed at the LMC conference, GPs raised "deep concern" over the suspension and were concerned in particular about the "optics of this action being taken against a colleague in the final stages of pregnancy." The BMA suspended Jameel in early November because of complaints by staff, reports said.

The motion also stated that the way the episode was handled was "contradictory to the recommendations of the Romney report into institutional sexism within the BMA."

In 2019 Daphne Romney's independent review into sexism in the BMA found the association had a discriminatory culture in which women were undermined, bullied, and even sexually harassed and leaders had failed to tackle the behaviour.

More recently the BMA said it had made "real and meaningful progress" on putting the report's recommendations into action. However, at its 2022 annual representative meeting doctors said that the BMA needed to do more to improve inclusion of women and members of minority groups.

"Shrouded in opacity"

At the start of the conference its chair, Shaba Nabi, spoke about the absence of Jameel, who was elected in 2021. Nabi said the reported suspension had been neither confirmed nor denied by the BMA and that Jameel had planned, despite her late pregnancy, to "address conference today and listen to debate."

"The situation we now find ourselves in is actually unprecedented, with a chair unable to perform BMA duties. It significantly impacts on conference as well as planning a vision for a new GP contract," Nabi said. "I would like to acknowledge the objections expressed by many of our colleagues about this process. It is felt that this is a process that is shrouded in opacity and has led to our first ever female GPC chair being unable to perform her duties despite wishing to be here today."

BMA co-chief executive officers Rachel Podolak and Neeta Major said, "Any case referred to the resolution process is confidential until the process has reached a conclusion, and we do not comment on any specific active investigation."

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2022;379:o2864

Core hours, patient records, and other key conference motions

Core GP hours

The BMA must negotiate for the new GP contract to reduce core working hours to 9 am to 5 pm, with practices able to start earlier or finish later on certain days, as per extended hours, to meet local need and if the practice is able to staff this. The motion, passed at the conference on 24 November, said that current core hours (8 am to 6.30 pm, 52.5 hours a week) were longer than for most full time jobs. GPs said that this indirectly discriminates against GPs with childcare duties, which mostly affects female GPs, because of the "still patriarchal nature of English society."

Hours, not sessions

Another motion demanded that any new BMA model contracts define GP working schedules in terms of hours rather than sessions, because referring to GPs as full time, part time, or full time equivalent in terms of numbers of sessions worked "fails to capture the real hours worked by many GPs." The motion, passed in all parts, said NHS workforce data collection should also look at actual hours worked rather than sessions.

Junior doctors' strike

GPs voted to offer "public support to all junior doctors, specifically GP registrars" who are considering taking industrial action over pay. The emergency motion, passed in full, instructed the BMA's England GP committee to work with the GP trainees committee to "develop guidance" for GPs on how to inform, empower, and support GP registrars during industrial action. Additionally, it called on the BMA to create a public information campaign to educate the public as to why GP registrars are being balloted for industrial action.

Elisabeth Mahase, *The BMJ*
Cite this as: *BMJ* 2022;379:o2871

WAITING until a planned renegotiation of the contract in **2024** to boost funding would be too late for many practices, GP leaders warned

THE BIG PICTURE

Beach nudity spreads skin cancer message

Thousands of people pose naked on Bondi Beach in Sydney, at sunrise last Saturday. They were part of installations created by Spencer Tunick (right), an American artist and photographer, that were commissioned by the charity Skin Check Champions during Australia's National Skin Cancer Action Week.

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2022;379:o2882

INSERTS: LISA MAREE WILLIAMS

DON ARNOLD

EDITORIAL

Government's spending plans

Investment falls short and politicians duck social care reform—again

The UK's new chancellor, Jeremy Hunt, set out the government's latest plans for tax and spending in the autumn statement on 17 November.[1] UK public finances are being hit by weak growth—the economy is now shrinking and projected to end this parliament no bigger than it started—and high interest rates.[2] Hunt, who was previously the NHS's longest serving health secretary (from 2012 to 2018), told the country that "difficult decisions" were needed[3] but provided some top-up funding for the NHS and social care.

