this week

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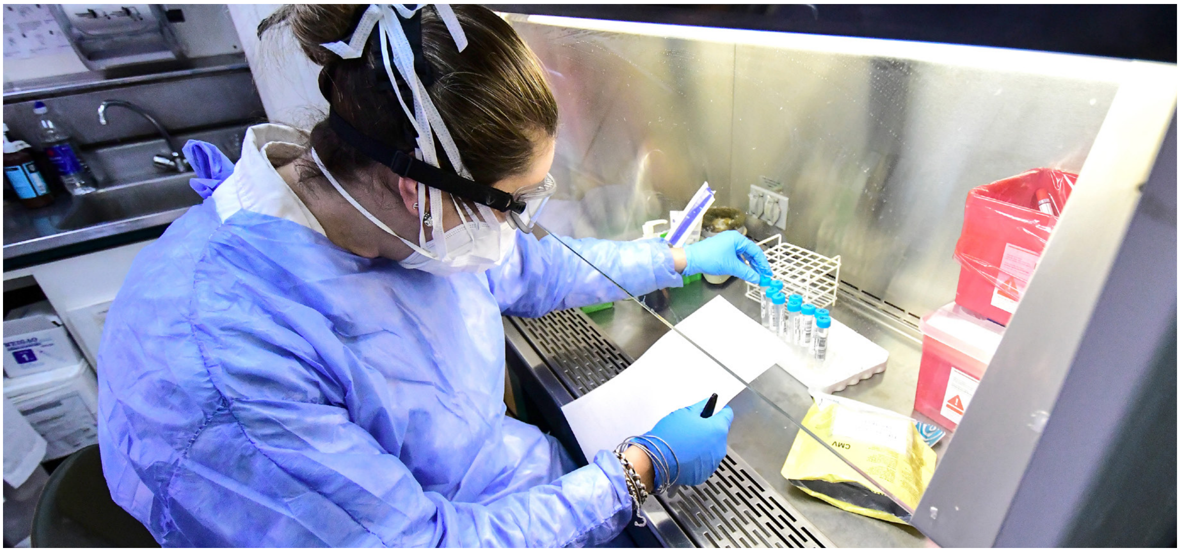


Statisticians call for better IVD control

In vitro diagnostic tests need stricter regulation, says the Royal Statistical Society, to ensure they are fit for purpose

Statisticians have called for better regulation of in vitro diagnostic (IVD) tests to ensure they are statistically sound and fit for purpose. The Royal Statistical Society (RSS) report was prompted by concerns about lateral flow tests used during the pandemic, although the recommendations cover all new diagnostic tests.

At the same time the MHRA, the drugs regulator, ordered a snap consultation as part of a drive to improve the safety of some high risk tests, including over-the-counter self-tests for HIV, glucose levels, and hepatitis and screening tests for a range of cancers.

The RSS report has been submitted to the covid-19 inquiry, which is gathering evidence on the effectiveness of testing technologies used in the pandemic. A working group of statisticians, co-chaired by Jon Deeks, professor of biostatistics at Birmingham University, and Deborah Ashby, a former RSS president and professor at Imperial College London, collaborated on the report with coauthors from Oxford, Cambridge, Edinburgh, and Birmingham universities and the London School of Hygiene and Tropical Medicine.

Deeks said, "The pandemic provided a microcosmic insight into inadequacies in current processes to evaluate and regulate diagnostic tests. It's important we learn from these failures and establish robust processes that can be applied across diagnostic tests."

Deeks presented the report at the Evidence Based Diagnosis conference in St Andrews on 29 May, co-hosted by *The BMJ*. The report, which has 22 recommendations, is published in the *Journal of the Royal Statistical Society*.

A key recommendation is that field or clinical evaluation studies be carried out to evaluate the performance of an IVD for each intended use, including the person to be tested, the target condition, and the facilities where testing occurs.

Another recommendation is for direct comparison of alternative IVDs and test strategies to provide evidence that directly informs clinical and public health decision making. On regulation, the report says the MHRA should collaborate with independent experts to revise the IVD licensing process.

On 21 May the MHRA launched a four week consultation on a policy that would require manufacturers to comply with additional measures for certain high risk IVDs, such as blood tests used to identify blood type before transfusions and tests to identify life threatening diseases.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;385:q1184

LATEST ONLINE

- Gaza: Just one working hospital remains in Rafah, as healthcare workers' death toll reaches 500
- Texas court rejects legal challenge by women denied abortions for dangerous pregnancies
- Private clinics are told not to prescribe puberty blockers

SEVEN DAYS IN

Junior doctors announce five day walkout ahead of general election

MARK THOMAS

Junior doctors in England have announced a five day walkout from 7 am on 27 June to 7 am on 2 July, after three months of talks with the government failed to result in a credible path to restoration of pay lost over the past 15 years. The move followed an announcement on 15 May that the BMA Junior Doctors Committee and the government had agreed to consider mediation.

JDC co-chairs Robert Laurenson (left) and Vivek Trivedi (far left) said, "For more than 18 months we have been asking Rishi Sunak to put forward proposals to restore the pay junior doctors have lost over the past 15 years—equal to more than a quarter in real terms.

"When we entered mediation with the government, we did so under the impression we had a functioning government that would soon be making an offer. Clearly, no offer is now forthcoming. Junior doctors are fed up and out of patience."

They said if Sunak made an offer acceptable to the committee they would call off the strike.

Saffron Cordery, deputy chief executive of NHS Providers, said of the "worrying" announcement: "Nearly 1.5 million appointments have been delayed since industrial action began, with strikes having now cost the NHS an estimated £3bn. Politicians and unions must urgently find a way to resolve all disputes."

Zosia Kmietowicz, *The BMJ* **Cite this as:** ***BMJ*** **2024;385:q1183**

Physician associates

BMA "clarifies" details of supervision of MAPs

Medical associate professionals, including physician associates, must have an immediately available, named supervisor in all healthcare settings, the BMA said in new guidance. It emphasised the importance of supervising doctors having allotted time for discussions and for reviewing patients, in accordance with existing guidance on scope of practice. Phil Banfield, the BMA's chair of council, said this would ensure doctors and employers were clear about their responsibilities and would win public confidence, but NHS Employers criticised the BMA for not involving other organisations in the guidance.

Cancer vaccines

NHS England launches scheme to boost sign-ups

Thousands of patients being treated for cancer in England could be invited to take part in trials of personalised vaccines as part of the NHS Cancer Vaccine Launch Pad scheme. The announcement came as the first patient in England was treated with a personalised bowel cancer vaccine, after an agreement with the German biotechnology company BioNTech to provide as many as 10 000 patients with precision cancer immunotherapies by 2030. The vaccines currently being trialled use mRNA and aim to stop cancer returning by enabling the patient's immune system to identify and destroy cancer cells.

Community services

Shift of spending has not matched promises

Promises by governments to move more care in England from hospitals to the community are not being met because of uneven funding, the Nuffield Trust has found. Spending on NHS community health services in 2022-23 was 4.2% below that of 2016-17, and public health spending was cut by 24%. In contrast, increases were seen in acute services (4.4%), mental health (5.3%), ambulances (5.2%), and primary care (3.3%). Sally Gainsbury (left), senior policy analyst at the trust, said, "Only by investing in care in our communities can we hope to address the many challenges presented by an ageing population and widening health inequalities."

Community pharmacy model is broken, say MPs

The Community Pharmacy Funding Framework is unfit for purpose and should be overhauled if more clinical services are to be delivered and increasing demand for drugs is to be met, says a report by the Health and Social Care Committee's pharmacy inquiry. The MPs recommended an independent review to identify weak links in the drug supply chain and determine how to respond to shortages better.

NHS constitution

Election disrupts key debate

Patient campaigners, including National Voices and the Richmond Group of Charities, called for a pause in government consultation on the NHS constitution or for an appropriate extension until after the general election. They said the consultation by the Department of Health and Social Care "falls worryingly short in terms of accessibility" and estimated that as much as a quarter of the population were "excluded from being able to respond and have their say on a document that will directly impact their experience of healthcare."

Violence

Man is charged over stabbing of GP in Kent

Richard Scott, a GP, was taken to hospital after being stabbed in the arm at the Barnard Medical Group's premises in Sidcup, Kent (above), on 23 May. The attack happened on the day the local medical committees' conference called for tougher sanctions on patients who attack GPs and their teams. Gary Bartlett, 63, of Saxon Walk in Sidcup, appeared at Bromley Magistrates' Court on 25 May charged with possession of an offensive weapon—a large kitchen knife—in a public place, as well as grievous bodily harm with intent.

Preparedness

WHO members pledge to agree treaty within a year

The World Health Assembly, the annual meeting of the World Health Organization's 194 member states, has agreed amendments to the International Health Regulations 2005 and committed to complete negotiations on a global pandemic agreement within a year.

MEDICINE

International news

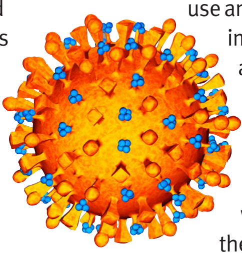
Surge in STIs risks global development goals

Rising cases of sexually transmitted infections and a slowdown in the decline of new cases of HIV and viral hepatitis mean the world is currently "off track" to meet targets for reducing new infections, which result in 2.5 million deaths a year, WHO has warned. Syphilis, gonorrhoea, chlamydia, and trichomoniasis account for more than a million new infections a day, and the goal is to reduce these to fewer than 150 million a year by 2030, but cases of syphilis (above) and treatment resistant gonorrhoea are increasing in many regions. Countries must do all they can to achieve the ambitious targets they set for themselves, said WHO.

WHO has called on countries to do all they can to reduce cases of syphilis and other STIs

First US bird flu case with respiratory symptoms

The US has recorded respiratory symptoms in a person with H5N1 flu (right), in what is thought to be the third human case in an ongoing outbreak among dairy farms. All previous confirmed cases of the infection in people had symptoms of conjunctivitis but no respiratory problems. The patient was being treated with oseltamivir and their symptoms were resolving, and there was no indication of person-to-person spread of A(H5N1) viruses so far, said officials. But the development has worried experts, given that influenza virus spreads through the airways, raising the risk of the virus mutating to achieve person-to-person transmission.



Call to reduce global death toll of antibiotic resistance

More than 750 000 deaths associated with antimicrobial resistance (AMR) could be prevented in low and middle income countries every year by improving infection control, increasing access to clean water and sanitation, and promoting uptake of child vaccines, a *Lancet* series has found. The authors propose global targets for AMR to be adopted at the UN General Assembly in September 2024, including a 20% reduction in inappropriate human antibiotic use and a 30% reduction in inappropriate animal antibiotic use. Without action the global death toll will rise steadily, they warn, with babies, older people, and those with chronic illness being the most vulnerable.

Dengue

Disease is "still global threat" to public health

Dengue "remains a global threat to public health," WHO has said, with more than 7.6 million cases reported in 2024, including 3.4 million confirmed cases, more than 16 000 severe cases, and more than 3000 deaths. While a substantial increase in dengue cases has been reported worldwide in the past five years, the rise has been particularly pronounced in the Americas. Currently, 90 countries have known active dengue transmission, not all of which have been captured in formal reporting.

Cite this as: *BMJ* 2024;385:q1221

PRIVATE HEALTH

The UK had **898 000** admissions to private hospitals in 2023—the highest ever and up **15%** on 2019. The biggest rise was in self-paid admissions, up **39%** since 2019. Insured admissions rose by **7%**

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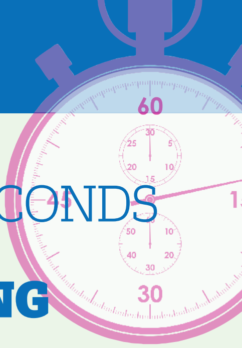


SIXTY SECONDS ON . . . PREPPING

BATCH COOKING CAN BE HELPFUL?

This isn't about cooking, it's about prepping for an emergency, such as when you were told you must stay at home during the pandemic.

THE LOO ROLL IS STILL IN THE LOFT

That's a start. The UK government has published new guidance encouraging all homes to have an emergency kit with enough non-perishable food that does not need cooking (so, tinned) for three days, with a minimum of 3 L of bottled water, ideally 10 L, for each person a day. Oddly, it doesn't mention loo roll.

DRIED PASTA IS NO GOOD, THEN?

No. But we should stock up on wind-up or battery powered torches and radios, spare batteries, power packs to charge our phones, a first aid kit, and hand sanitisers or wipes.

GREAT, I'LL BUY THAT LOT NOW

Hold on. Retailers are urging people not to do that all at once. A mad rush, coupled with post-Brexit red tape that makes it more difficult to restock, could leave the shelves looking bare.

DO PEOPLE HAVE ENOUGH STORES?

Good question. A poll released at the London Defence Conference on 22 May found that only 15% of people have an emergency kit, and more than 40% do not have three days of non-perishable food. So a gradual restocking is probably in order.

IS THAT EVERYTHING?

Not quite. We should also keep paper lists of things such as medications, news radio station frequencies, and phone numbers of power and insurance companies and close relatives, to be kept along with important documents such as birth certificates and passports in case of rapid evacuation.

CRIKEY, WHAT'S EXPECTED?

It could be a power cut, extreme weather events, another pandemic, ash cloud, cyberattack, or war.

ISN'T THIS A BIT OTT?

There are precedents. Sweden recommends a week's worth of supplies, as does Switzerland, which has also stockpiled food to feed its 8.7 million residents for up to four months.

Ingrid Torjesen, London

Cite this as: *BMJ* 2024;385:q1161

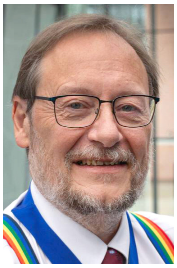
Labour's pledge to clear NHS waiting list in five years will be "hard to achieve"

The Labour Party's general election campaign pledge to clear the backlog of NHS patients waiting more than 18 weeks for treatment within one parliament will be a challenge, experts have said.

While they broadly welcomed the party's intentions, leading health professional bodies and think tanks insisted that these could be fulfilled only with sufficient funding, staff, and support for the workforce.

"It will take more than a few new scanners to deliver this promise and much more engagement with, and recognition of, staff who are leaving the NHS due to poor pay, conditions, and exhaustion," said BMA council chair Philip Banfield.

Calling for additional funding in NHS capacity, Tim Mitchell, president of the Royal College of Surgeons of England, said, "It is good for all parties to set out ambitious plans, but the sums have to add up if we want the NHS to be transformed."



The elephant in the room remains pay for the expertise of doctors
Philip Banfield

The NHS waiting list for elective care stands at 7.5 million treatments, and for over 40% (around 3.2 million) of these the wait is longer than 18 weeks.

The current target—that 92% of patients in England should start their treatment within 18 weeks—has not been met since 2016. Labour has pledged to hit the 92% target by the end of a five year parliament if it wins power on 4 July.

It said hospitals would be told immediately to start establishing weekend and evening clinics, citing "proven" local examples of NHS trusts setting up such "high intensity" theatre lists.

The shadow health secretary, Wes Streeting, told the BBC's *Today* programme on 29 May that the country faced a challenge "far greater" than in 1997 and that waiting lists could reach 10 million if the Conservatives were returned to office. "Our first step will deliver 40 000 extra appointments at evenings and weekends, paid for by clamping down on tax dodgers and closing non-dom loopholes," he said.

Spread thinly

Labour said it would roll out new ways of working, such as hospitals in the same area sharing staff and

THE NHS WAITING LIST for elective care stands at 7.5 million treatments, and for over 40% of these the wait is longer than 18 weeks

What are the main parties promising on health?