Overall health spending will now grow by 1.2% a year in real terms over the next two years—less than in the decade before the pandemic (2% a year) and much less than the long term average (3.8%). Spending on the NHS will grow faster (2%) but still falls short of the growth needed to keep up with increasing demand for services and deliver pre-pandemic levels of care.[4]

Just how short the NHS will be depends on how you calculate what the service can buy with its extra cash. For example, last month NHS leaders estimated that the health service could face a shortfall of around £6bn-£7bn next year because of higher inflation and staff pay increases.[5] The government has pledged only around half this amount and also wants the NHS to make efficiency savings of 2.2%—well above past efforts.[6]

The NHS will have to make its own difficult decisions. The waiting list for routine hospital treatment is now over 7 million,[7] and emergency care is under extraordinary strain. Performance targets are being missed all year round. So where should the health service focus resources? NHS leaders must set clear priorities for services, and politicians should be honest about the consequences for patients.

Health is shaped by social and economic conditions, such as jobs and income

Hugh Alderwick, director of policy, Health Foundation, London
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The autumn statement also set out new NHS policy. The government will publish long term projections of the numbers of doctors, nurses, and other professionals needed in the NHS. This is welcome and could inform better planning. But projections will do little good without a long term strategy for recruiting and retaining staff, or the funding needed to deliver it. The NHS still has neither.

Hunt also announced a review of how the NHS's new integrated care boards—area based agencies responsible for system planning—can "work with appropriate accountability and autonomy."[1] These boards were established only in July. Policy makers should avoid yet more structural changes and focus on what local teams need to improve services instead. More staff in the right places would help. Better alignment of NHS policy—like targets and payment systems—around the system's objectives is needed too. But so are the basics such as modern buildings, equipment, and IT. Over the past decade, UK investment in healthcare capital as a share of GDP has been consistently lower than that in comparable countries.[9]

Prolonging public policy failure

Government also announced extra funding for social care—£2.8bn in 2023-24 and £4.7bn in 2024-25. More money is desperately needed: the system is on its knees, many people go without the care they need, and rates of poverty and deprivation among care workers are high.[10] But it's not clear how far the cash will go. Some will be eaten up by inflation, including increased energy costs for care providers, and some will depend on local authorities raising council tax. This could widen inequalities given that council tax is regressive[11] and its revenue potential is inversely correlated with local care needs.[12]

The extra money has also been traded for planned reforms to England's broken social care system. Government plans to cap people's care costs and introduce a more generous means test were set to be implemented in 2023. But these have been pushed back to October 2025—after the next election—and councils will be able to use the money earmarked for reform to meet current pressures instead. Sound familiar? The same reforms were legislated for in 2014, then delayed, then abandoned. And broader reform proposals have been promised then ducked for decades. Government has chosen to prolong this public policy failure, leaving vulnerable people without protection against potentially catastrophiccare costs.

Health is shaped by social and economic conditions, such as jobs and income.[13] Yet real household disposable incomes are projected to fall by around 7% over the next two years[2] and unemployment is set to rise. Beyond the NHS and other protected sectors, public services have been left to cope with rising inflation, which will affect what they can offer to the public and what they can pay staff.

A major spending squeeze has been pencilled in for after the next general election. Meantime, people will continue to feel the consequences of creaking public services in a nation getting poorer.

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EDITORIAL

Continuous flow models in emergency care

An inadequate response to the deep problems within the NHS?

Winter is not yet fully upon us and already emergency departments in the UK are struggling with unprecedented levels of overcrowding. Record numbers of patients are waiting for longer than 12 hours for an inpatient bed, with some spending days in the emergency department. Ambulances are unable to offload patients for want of space, impeding their ability to respond to the most urgent calls.[1] So serious is the situation that it has been suggested as the main cause of the spike in excess non-covid deaths seen over the summer.[2]

One possible solution currently attracting interest is the continuous flow model, first introduced in North America in the late 1990s.[3] Also known as full capacity protocols, these effectively mandate that a set number of patients are moved at set times from the emergency department to inpatient wards, regardless of whether a bed is available. This might mean putting an extra patient in a bay or two patients in a side room or boarding them in hospital corridors. In turn, this encourages wards to discharge existing patients, allows ambulances to offload new patients in the space created in the emergency department, and relieves pressure on the whole system.