Labour

In addition to its plans to tackle lengthy waiting lists for NHS treatment, Labour has set out how it would provide greater support at a local level to get more people with health conditions and disabilities into work as part of its wider national back-to-work plan.

Jennifer Dixon, chief executive of the Health Foundation, said Labour's pledge to devolve powers to councils to tackle economic inactivity was a "good start and will allow areas to be flexible to the needs of local employers and residents and to experiment" with different approaches.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024;385:q1223

Conservatives

On 1 June the Tories promised to provide more treatment in the community by building 100 new general practices in England. The party also pledged to expand the Pharmacy First scheme—launched by the NHS in January—to increase the number of treatments pharmacies can provide without people needing to see a GP first.

In an interview with BBC's *Sunday with Laura Kuenssberg* programme on 2 June the health and social care secretary, Victoria Atkins, was pressed on how the pledges squared with the party's record in government, including the closure of 450 practices since 2013 and of more than 1000 pharmacies since 2015. Atkins defended the Tories' record, insisting that it had hit previous targets to deliver more GP appointments. The latest pledges would make the health service "faster, simpler, and fairer," she said.

Liberal Democrats

The Liberal Democrats announced on 2 June that they would reverse cuts to the public health grant made by the Conservatives that had left the country with a "ticking time bomb of health challenges."

The £1bn of investment each year would reverse the 28% real terms cuts to the public health grant to local authorities since 2015, the party said, adding that this would be funded by a crackdown on tax evasion. The Lib Dems' deputy leader and health spokesperson, Daisy Cooper, said, "It is time to recognise that it is far cheaper to prevent ill health than to treat it." The party had already announced plans to boost GP numbers by 8000 and give people the legal right to see a GP within seven days.

The party also pledged to introduce free personal care to help elderly people stay longer in their own homes. Sarah Woolnough, chief executive of the health think tank the King's Fund, said it was "heartening to see a political party pledge to begin to address the crisis in social care."

IAN FORSYTH/GETTY

Keir Starmer meets health and social care students in Middlesbrough in April

working on joint waiting lists. It has already estimated that £1.3bn will be needed to deliver the extra 40 000 appointments and to double the number of scanners to ensure speedier diagnoses. Labour has previously also pledged to use spare capacity in the private sector, free of charge to patients.

Banfield said, "'Spare capacity'—either in the private sector or at evenings and weekends—relies on the same doctors already working in our NHS, 24/7. Expecting them to spread themselves even more thinly won't cut it, now that goodwill has been so roundly eroded over the last few years.

"The elephant in the room remains pay for the expertise of doctors needed to clear these waiting lists."

Matthew Taylor, chief executive of the NHS Confederation, said, "To make inroads in tackling the waiting list we need long term planning, which means the right support and resources to ensure the extra beds opened this winter continue to be staffed, as well as opening new theatres to keep tackling the backlog."

He said that NHS Confederation members wanted a £6.4bn a year boost to capital funding to tackle the backlog of repairs and to invest in new technology and equipment.

➲ DAVID OLIVER, page 317

Matthew Limb, London

Cite this as: *BMJ* 2024;385:q1186

Former heart surgery lead charged with 14 counts of sexual assault

Blackpool Victoria Hospital's former head of cardiovascular surgery has been charged with sexually assaulting six female members of staff. Amal Bose, 54, has been bailed and is due to appear for an initial hearing at Lancaster Magistrates' Court on 7 June.

Lancashire Police were contacted by Blackpool Teaching Hospitals NHS Trust in March last year. "Following a long investigation and after consultation with the Crown Prosecution Service, former consultant surgeon and head of cardiovascular surgery Amal Bose has now been charged," said the trust in a statement.

In a statement the police confirmed Bose had been charged with 14 counts of sexual assault relating to six victims. "The alleged offending occurred between 2017 and 2022. Some of the counts encompass more than one incident." The offences have been charged under section 3 of the Sexual Offences Act 2003, which makes it an offence to touch another person if the touching is sexual, without consent, and without a reasonable belief that the other person consents.

Bose qualified at the University of London in 1994, after studying medicine at St George's Hospital medical school, and joined the trust in 2012. He became head of the cardiovascular surgery department in 2020. He had interim conditions placed on his registration last July after a complaint to the GMC.

A trust spokesman said, "The trust can confirm that a former member of staff has been charged with offences of sexual assault. The trust has been working with Lancashire Constabulary and cooperating fully with their investigation. I want to reassure patients and their families that the hospital remains a safe and caring environment, and the provision of services continues as normal."

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2024;385:q1188

Private doctor struck off for trying to sell unproved treatments

A doctor in private practice who tried to sell unproved treatments to a patient with advanced cancer has been struck off the medical register after the patient's daughter, herself a doctor, complained to the GMC.

The conduct of Julian Kenyon, who was medical director at the Dove Clinic for Integrated Medicine in Hampshire, was "wholly unacceptable, morally culpable, and disgraceful," said Aaminah Khan, chairing the medical practitioners tribunal.

Kenyon was consulted in May 2022 by Patient A, a man who had had stage IV metastatic prostate cancer diagnosed in December 2019. He had already received androgen deprivation therapy, chemotherapy, and radiotherapy and had recently been started on enzalutamide, a relatively new hormone treatment.

Patient A consulted Kenyon about supplementing this with ozone therapy, but Kenyon instead offered him a treatment plan consisting of cannabidiol, Claricell, Similase, and sonodynamic/photodynamic therapy. These treatments would initially cost around £13 000, Kenyon said, but if they were unsuccessful further treatment would cost £20 000. He also suggested blood tests, at a cost of £750, which the patient declined.

Later that day Kenyon emailed the patient several research articles, of which he was either the lead or sole author, that he claimed provided the evidence for his treatment plan. Of the results from treating metastatic cancer, he wrote that "10% get a complete response, no tumour. 40% get increased survival, 50% get no response. It is completely without side effects."

Kenyon's evidence was so poor it in effect makes it a total fabrication
Aaminah Khan

Patient A declined the treatment a week later when contacted by Kenyon. He died in May 2023.

Kenyon was found to have recommended inappropriate treatment and to have failed to discuss the treatment's uncertainties or conventional treatment options. These were far from exhausted, said the GMC's expert witness, Simon Russell, a consultant oncologist. He added that Kenyon's studies were poor quality research. Khan agreed that the evidence supporting Kenyon's efficacy claims was so poor that "it in effect makes this a total fabrication."

In weighing sanctions, the panel considered two previous findings of misconduct against Kenyon by fitness to practise tribunals in 2013 and 2014. The first had found deficient care and issued a warning. The second led to conditions on his practice, later lifted, over similar claims for sonodynamic/photodynamic therapy.

He has 28 days to appeal before erasure takes effect.

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2024;385:q1192

Sex diversity is linked to better postoperative outcomes

Patients have better postoperative outcomes when surgery is carried out by teams with greater sex diversity, shows research published in the *British Journal of Surgery*.

Teams in which at least 35% of the anaesthetists and surgeons were women achieved the best results, as patients had 3% lower odds of experiencing major morbidity within 90 days of the procedure, the study found. Major morbidity was defined as postsurgical interventions such as endoscopy through to death.

The research team assessed data on 709 899 major inpatient procedures carried out in 88 hospitals in Ontario, Canada, from 2009 to 2019. They looked at the effect of sex diversity in anaesthetic and surgical teams on postsurgical outcomes, as well as the sex of the surgeons or anaesthetists.

Across the hospitals 102 400 patients (14.4%) experienced 90 day major morbidity, and the median proportion of female anaesthetists and surgeons per hospital per year was 28%. Overall, female surgeons performed 6.7% of surgeries, and female anaesthetists treated patients in 27% of operations.

The odds of 90 day major morbidity were even lower at 8% when patients were treated by female anaesthetists or surgeons.

Ingrid Torjesen, London

Cite this as: *BMJ* 2024;385:q1176

TEAMS in which at least 35% of the anaesthetists and surgeons were women achieved the best results

GP leaders reject “venomous” language that “condemns” physician associates

Local GP leaders have persuaded their peers to reject “venomous” and “patronising” language that “condemns” physician associates, at the annual conference of UK local medical committees.

The LMCs conference overwhelmingly carried a motion stating it “has increasing concerns about the development and promotion of PAs in general practice.” But a sub-motion stating that it “condemns the use of PAs in general practice for anything other than administrative or simple procedural duties” was lost.

Four speakers spoke specifically against the sub-motion. “Who do we condemn?” asked Hussain Gandhi of Nottinghamshire LMC. “Do we condemn PAs for existing, following what has been offered to them? Do we condemn practices for employing them based on what they’ve been asked to do?”

“Support don’t condemn”

Gandhi said the “venom” of the PA debate “worried” him, adding, “It’s the same way I heard people speak about my parents when they came to this country. Why are we making PAs the scapegoat for the fact that general practice has been underfunded for years? Support, don’t condemn.”

Felicity Day of North Yorkshire LMC called on delegates to reject the sub-motion, “so that practices retain the right to build their workforces as they see fit.”

Gerald Clancy of Oxfordshire LMC was one of five speakers in favour of the motion. “Unchecked, the failed PA experiment could lead to an extinction level event for the medical profession in the NHS,” he told a busy hall at the start of business on the second day of the conference.

Chris Morris of the GP registrars committee, also speaking in favour, said, “PAs working in general practice and seeing undifferentiated patients makes a mockery of our extensive training.”

Sarah Matthews, responding to the debate from the conference top table, flagged the word “complicit” as a “bit of a problem” in a

“Use mass resignation threat over contract”

GPs have told the BMA to “use the threat of mass resignation to improve the NHS offer to practices,” arguing that “being prepared to walk away may be more effective than industrial action.”

The motion, which passed, also instructed the BMA’s General Practitioners Committee to “develop viable alternatives” to the GMS contract, including “actively supporting GP practices to work outside the NHS.”

The committee entered a dispute with NHS England over this year’s changes to the contract, which were imposed in April. It has argued the below-inflation core funding rise of 1.9% would leave practices on the brink financially and at risk of closure.

Speaking in favour of the motion, Frances O’Hagan, a GP from Northern Ireland’s Southern LMC, said the threat of mass resignations had worked in Northern Ireland. “I warn you, don’t threaten anything that you’re not going to follow through on. You don’t threaten this to improve an offer—you threaten it because you’re going to do it,” said O’Hagan. “What happened with us was, instead of handing in undated resignations, we had a lot of dated resignations. That’s what brought the other side to the table. We have an agreement for this year.”

GPs from Scotland and Wales also spoke in favour of the motion, as well as GPC England’s chair, Katie Bramall-Stainer (below). She said, “The cavalry is not coming. You are the cavalry. Your destiny is a choice. Do not leave it to chance.”

She added, “Before we even start to consider undated resignations, we have to take action now. We have to vote in the ballot.”

GPs in England will be balloted from 17 June to 29 July on whether to take collective action over the imposed contract.

Although the motion passed in all parts, some GPs raised concerns over the section that called for alternative ways of working outside the NHS. They argued that the committees should focus on supporting GPs who were committed to working in the NHS and warned against general practice following the dental model.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;385:q1182

SARAH TURTON/GPDF

> **It's the same way I heard people speak about my parents when they came to this country** Hussain Gandhi

further sub-motion that stated that the conference "believes that the General Medical Council is complicit in the government's agenda to create a cheaper and inferior delivery model of primary care by using PAs in place of GPs."

But Paul Evans from Gateshead and South Tyneside LMC responded, "I absolutely stand by this," drawing enthusiastic applause from the floor. Earlier, he had proposed the sub-motion, saying, "The GMC have clearly been complicit: it has literally taken money to deviate from its job of regulating doctors to regulating another profession."

Delegates also overwhelmingly carried a separate motion calling on the BMA's general practitioners committees across the UK to lobby the government "to ensure that general practitioners are the main provider of primary care, and ensure that any plans of replacing this professional workforce with non-medical professional entities be rejected."

Jennifer Richardson, *The BMJ*

Cite this as: *BMJ* 2024;385:q1162

Conference roundup

Patients should be able to self-refer to ADHD services

The BMA's GP committees across the UK will "work with and lobby" relevant stakeholders to allow patients to "self-refer to NHS ADHD and other neurodiversity services, without the requirement to consult their GP." Proposing the motion, Annie Farrell, chair of Liverpool LMC, said that poor NHS provision had left a "vacuum" for patients. Her own local NHS was "shelling out hundreds of thousands of pounds for private online assessments," which could be of variable quality. Patients should have access to a "local, comprehensive, appropriately funded and staffed service," said Farrell.

Call to review maternity record keeping systems

Delegates voted for a review of standalone maternity clinical record keeping systems and for the records to be interoperable with GP systems. The motion raised concerns about the development of healthcare computer systems that do not integrate adequately with general practice clinical systems. Rachel Rutter, the GP who proposed the motion, said that the siloing of patient data "bred inefficiency" and put patients and GPs at risk.

GPs ask to be able to treat their own patients privately

GPs said they should be able to treat their patients privately "in the same way [as] other appropriately trained clinicians" such as secondary care doctors. Representatives urged the BMA's GP committees to "ensure there are no contractual restrictions on practices seeing private patients, subject to appropriate fair systems" and ensure that practices are "not unfairly penalised financially by seeing private patients in NHS facilities." GPs are allowed to treat patients privately only if they are registered at other practices. Proposing the motion, Ben Lees of Gloucestershire LMC, said, "Consultants can offer private consultations, regardless of whether they are seeing them on the NHS—why are GPs treated differently?"

Delegates share stories of patient violence amid calls for tougher sanctions against perpetrators

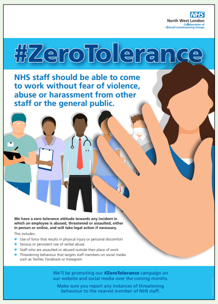
GPs' leaders have called for tougher sanctions on patients who perpetrate violence against doctors and their teams and more support for surgeries to recognise the surge in incidents occurring in general practice.

Representatives at the conference heard firsthand accounts from GPs who had been on the receiving end of violence from patients. The meeting passed a motion demanding that the criteria for inclusion in violent patient schemes be relaxed.

It also called on all UK governments to ensure funding for violent patient schemes was increased and for the BMA's UK General Practitioners Committee to lobby governments for more severe sanctions on perpetrators.

In 2022 a *BMJ* investigation found that the number of violent incidents at UK general practices recorded by police forces had almost doubled over the previous five years.

Sally Tyrer, a GP in North Yorkshire who proposed the motion, described an incident that occurred in her local area last year, when a small rural surgery was set on fire by a patient while staff and patients were in the building. Tyrer said, "This horrific incident caused massive damage to the building, untold lasting damage to the staff, and shook our primary care community to its core." She said that, although they hoped the incident would be a one-off extreme example, "it was actually the beginning of a worrying trend" and that referrals to their local special allocation service (SAS; originally known as the violent patient scheme) had increased "like never before."



NHS staff should be able to come to work without fear of violence, abuse or harassment from other staff or the general public.

We have a zero tolerance attitude towards any incident in which an employee is abused, threatened or assaulted, either in person or online, and will take legal action if necessary.

This includes:

- Use of force that results in physical injury or personal discomfort
- Serious or persistent use of verbal abuse
- Staff who are assaulted or abused outside their place of work
- Threatening behaviour that targets staff members on social media such as Twitter, Facebook or Instagram

We'll be promoting our #ZeroTolerance campaign on our website and social media over the coming months.

Make sure you report any instances of threatening behaviour to the nearest member of NHS staff.

The SAS scheme was introduced in 2004. It provides primary care services in a secure environment—usually a GP surgery after hours, with additional onsite security—to patients who are referred to the scheme after being removed from their own GP's patient list because of an incident that was reported to the police. But Tyrer argued that the scheme was not fit for purpose.