The evidence underpinning "continuous flow" is encouraging but slight. Both the Royal College of Emergency Medicine[9] in the UK and the American College of Emergency Physicians[10] recommend continuous flow models only within the context of appropriate governance to maintain patient safety.

The risks associated with emergency department crowding are substantial. The continuous flow model offers a way to share risk, as well as a mechanism to make bed management leaner and more efficient, thereby forcing patient flow.

LYNSEY ADDARIO/GETTY IMAGE

Allowing substantial crowding on inpatients wards will simply replicate the risks already described in emergency departments

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Stevan Bruijns, consultant in emergency medicine, Yeovil District Hospital NHS Foundation Trust

Emergency department crowding also becomes visible to the whole hospital, particularly senior operational and inpatient teams.

Caveats

There are, however, important considerations that should inform any discussions about implementing continuous flow models. First, studies of this approach describe small numbers of patients being boarded for relatively short periods. Currently, in NHS acute trusts, it is not uncommon for scores of patients to be waiting for beds in emergency departments, sometimes for days.

Allowing substantial crowding on inpatients wards will simply replicate the risks already described in emergency departments. Worsening nursing staff to patient ratios may be detrimental to patient safety, especially when trusts already preferentially staff "front door" services such as the emergency department. An additional danger is that the increased burden on ward staff may prove intolerable and exacerbate long term staffing challenges.

Second, the main mechanisms through which continuous flow models operate are tighter bed management and encouraging patient discharges downstream. However desirable such forced flow might seem, the literature suggests this might increase patient harm. For example, 30 day mortality increased by 3.8% in US hospitals that reduced length of stay in response to emergency department crowding caused by closure of an adjacent institution.[12] Drives to improve patient flow can also result in other bed management practices associated with increased mortality or length of stay: multiple bed moves, moving patients at night, and patients being placed under the care of the wrong team.[13-15]

Third, qualitative studies of continuous flow models highlight that they are highly resource intensive.[16 17] Success is contingent on support of senior managers, the creation of organisational solidarity and accountability among staff, additional or redeployed staff to support areas with boarded patients, real-time bed management systems, and a deep understanding of institutional bottlenecks. The work required for successful implementation has been described as "all consuming."[17] Rather than being a quick fix, the continuous flow model was found to rapidly exhaust its usefulness, specifically in the face of chronic bed shortages.

This evidence suggests that a continuous flow model might help individual organisations, particularly those that already have the resources and governance in place. Others might consider how the model works and evaluate whether less extreme measures might bring about some of the same benefits. Clearly, however, it is not a magic bullet for the current complex system level problems within the NHS: too few beds, too few staff, and too little funding across the whole health and social care system. Unless and until these are fixed, the continuous flow model is just another bit of papering over the cracks.

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SOCIAL MEDIA

RIP #medtwitter? What Twitter's potential collapse could mean for tweeting doctors

The platform has proved invaluable for many medical professionals, but what happens now that it's owned by Elon Musk? **Chris Stokel-Walker** reports

Many people have been saying their farewells to mutual followers on Twitter in the past few weeks since the South African entrepreneur Elon Musk bought the social network for $44bn. Musk has taken the platform in a very different direction from what went before, both in terms of the types of content accepted on the platform (Musk is a "free speech maximalist") and behind the scenes, where he has shed more than half the site's staff in a month.

Those concerns have been amplified in the past week, as problems with the platform's reliability start to raise their head. Twitter users—including those on the vibrant community of medics who gather under the umbrella #medtwitter—have started to worry.

"Doctors have been on Twitter for a long time," says Rohin Francis, a cardiologist who is a member of #medtwitter. "But it feels like it's really kind of developed into an important community in the last few years, and I think maybe the pandemic has clearly brought a lot of high profile attention to some medics."

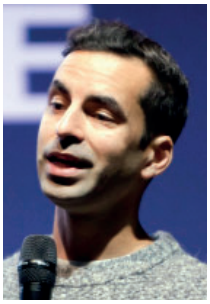
In the past week posts tagged with #medtwitter have reached 1.3 million people, an analysis by BrandMentions shows. That's one of the key reasons that Xand and Chris van Tulleken, the identical twin brothers both of whom are doctors and broadcasters, use the platform. "As broadcasters, it is unbelievably useful to have access to trusted people," says Xand van Tulleken. "It's so useful if I'm preparing an item for a show to get the commentary that's just sort of pouring out of certain people." He points to the way in which #medtwitter helped during covid—and also enabled interaction with people outside the medical field while providing crucial, data driven insights—as an example of the community at its best.

Van Tulleken found the Twitter feeds of people like the *Financial Times* journalist John Burn-Murdoch, mathematician Adam Kucharski, and barrister Adam Wagner hugely useful for their insights into how cases spread and the legality of specific covid restrictions during the pandemic.

The ability to dip in and out of conversations is what makes #medtwitter and its adjunct communities so useful, says van Tulleken. "It's someone you don't have to hassle; they can distribute it to everyone, and you can follow up in questions in person if you need to—and people are usually very responsive," he says.

"Educationally, it's a brilliant tool," agrees Hassan Ali Beg, a cardiology registrar working in the NHS in the north east of England. "There's a very active community on Twitter, including very high impact people within their field, [who are] getting invaluable insights from experts giving their commentary on things," he says.

It is unbelievably useful to have access to trusted people
Xand van Tulleken



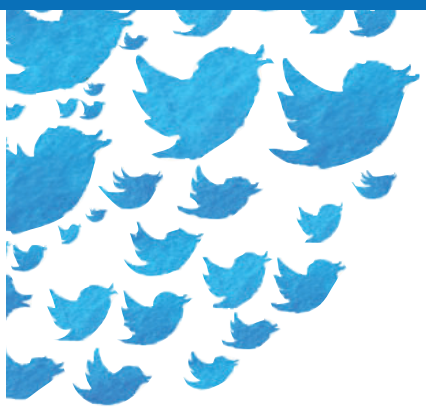
You've got the most junior doctors being absolutely fearless
Rohin Francis

Hot button issues

It's that idea of eavesdropping on conversations with the smartest people in the room that van Tulleken would miss the most if Twitter were to "go in the night." He says, "I don't think there is any way of getting that kind of curated, filtered analysis in real time from anywhere else." Although a range of other websites serve the medical community, few places match Twitter for the combination of real time distribution and discussion of hot button issues in the community. "It's the starting point for most immediate inquiries for me now," he says.

That's the case for Ali Beg, too, who admits that #medtwitter has helped broaden his research and reading of the academic literature that underpins medicine. "Since joining Twitter and participating in #medtwitter, I've increased my engagement with the literature, albeit based on stuff people tweet about more often," he says. That's helped make him a better and more well read doctor, he says. Indeed, he believes it aided his career progression. "I think it helped me secure my registrar role by exposing me to things I may not have encountered quite so easily," he says. "It made me a more competitive candidate by improving my education in my field."

For Francis #medtwitter, for all its faults, has been a net positive rather than net negative experience overall. "I'm quite invested in Twitter as a platform and have certainly spent quite a bit of time on there," he says. "It's benefited my career, for sure."



It flattens hierarchies and helps ensure all voices are heard

People power

Ali Beg also says Twitter has been useful in holding organisations to account when it comes to issues faced by frontline staff. He points to tthe Royal College of Emergency Medicine "messing up exam results" earlier this year by telling people who had failed that they had passed and its failure adequately to acknowledge the issue. "The initial response was not at all contrite," he says. "But when they got dragged over hot coals by doctors in public they apologised."

A similar thing happened with Sarah Clarke, a consultant cardiologist at Royal Papworth Hospital NHS Foundation Trust in Cambridge and recently installed president of the Royal College of Physicians, who, Ali Beg says, "overstepped her role" by condemning staff who planned to go on strike over a dispute about pay and conditions. The BMA told Clarke to apologise for her comments, in part because of the outcry on Twitter.