"The providers on the whole lack funding, training opportunities, and adequate security. Many of the patients on the SAS scheme have significant vulnerabilities and complex health needs. Our rurality means that they often have to travel significant distances on limited public transport."

Tyrer called for better funding for the SAS scheme and a rewrite of the rules to ensure easier inclusion in the scheme. "Above all we need a strong, unequivocal message that violence against primary care is unacceptable," she said.

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2024;385:q1159


NEW DELHI MUNICIPAL COUNCIL

THE BIG PICTURE

New Delhi records its highest ever temperature

New Delhi recorded a temperature of over 50°C on 26 May—its highest ever—and 37 other Indian cities reached 45°C the same week. One related death has been officially recorded, although at least 13 more have been reported nationwide.

Officials are looking to verify the record breaking temperature reading, with some speculating that it may have been due to a faulty sensor. Nevertheless, officials have warned of potential water shortages in the capital.

The India Meteorological Department warned of a "very high likelihood of developing heat illness and heatstroke in all ages," with "extreme care needed for vulnerable people." The heatwave, which has been ongoing for weeks, has been classed as "severe," meaning 6.5°C above average.

Chandrakant Lahariya, a doctor in Delhi, told the BBC that medical consultations had risen during the heatwave. It was having a particularly negative effect on elderly people with pre-existing conditions, he said, and on "some of the poorest and migrant workers who are working in the construction sites and other places."

India's national grid has seen its highest demand this year for power, at 239.96 gigawatts, as people turned to using air conditioners at home and in offices. Bhajanlal Sharma, chief minister for the state of Rajasthan, said that round-the-clock monitoring was being done to ensure a continued supply of electricity and water, adding that leave had been cancelled for officers and staff in the electricity, public health engineering, and medical departments.

The high temperatures may also affect the country's general election result. The Election Commission said that turnout in the Delhi region was down from 60.5% in 2019 to 57.67%, the lowest in 10 years.

Election rallies held in countries that experience high temperatures can contribute to the risk of heatstroke and heat stress. In India thousands of people have attended political events outdoors during the hottest hours of the day, despite health authorities urging them to avoid going outside from 11 am to 4 pm. But the difficulties in accurately recording deaths caused by heat mean that mortality figures are hard to judge.

A peer reviewed study published on 14 May by the World Weather Attribution research group reported that extreme temperatures in South Asia "are now about 45 times more likely and 0.85°C hotter," because of climate change.

Mun-Keat Looi, *The BMJ* **Cite this as:** ***BMJ*** **2024;385:q1198**

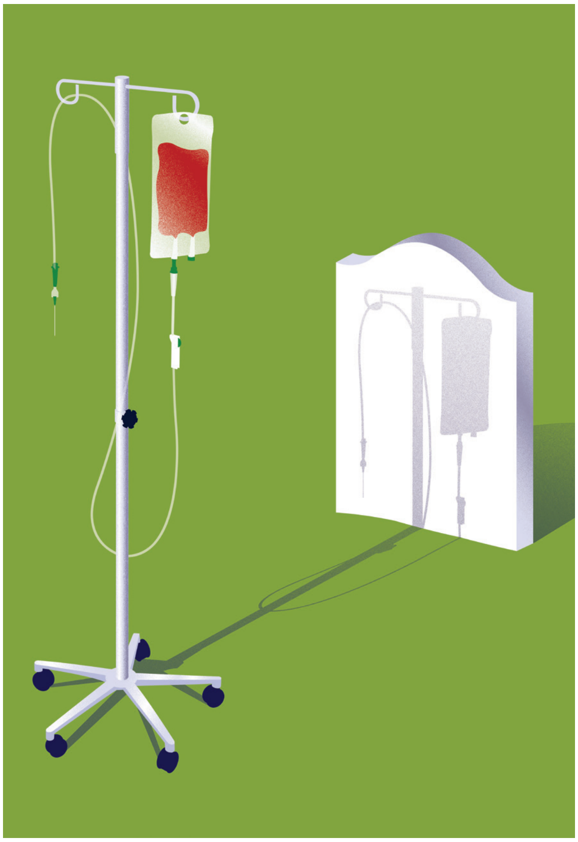
INFECTED BLOOD INQUIRY

Infected blood: an appalling medical failure

The role clinicians played in the biggest treatment disaster in NHS history has been laid bare by the Langstaff six year inquiry. **Clare Dyer** reports

When Arthur Bloom died in 1992 aged 62, an obituary published in *The BMJ* lauded him as "one of the world's leading authorities on haemophilia and von Willebrand's disease." A professor of haematology at the University of Wales College of Medicine, Bloom chaired the UK Haemophilia Centre Doctors' Organisation (UKHCDO) "when the transmission of HIV by clotting factor concentrates was first recognised and early measures taken for its prevention."

DHSS staff did not attempt to interfere with the practice of clinicians Diana Walford



NEIL WEBB

Another obituary, published in the Royal College of Physicians' "Inspiring physicians" series, stated that Bloom's "meticulous scientific work and dedication to his patients" meant that the haemophilia centre in Cardiff, which he headed, became "one of the finest in Europe, with an international reputation for excellence." However, a recent caveat to that obituary, published on the college's website, notes that "Bloom has since been found to have played a significant role in the infected blood public health scandal."

The six year inquiry into that scandal, chaired by the former high court judge Brian Langstaff, found a catalogue of failures amounting to "a calamity" by successive governments, officials, and doctors that had allowed tens of thousands of people to be infected with HIV and hepatitis C, in the biggest treatment disaster in NHS history. "This disaster was not an accident," says Langstaff. "The infections happened because those in authority—doctors, the blood services and successive governments—did not put patient safety first."

Langstaff, who describes the scale of what happened as "horrifying," says in a footnote to the summary of his report, "I acknowledge that many clinicians devoted a life to serving medicine, and there may have been a range of reasons why people allowed these failings to happen or caused them by their own actions. This sadly does not diminish the appalling nature of what occurred."

Bloom's influence

From 1970 to the early 1990s an estimated 30 000 people in the UK were given blood products or blood transfusions infected with hepatitis C or HIV, and more than 3000 have died as a result. Around 1250 people with bleeding disorders were infected with HIV, and three quarters of them have died. Almost all of those with haemophilia who were infected with HIV were also infected with hepatitis C.

The 2500 page inquiry report lays bare the key role that Bloom played. From 1979 to 1985 he was the leading haemophilia specialist in the country, chairing the UKHCDO. His centre at Cardiff was one of seven supraregional reference centres. The report finds it "difficult to understand why UKHCDO and the reference centre directors were so painfully and dangerously slow to recognise and react to the risks of AIDS being transmitted to their patients."

As for officials in the then Department of Health and Social Security (DHSS), who were equally slow to react, they were largely taking advice from one clinician—Bloom. Diana Walford, who was a medical officer in the DHSS at the time, told the inquiry that the department's medical staff "did not attempt to interfere with the practice of clinicians, who jealously guarded the concept of clinical freedom."

Bloom's views, says the report, were also "heavily influential" on the Haemophilia Society, the charity representing people with haemophilia, leading it to adopt a "head in the sand" attitude and to downplay the risk of developing AIDS.

The spread of AIDS

By the mid-1960s people with haemophilia were being treated with the frozen blood product cryoprecipitate. By the early 1970s drug companies, chiefly in the US, began separating the factor VIII protein from pooled plasma, creating products that were much more convenient to use and could be administered at home.

The UK was still not self-sufficient in blood products, and the commercial products, which were licensed for use in the UK from 1973, were embraced by haemophilia centres. But the plasma was pooled from the blood of tens of thousands of paid donors, many from high risk groups such as prisoners and drug addicts.