The Clarke controversy was an example of why #medtwitter is important, says Francis. "It's just so different to how we interact in real life with people at that kind of level," he says. "You've got the most junior doctors being absolutely fearless." Although he says he doesn't condone some of the personal attacks on Clarke, he does think that a benefit of #medtwitter is the way it flattens hierarchies and helps ensure all voices are heard.

"It's been quite powerful, in that respect," says Ali Beg, while acknowledging that it's not all "sunshine and rainbows." He points out an element of "toxic positivity" inherent in #medtwitter, claiming that some people in the community try to stifle open debate by smothering those who raise concerns with calls for rationality—calls often appended with hashtags such as #bekind #oneteam. "It's not really listening to genuine, valid concerns about things," says Ali Beg.

That's a worry shared by Eric Strong, clinical associate professor in medicine at Stanford University, California. Strong joined #medtwitter around eight years ago at his sister's exhortation. She is a teacher and had used Twitter and its community building tools to develop a fruitful set of contacts to help her with her job. She believed there must be something similar for medicine. "Initially, it felt kind of cool, because it was exactly like my sister described it for teachers," he says. "It was a way to connect with people all around the world with different ideas, knowledge and experience than I had."

It's not all sunshine and rainbows. There's an element of toxic positivity
Hassan Ali Beg

Yet Strong thinks that over time the initial idealism inherent in #medtwitter vanished and in its place a more toxic, insular culture has developed. The community became tribal, he says, partly in response to attacks during the covid pandemic by those who denied its existence or sought to downplay its severity. Strong worries that, by taking an aggressive approach to see off covid deniers, the #medtwitter community has also adopted some of that attitude as its own. "In addition to ad hominem attacks against both laypersons and other physicians they disagreed with, people also created these huge echo chambers," he says. He thinks that #medtwitter is now led by a few dozen "super-users" who use the weight of their massive followings to drive the conversation. "Because of how our brains work with social media, negativity drives more clicks and shares than positivity, [which] reinforced all these negative aspects of it," he says.

Francis too fears that #medtwitter has changed, not always for the better. "I have found myself stepping back a little bit from a lot of the discussion, because I found that it is becoming a bit toxic and a bit tribal," he says, adding that "people already were quite disinhibited online."

That said, the lack of adequate replacements (box) means that the potential loss of #medtwitter has its most active participants worried. "It's really changed the whole landscape of medicine," says Francis. "And its loss would be keenly felt."

Where would #medtwitter users go if Twitter disappears?

#medtwitter has a complicated past—and an uncertain future. But if Twitter were to disappear tomorrow, where would the denizens of #medtwitter go?

Mastodon, an open source alternative to Twitter, has been pinpointed as one potential place to which users could decamp—but it has issues when it comes to ease of use, onboarding users, and communicating across "instances" (or servers on Mastodon). "There is a group of people doing both platforms right now," says Eric Strong at Stanford University.

"Tomorrow, if Elon Musk put a lock on the door and said, 'I'm out. We're done. The company's gone,' I think that's the best alternative. But it's not the same. It's going to take years to get back to that same level of engagement and familiarity."

There are the platforms and forums that predated #medtwitter, such as Doctors.net.uk, which boasts a community of nearly a quarter of a million users. However, that forum is meant for conversations within the profession and lacks Twitter's ease of communicating key messages from medicine to the broader populace.

Another option could be Reddit, where subreddits such as r/JuniorDoctorsUK (reddit.com/r/JuniorDoctorsUK) provide a place for peers to exchange knowledge, concerns, and tips. However, the UK based Reddit community is underpowered when compared with its US alternative, says Francis—and also lacks the inter-hierarchical element that Twitter provides by giving opportunities for junior doctors and their more senior colleagues to interact on the same level.

"Reddit seems to be mostly dominated by more junior levels," says cardiologist Rohin Francis. "The great thing about Twitter was you have all kinds of levels of doctor there—that's one of its great strengths."