By the mid-1970s there were repeated warnings about the risk of infection from factor VIII imported from the US. The virus that causes hepatitis C wasn't identified until 1988, but there were warnings of its risks from 1974. For some time

JEFF MOORE/PA/ALAMY

The inquiry report from Brian Langstaff (left centre) lays bare the role that Arthur Bloom (above), professor of haematology, played in the scandal

a number of doctors held the view that hepatitis C was a mild or benign disease—which was "a collective failure of judgement among the many who asserted it," says the inquiry report. By 1978 there were reports that the virus, then named non-A non-B hepatitis, was linked to persistent liver damage.

In July 1982 the assistant surgeon general of the US wrote to all haemophilia centres in the country to alert them to the spread of AIDS to people with haemophilia. A week later the US Centers for Disease Control and Prevention (CDC) reported three cases of AIDS in people with haemophilia. In the UK, Harold Gunson, consultant adviser on blood transfusion to the chief medical officer at the DHSS, was alerted that same month.

At a meeting at Heathrow Airport in January 1983 including 21 doctors who treated haemophilia, John Craske, a virologist with the Public Health Laboratory Service, told attendees that AIDS was an "intractable" disease and that five of 10 people in the US who were infected had died. In March 1983 Bruce Evatt of the CDC wrote to Bloom to tell him that the US had 13 confirmed cases of AIDS among people with haemophilia and a further five highly suspect cases. All had received factor concentrates. The inquiry report notes, "There is no evidence that Professor Bloom circulated this letter at the time."

In April 1983 Bloom reported a probable case of AIDS at his own haemophilia centre to the Communicable Disease Surveillance Centre. But a few days later he sent a statement to the Haemophilia Society's members saying that "the cause of AIDS is quite unknown and it has not been proved to result from transmission of a specific infective agent in blood products." He added that the number of AIDS cases was small and that, "in spite of inaccurate statements in the press," he was unaware of any proved case in "our own haemophilic population."

In May 1983 Spence Galbraith, director of the Communicable Disease Surveillance Centre, sent a paper to the DHSS in which he stated, "I have reviewed the literature and come to the conclusion that all blood products made from blood donated in the USA after 1978 should be withdrawn from use until the risk of AIDS transmission by these products has been clarified."

A few days later a meeting of UKHCDO reference centre directors decided that it would be "circumspect" to use only NHS materials for young children and people with mild haemophilia but that there was, "as yet, insufficient evidence to warrant restriction of the use of imported concentrates in other patients in view of the immense benefits of therapy."

But in October 1983—two months after the UK's first known death from AIDS in a person with haemophilia—Bloom dismissed a suggestion at the UKHCDO's annual general meeting that patients should revert to using cryoprecipitate, saying that "he felt that there was no need for patients to stop using the commercial concentrates because at present there was no proof that commercial concentrates were the cause of AIDS."

"There can be little doubt," says Langstaff in his report, "that possibly by March 1982, and certainly from July 1982 onward, it was known in the UK to both some clinicians and some within government that there was a real risk that blood, and blood products in particular, might transmit the cause of AIDS." By the end of 1982, says the report, "haemophilia centre directors (according to Charles Rizza, the director of the Oxford haemophilia reference centre) knew there was a real risk that AIDS could be transmitted by an infectious agent carried by blood products."

Clinicians should have made time limited changes, such as reverting to cryoprecipitate, to deal with the crisis, Langstaff concludes. But the official rhetoric was "that of reassurance rather than realism." Haemophilia clinicians "failed to adjust treatment policies

as should have occurred; failed to tell patients adequately of the risks to them as individuals; and when infections were known, frequently failed to tell the patient concerned as soon as they reasonably could, or appropriately."

The failure to explain the risks and benefits of treatment to those being treated was "widespread and profound."

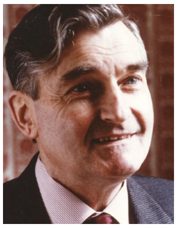
Children infected

Despite the UKHCDO's conclusion that it would be "circumspect" to use only NHS products for young children and people with mild haemophilia, children were given commercial products during trials without their parents' informed consent. Among those instrumental in the research was Craske of the Public Health Laboratory Service.

The report states, "Previously untreated patients—in particular children—were sought out to become the subject of research, and in some cases to be given treatments which were unnecessary or conferred no advantages but only additional risks."

Around 380 children with bleeding disorders were infected with HIV. "Many of those died in childhood or young adulthood, having endured a level of pain and fear that no child or young person should ever have to face," says the report. "How did it happen that in the second half of the 20th century so many children could be infected with fatal viruses from their NHS treatment?"

What happened to the pupils at the Lord Mayor Treloar college in Hampshire—which was seen as a unique resource for research owing to the number of children with haemophilia who boarded there and the presence of an NHS haemophilia centre on site—was a "nightmare of tragic proportion," says the report. Of the 122 pupils with haemophilia who attended the school from 1970 to 1987, only 30 survive.



All blood products made from blood donated in the USA after 1978 should be withdrawn from use

Spence Galbraith

Pupils were enrolled in trials of prophylaxis and given weekly or more frequent injections using large amounts of commercial concentrate from different manufacturers. The risks were downplayed, and parents didn't give informed consent. Langstaff concludes in his report that it was known at the time that this "enthusiastically intensive and largely indiscriminate" use of large amounts of different commercial concentrates was unsafe. He states that clinical staff were well aware that the heavy use of these products risked causing AIDS.

EDITORIAL

Inquiry details failure after failure

Even now, transfusion practices could and should be safer

The final report of the UK Infected Blood Inquiry exposes the catastrophic failings that devastated lives through transfusion transmitted HIV and hepatitis viruses.[1]

Other countries completed similar inquiries over 20 years earlier,[2 3] and Brian Langstaff, the inquiry's chair, condemned deliberate delays by successive governments that effectively silenced more than 30 000 people. By the time the inquiry was finally commissioned in 2017, almost 3000 people had already died of illnesses caused by infected blood and blood products.[4]

Failure to invest in domestic production of factor VIII in the 1970s is one of the many ways in which patients were failed.[5] Of those infected with HIV, 1250 had the clotting factor VIII deficiency haemophilia A[6] and were infected by imported factor VIII concentrates made from blood from high risk donors, such as drug users and prison inmates. Most patients with factor IX deficiency—haemophilia B—were treated with UK produced concentrates and remained HIV negative, but many became infected with hepatitis C. At that time, 1 in 1500 UK donors had this yet to be identified virus.[7]

BENJAMIN CREMAL/GETTYIMAGES

The report was particularly critical of the UK government's response to the emergence of HIV. The UK continued to express uncertainty that HIV was a bloodborne virus despite clear warnings from the US Centres for Disease Control and Prevention (CDC) in March 1983. This was followed by false claims, repeated over many years, that the infections were inadvertent and that patients were given the best treatments available at the time. Langstaff strongly condemned the cover-up and a consistent failure to prioritise patient health and safety in decision making.

While clinicians were impressed by the rapid effectiveness of the novel clotting factor concentrates and their ease of administration, the report emphasises that the potential for transmitting bloodborne infections had been known since the inception of the NHS in 1948.

Had the risks been explained to patients or their parents, fewer would have been infected. Further, had they been told of their infections in a more compassionate way and properly supported in the aftermath, their trauma could have been substantially reduced.[8]

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Elisabeth Buggins, patient representative, Chetton, Shropshire

In October 1979 Craske had alerted the school to the fact that mixing different manufacturers' products might increase the risk of hepatitis.

As well as those infected through blood products, around 26 800 people were infected with hepatitis C, and 80 to 100 were infected with HIV through blood transfusions. The overenthusiastic use of blood by clinicians in the 1970s and the early 1980s, particularly surgeons and obstetricians, caused some patients to be given unnecessary transfusions. Women were "topped up" after labour to help get them "up and about" caring for their babies, when they could have been given iron tablets. Doctors delayed "telling patients they had hepatitis C, or should be tested for it, thereby preventing the individual from controlling its worst effects, seeking timely treatment, and limiting the spread to others."

The UK wasn't alone in having an infected blood scandal. In some countries, such as Canada, France, and Japan, criminal prosecutions were brought decades ago. But the UK is an outlier in having resisted an investigation into the facts for so long. Successive UK governments covered up the truth, claiming that the infections had been inadvertent and that the treatment given was the best available.

Clare Dyer, legal correspondent, *The BMJ*

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Unsurprisingly, the inquiry report recommends greater patient involvement in decision making at all levels of healthcare. Supporting patients to be decision makers in their own care is both ethically right and clinically helpful.

Easy access to comprehensive personal health records is important, for example, to correct errors and encourage shared learning for delivery of holistic care.[9] Seeking patients' perspectives on treatment through clinical audit and quality improvement should be routine.

Engaging patients as partners at policy level is equally important, and the inquiry heard how patients in Ireland have been part of a Product Selection Monitoring Advisory Board since 2002,[10] leading to better outcomes for patients with haemophilia and improved cost effectiveness.

Langstaff's recommendations also focus on current blood transfusion practice, with implications for more than 3000 patients each day across the UK. Patients can be confident that infection safety standards are now rigorous,[11] but comprehensive national audits in 2021 and 2023 show that documented evidence of consent to transfusion was still missing for a third of patients.[12]

Ensuring better care

The traceability of blood from donor to recipient remains unreliable, and data on clinical outcomes following transfusion are poorly documented and not systematically collated to enable feedback to clinicians and hospital leaders.[13] According to hospital transfusion staff, local NHS trusts are still ignoring major safety concerns despite a fourfold increase in transfusion related death rates over the past 10 years in the UK (35 deaths in 2022 *v* 9 in 2012).[14]

In responding to the report, the UK prime minister, Rishi Sunak, promised comprehensive compensation for affected patients and their families, and the chief executive of NHS England, Amanda Pritchard, committed to addressing the failings and preventing future harm. Immediate fixes are available,[15] including increased use of evidence based, inexpensive alternatives to blood transfusion, such as tranexamic acid for patients having surgery, and more diligent correction of pre-operative anaemia. These will also help with ongoing concerns over blood shortages.[16-18] Consent for transfusion of any blood product should be embedded within the Getting It Right First Time programme,[19] which aims to reduce variations in practice across the NHS, and funding to enhance electronic clinical systems for safe blood transfusion should be prioritised.[20]

Progress in these areas, including transfusion training for all relevant healthcare workers and improved staffing,[21] is long overdue. Clear ownership of the problems remaining within transfusion practice is now required, along with the development and implementation of effective solutions through stronger leadership, an improvement mindset, full partnership with patients, evidence based practice, and an enduring focus on patient safety.[22] These tenets would also help to address NHS failings in other areas[23-25] and reduce the risk of further patient harm in future.

Profound harm has already been done to the individuals and families affected by infected blood. For many, the inquiry's report has sadly come too late, but its findings and recommendations can still stop a growing complacency over the safety of transfusion practices.

The report is also a clear signal to involve patients as equal partners in transforming the use of blood and blood products, protecting them from the harms we know about and remaining ever vigilant for new threats.

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Find the full version with references at http://dx.doi.org/10.1136/bmj.q1220

INTERVIEW

Taking women's pain seriously: the surgeon who spoke out about vaginal mesh

Sohier Elneil, a surgeon, expert in women's pain, and founder of the first NHS vaginal mesh removal centre, speaks to **Rebecca Coombes** about fighting for better care for her patients

Sohier Elneil came into the public eye when she started speaking out about the devastation that implantation of vaginal mesh had caused to many women. For over 25 years, mesh was used to treat pelvic organ prolapse and stress urinary incontinence in the UK. Its use is now suspended outside of strict conditions, but it is still in use globally, including in Europe and parts of the US.

Elneil might have angered many professional colleagues with her outspokenness, but she has found vindication in the findings of a national inquiry that led to sweeping changes in women's care. She spoke to *The BMJ* as she took up her post as the first professor of urogynaecology at University College London (UCL).

CV

Sohier Elneil, consultant urogynaecologist and uro-neurologist at UCL University Hospitals NHS Foundation Trust and the National Hospital for Neurology and Neurosurgery.
MBChB, University of Zimbabwe

1990-97 Training posts, Addenbrooke's Hospital, Cambridge

1991-92 Medical officer, Addis Ababa Fistula Hospital, Ethiopia

1995-2001 Research fellow/PhD student, University of Cambridge

2002-04 Trainee in urogynaecology, UCL

2004 Consultant, UCL

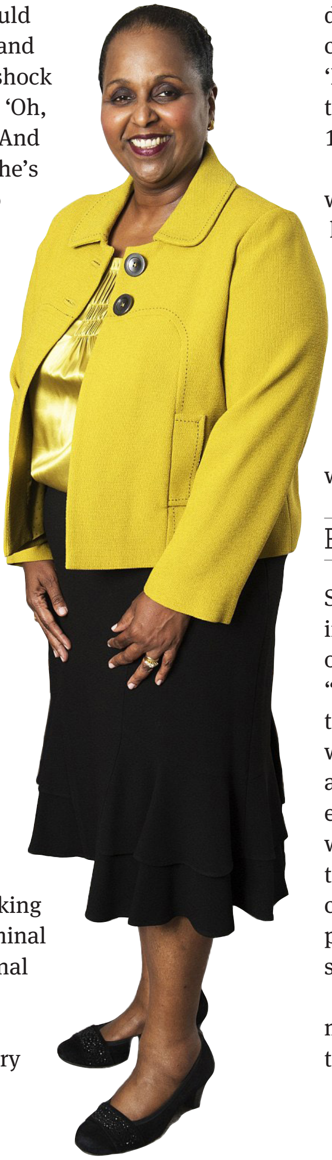
2020-23 Clinical lead for London Mesh Complications Centre
UCL professor of urogynaecology

2021 to date Chair of NHS England research and education group on mesh

Speaking out made me a pariah

Elneil's first case of extracting mesh was in 2005, a job she describes as "horrible." "At the beginning, the women's stories had a terrible effect. I couldn't believe they were so badly treated," she says.

"I was surprised because when I was in Africa [where Elneil spent some of her childhood], I understood it as there were strong patriarchal societies that could explain it. In my head, England was not like that. So I got a shock because patients would say, 'Oh, so-and-so put the mesh in.' And I would think, 'I know him, he's a nice guy, why would he do this, and why would you not help her?' I couldn't comprehend it."



Elneil started talking at societal and college events about the problems with mesh but found few allies. At first she was simply excluded from events, but soon the attacks became personal. She was reported to the GMC many times, mainly by fellow urogynaecologists, the biggest implanters of mesh. "I was very upset. It felt like a war. They were saying I was removing mesh and harming patients unnecessarily."

Elneil encountered women injured by mesh implants in 2007 while working in a clinic focused on abdominal and pelvic pain at the National Hospital for Neurology and Neurosurgery, London. "I remember examining the very first patient—she still comes to see me once every few years—and you could feel the mesh come through into the vagina. That was the beginning. You'd ask women, what surgery did you have? And they would reply, 'Oh, I was told it was just a little tape or a ribbon.'"

There was a lack of understanding from surgeons about how women work

Elneil says the patients she saw had not been listened to, and their surgeons had been blind to the efficacy of the device, partly owing to the massive commercial push for mesh products. "These surgeons didn't explain the possible complications. It was all about: 'I'm telling you this is the right thing for you.' They were almost 100% men."

She adds, "I also think there was a lack of understanding of how women work; that the vagina isn't just a piece of skin. The justification was that mesh was fine for hernias. But you're putting a piece of immobile plastic in a mobile tissue—a vagina, bladder, rectum that moves—so how is it not going to wear and tear?"

Financial incentive

Surgery that involves any form of implant operates in a huge field of commercialisation, Elneil says. "If you find one simple product that you can implant in a patient with a very common problem, you are talking serious money," she explains. "With mesh, it started with two or three companies. And then several device companies created a version of it, cutting products in different shapes and sizes."