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WOMEN'S HEALTH

GPs caught in media spotlight on menopause

Exponents claim that a revolution is long overdue. For GPs facing pressure to prescribe hormone replacement therapy, recent high profile media attention on the treatment—and off-licence testosterone prescribing—is a mixed blessing, writes **Sally Howard**

Menopause is certainly big news at the moment. Last week, NHS England published its first human resources guidance for supporting colleagues through menopause, including allowing flexible working, to much fanfare—and media coverage.

There is a flipside to such positive developments: thanks to a rise in media representations of menopausal women, the UK is in the throes of what Susan Davis, an Australian clinical endocrinologist who is an adviser to the NHS menopause group steering committee, terms "menopause hysteria." And GPs are caught in the middle of it.

North Yorkshire GP Heather Wetherell tweeted in exasperation on 5 August: "[Hormone replacement therapy (HRT)] appointments demand totally out of control. This week we filled two surgeries with nothing but HRT queries. Yes, that's two surgeries of clinician appointments that patients with other illnesses weren't able to access." Wetherell has been treating menopausal women for three decades—for characteristic symptoms including hot flushes, vaginal dryness, and sleep problems—most of whom were, historically, she says, "so appreciative."

Wetherell noticed a mood shift after the May 2021 airing of *Davina McCall: Sex, Myths and the Menopause*, a Channel 4 documentary in which the presenter claims to have found "caseloads" of women whose GPs had declined to give them HRT, saying they didn't need it or were not menopausal. In June 2021 Labour MP Carolyn Harris formed a new All-Party Parliamentary Group (APPG) on menopause calling for a "menopause revolution" in "workplace policy, medical school training, public health messaging, and school curriculums."

"The demand in the past six months is like nothing before and I fear that my knowledge, like that of my colleagues, is now considered worthless," Wetherell says.

Davis says this is not an isolated case, "I understand it's shocking for British GPs right now," she says. She recently delivered a lecture at the British Menopause Society conference on the evidence base for testosterone use, an intervention championed by McCall.

The controversy is such that in May the Royal College of General Practitioners (RCGP), the Royal College of Obstetricians and Gynaecologists, and the British Menopause Society made a joint position statement. It pointed to the rise in requests for support from GPs that fall outside of current licensing and prescribing guidelines, such as requests for testosterone, and stated that it only supported testosterone "for supplementation of menopausal women with low sexual desire, if HRT alone is not effective, with women needing to be fully oestrogenised first." Testosterone is usually given as topical gel (1%) and is currently licensed for the treatment of males whose bodies do not make enough natural testosterone (hypogonadism).

NHS England is consulting on a women's healthcare pathway, and the National Institute for Health and Care Excellence (NICE) has begun the process of reviewing its 2015 menopause guidance. In October, the APPG on menopause published the report of its year long inquiry, saying that widespread action was needed "across all spheres" to tackle delayed diagnosis and difficulties in accessing HRT. Its recommendations included the scrapping of prescription charges for HRT in England, as in the UK's devolved nations, and the offer to all women of a health check at age 45 to help diagnose menopause earlier.

IMPROVING MENOPAUSE CARE QUALITY

NICE's 2017 menopause quality standards, endorsed by the RCGP, identify five areas as a priority to improve the care of patients:

- Diagnosis of perimenopause and menopause without the need for confirmatory laboratory tests
- Diagnosis of premature ovarian insufficiency with follicle stimulating hormone tests
- Ensuring those diagnosed with premature ovarian insufficiency are treated with HRT or combined hormonal contraceptive
- Reviewing those on HRT initially at three months and then at least annually
- Ensuring those who may experience a medical or surgical menopause are given information about fertility and the menopause prior to treatment

I fear that my knowledge, like that of my colleagues, is now considered worthless
Heather Wetherell

Davina McCall's documentary claimed to have found caseloads of women whose GPs had declined to give HRT

"T" and "wonderdrugism"

Central to GPs' gripes are the "wonderdrug" narratives that have arisen around HRT as well as off-licence testosterone use in women. Irene Redolat-Castella is a GP who has also seen a rise in patients presenting to her Redcar surgery requesting GPs prescribe these hormones.

"We're hearing condescending comments to clinicians, demands for testosterone off-label, as well as unrealistic expectations of HRT being the panacea for total happiness and bliss," Redolat-Castella tells *The BMJ*.

For Harrogate GP Chris Preece, such patient presentations are troubling. "I've got lots of patients suddenly asking for an off-licence drug," he says, "a proportion of whom are coming into the consultation primed with the view that any reticence to prescribe it on my part reflects either ignorance, misogyny, or both."

Obstetrician and academic Susan Bewley, who has an interest in overmedicalisation, believes the testosterone vogue—the synthetic androgens are dubbed "T" in commercial market parlance—smacks of wonderdrugism. "There are myriad voices saying its use is 'safe.' But safety is always relative to a drug's use," Bewley says. "Insulin, for example, can be safe if you have diabetes, but fatal if you don't."

Bewley adds that we also lack information about potentially damaging effects of testosterone use in women, pre- and postmenopausally. "We don't know if it has lasting effects on atrophy of the uterine lining, vulval skin, and urine infections, or whether it impacts pregnancy health or babies' outcomes," she says.

Preece sticks to British Menopause Society guidance, making sure that patients' oestrogen levels are sufficient (with HRT) to prevent grave side effects before contemplating off-label testosterone prescription, and stressing that testosterone is a limited treatment for low libido only. He warns patients that long term risks, including side effects such as acne or hirsutism, are poorly understood.

Davis says that while testosterone supplementation is useful for "a small subset of women," she is concerned the synthetic hormone is being touted as an "elixir."

"There is irrefutable evidence that testosterone therapy may improve sexual interest and reduce sexual distress in postmenopausal women with low desire and distress not caused by other factors (such as hypoactive sexual desire disorder), with efficacy being low to moderate for the majority," she explains.

By contrast, Davis says, the prescribing of testosterone as a treatment for fatigue, brain fog, and low mood is based on testimonials and anecdotes and not evidence. She is concerned that patients with depression will not be treated, and relationship problems that might require counselling could be overlooked, as a result of this "golden pillism."

Redolat-Castella has prescribed testosterone to women, but has discontinued the prescription in many cases. "My experience is that it hasn't been that helpful in improving symptoms and I have discontinued in these cases because of lack of effect; additionally, some forms are now out of stock," she says.

I didn't give the GP the option to try and talk me out of it

A PATIENT, IMPATIENT

Claire Waite Brown, Oxford, aged 50

"Watching the show (*Davina McCall: Sex, Myths, and the Menopause*) made me realise I was menopausal in the first place and explained a lot about experiences I had had, including reduced libido. I phoned my GP surgery and asked for a female doctor I had seen before.

"At the appointment, I exaggerated my symptoms a little—talking about night sweats that I had actually stopped having, but drawing on past experience of these. I said that I wanted HRT for my sex life, which has been affected by my menopause transition. I went to the surgery saying 'this is what I want,' and didn't give the GP the option to try and talk me out of it.

"We discussed the various options so I could choose what I wanted and she questioned why I thought HRT would help, but in the end she did prescribe HRT patches—oestrogel with utrogestan100.

"If it hadn't been for the show, I wouldn't have called my GP but I do feel the prescription has positively impacted my sex life."

I've got lots of patients suddenly asking for an off-licence drug
Chris Preece

Safety is always relative to a drug's use
Susan Bewley

Testosterone supplementation is useful for a small subset of women, but it is not an elixir
Susan Davis

Disease mongering

Ash Paul, a public health doctor interested in evidence based health services commissioning, believes that positioning menopause as a "long term female hormone deficiency" is a "classic case of disease mongering."

"Disease mongering describes a process of widening the boundaries that define medical illness in order to expand markets for those who deliver treatments," Paul says. He points to the overuse of the argument of the "risks" of natural menopause onset in view of the paucity of data around natural menopause onset.

Margaret McCartney, a *BMJ* columnist and advocate for evidence based medicine, tweeted on 18 June: "OK. Fed up of this now. If you are a doctor commenting on HRT and how useful it is/is not, and on the role of testosterone, please can you make sure your financial relationships with pharma are easy to find and with enough detail to enable an informed judgment on their impact."