As the use of mesh became mainstream, the pressure to conform was felt even in the operating theatre. Elneil recalls being pressured by a sales representative in her own operating theatre in 2006. “This representative used to just show up in my theatre and demand to know why I wasn’t putting in mesh, and why not her brand. I was at a major London teaching hospital. I could put my foot down, but it made me question whether I was doing something wrong—that’s how she made me feel.”

Other doctors, Elneil says, were offered financial incentives. “For example, they would say, ‘I'll take you on a trip to America, and we can go to show you this doctor in Denver.’ And people fell for that.”

The RCOG is too safe as an institution. It needs to rethink how it approaches women’s health

A MINORITY WITHIN A MINORITY

Around 350 of 18 000 professors in UK academia are black and female, meaning that Elneil represents just 2% of the professoriate.[2] “The fact that in academia you hardly have any women in senior roles is quite a bit of a shocker,” she says. “And then you add to it being black.” She thinks that opportunities might be better for black female clinicians in the NHS today than when she began her career, but progress in academia is hard. “I say credit to UCL and credit to Cambridge, they made it possible for me to progress.”

Elneil gained academic kudos despite many years of being denied protected academic time. “There was always a reason why I wasn’t good enough for them. So I had to do my academia in my own time, in the evening, and at weekends, doing research in my clinical setting. I had quite a mixed bag of research, but I worked outside the box to make it happen.” Much of her research has been on nerve disturbance in the bladder and neuromodulation. At UCL University Hospitals NHS Foundation Trust, she runs the neuromodulation programme for bladder and pelvic floor dysfunction, for patients for whom most other treatments have failed.

Despite her seniority, however, Elneil can still be made to feel that she doesn’t belong. “There is still almost a shock when I show up because people aren’t expecting to meet this person. I’ll go onto a ward because I’ve been asked to give a second opinion, and there’s an assumption that I can’t possibly be the consultant.”

Elneil credits her upbringing with her success in a system that often seems stacked against her. Born to Sudanese parents, she had a happy childhood moving between Switzerland, where her father was one of the deputies of the director general of the World Health Organization, and Africa. In England, she accompanied her sister to boarding school. It was a privileged childhood, but “we came from stock where we fought for justice and people’s rights.”

As well as wanting to fulfil her parent’s expectations, Elneil also wanted to open the door for others. “A lot of black women can’t quite believe you can do it. And I’m saying you not only can come here, you must be here.”

Listening to women

Early on in her career, Elneil noticed how women were often ignored in clinical settings. Her experience of this, when working with patients with fistulas and female genital mutilation in Africa, led her to intervene on behalf of women left with chronic pain after mesh surgery.

“Fistula is the worst form of traumatic childbirth outcome,” Elneil says. “It goes back to really poor obstetric care, a lack of antenatal support, and a lack of help at the very beginning of the whole journey. These women never had good care. The impact on me was phenomenal.”

Elneil also noticed that surgical trainees she met at that time had very little respect for the women they were treating. “They didn’t ask the women, ‘What do you want?’ They didn’t say, ‘How could we help?’ There was no explanation, no discussion.”

Many decades later, she gave evidence to the Cumberlege review, the scope of which included the harms of vaginal mesh, and the final recommendations of which included establishing mesh removal centres in the NHS. “The centre I built in London was based on the women’s vision; they wanted psychological input, they wanted physiotherapy support, they wanted options because some wanted all of the mesh removed, some of them didn’t want it removed at all, they just wanted to be monitored. We devised a really complex plan of action.”

Overhauling the specialty

On reflection, Elneil thinks that the field of urogynaecology needs to be healed in the wake of a scandal she says is similar to the one uncovered by the infected blood inquiry. The use of mesh needs to be re-evaluated, and women’s health needs an overhaul, she adds.

“The RCOG [Royal College of Obstetricians and Gynaecologists] is too safe as an institution, and it needs to rethink how it approaches women’s health; it needs an overhaul. There is a tendency not to take the bull by the horns. But you need to speak openly so you can deal with it. This is about politics with both a small and a big p,” she says.

“I feel very sorry that in obstetrics and gynaecology where we are serving the health of women, there is still a lack of understanding about what women want. More of us who work directly with women need to be at the table, as do the women themselves.”

Rebecca Coombes, *The BMJ*

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EDITORIAL

Global child mortality falls to historic low

Target to end preventable deaths among under 5s is within reach, UN data show

The 2023 report of the United Nations Interagency Group for Child Mortality Estimation shows a remarkable 51% fall in global mortality for children aged under 5 years between 2000 and 2022, from 76 deaths/1000 live births to 37/1000.[1]

This is a historic low: millions more children are surviving as low and middle income countries advance towards reducing under 5 mortality to ≤25 deaths/1000 live births by 2030, one of the targets set out in the UN Sustainable Development Goal on good health and wellbeing.[2]

The fall is encouraging, but 4.9 million children under 5 years still died in 2022.[1] Although 134 out of 200 countries achieved the under 5 mortality target, the rest, most in sub-Saharan Africa and southern Asia, are still struggling. Prevention and treatment of leading causes of deaths in children under 5, including infectious diseases (pneumonia, diarrhoea, and malaria), prematurity, and birth asphyxia or trauma remain inadequate in many countries.[1]

Further, glaring inequity in child survival rates was observed across regions and countries, underscoring a need to rethink implementation of evidence based interventions to mitigate threats to child survival.

Glaring inequity in child survival rates was observed across regions and countries

Effective interventions

Cambodia, Malawi, Mongolia, Rwanda, Sao Tome and Principe, and Uzbekistan have reduced under 5 mortality by over 75% since 2000, in the face of resource constraints and poverty. They used simple, affordable, high impact interventions at scale. Integrated health strategies encompassing promotive, preventive, and curative services across the care continuum were anchored on strong primary healthcare systems and public health interventions, including improved sanitation, clean water, and hygiene.[3-10]

Sub-Saharan Africa has the highest under 5 mortality. In Chad, Niger, Nigeria, Sierra Leone, and Somalia the under 5 death rate exceeds 100/1000 live births because of systemic challenges, including inequity in access to healthcare, food insecurity, and political instability.

Southern Asia, with a similar share of global births, accounted for 26% of the global deaths among under 5s.[1]

We know what works. Maternal survival programmes spanning high quality antenatal care, nutrition, and safe and respectful care should be integrated with newborn health initiatives.[7-14] Effective multifaceted interventions include access to skilled healthcare staff within a functional care system (encompassing antenatal, birth, and essential newborn care and immunisation), integrated management of childhood illnesses, and efficient referral systems for severe illness.[11,12]

Prevention

Prioritising preventive healthcare is essential and cost effective. Community based approaches facilitated by community health workers and supporting delivery of preventive and curative healthcare services bring healthcare to where people live especially in underserved areas.

Scaling up efforts to tackle the social determinants of health through collaboration among stakeholders, including private sector, non-governmental organisations, development partners, academia, and researchers, can accelerate progress in child survival.[3,10,12] Stakeholders' activities should be aligned with national strategic aims and programmes to reduce poverty and hunger, improve education, and promote gender equality and environmental sustainability.

Better data

High quality, timely data on births and deaths are essential to plan and prioritise interventions, specifically targeting the families most at risk. We need to replace global estimates with data from robust civil registration, vital statistics, and health information systems that capture births, deaths, and causes of death in every country. Current global estimates of under 5 mortality for low income countries are on average 7.9 years old compared with 2.1 years in high income countries.[1]

Improved access to quality healthcare, robust data systems, sustained funding, and strategic resource allocation are essential to child survival aspirations and fostering the "thrive and transform" agenda that develops a country's human capital through its children.[12]

Accountability mechanisms at all levels, including independent assessment of government commitment to policies, are vital to ensuring progress and sustained political commitment.[18] The child survival goal can be achieved; how soon depends on the unwavering dedication and cooperation of people in all sectors.

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