Louise Newson, a Warwickshire GP who regularly appears on *This Morning* as a menopause specialist, is a leading proponent of the theory of menopause as a female hormone deficiency and champions the use of testosterone by menopausal women for improved concentration, sleep, libido, energy, and stamina. She appeared on the Davina McCall programme, and has previously declared accepting financial payments from pharmaceutical companies including HRT and testosterone manufacturer Besins.

Her statement says, "At no stage has any company with which I have had a financial relationship with ever influenced the medical advice I have given to patients or others. Nor has any such company had any control over the content of any lectures, articles, or any other work I have done nor over the content of my website."

Newson declined to be interviewed by *The BMJ*, providing a statement: "While Newson Health clinic has been open, neither the clinic nor Dr Newson have received any funding from any pharmaceutical companies. Any outside funding that Dr Newson has received in the past has been declared in the correct way." *The BMJ* makes no claim to the contrary, although others are not quite as clear in their financial declarations as Newson.

Regarding the prescribing of testosterone, Newson cited the 2015 NICE menopause guidance and its recommendation to "consider testosterone supplementation for menopausal women with low sexual desire if HRT alone is not effective." Newson added, "Patients in our clinic are assessed for various menopausal symptoms including low sexual desire. We follow this NICE guidance when we prescribe testosterone for our patients."

Towards better treatment

The joint position statement on the menopause welcomes political and media interest in the menopause as well as "the increased understanding of patients."

Similarly, Haitham Hamoda, the chair of the British Menopause Society, celebrates the erosion of stigma that's come from increased media representations of women going through the menopause, particularly in the workplace. Hamoda tells *The BMJ* that he would like to see individualised care and an end to the "postcode lottery" that some women face when it comes to quality of care in general practice.

The recent APPG report also expressed concern about the postcode lottery of menopause treatment. The group called for the creation of a national formulary for HRT to ensure that doctors can access the most accurate guidance on prescribing, for menopause to be incorporated in the GP Quality and Outcomes Framework to improve diagnosis and treatment, and for updated menopause training to be provided for GPs, other healthcare professionals, and medical students in training.

Hamoda says that menopause is an area in which he would expect most GPs to be up to date on patients' options. "In fact, most GPs offer good advice: telling patients what to expect in terms of symptoms and management options," Hamoda says. "Though you do have a small group of GPs who may not be aware of all treatment options who are anti-intervention and another small group who think that HRT is the answer to everything," he says.

If you're a doctor commenting on HRT please make sure your financial relationships with pharma are easy to find
Margaret McCartney

I'd like to see the end of the postcode lottery that some women face
Haitham Hamoda

Menopause and the Workplace, a 19 July report published by the House of Commons Women and Equalities Committee, recommends that training on menopause should be a mandatory aspect of continuing professional development requirements for GPs and that until then, "all GP surgeries should ensure that at least one member of their clinical staff has received specific training around menopause," with a menopause specialist or specialist service in every clinical commissioning group area by 2024.

Wetherell believes the current surge of demand in general practice could be alleviated if HRT moved to being managed by online pharmacies. Pressure might be alleviated, too, by the arrival of new NICE guidelines—to be published in August 2023 and to focus on managing urogenital atrophy, the long term benefits and risks of hormone replacement therapy, and cognitive behavioural therapy for managing menopausal symptoms. Also potentially helpful will be the arrival of a wider variety of treatments for menopause, including non-hormonal treatments for hot flushes.

Redolat-Castella believes the overemphasis on HRT's global benefits obscures the fact that for some women such treatment can be beneficial and "make them feel like themselves again." She says, however, that HRT is not guaranteed to "cure" tiredness, irritability, or emotional lability in postmenopausal women and "expectations should not be so high."

Menopause revolution aside, Preece would like to see a cooling of the media stoked antipathy towards GPs as menopause gatekeepers. "It is not our role as GPs to block necessary treatment or be obstructive and any media narratives that claim that this is our intention are damaging—for both GPs and patients," he says.

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