

this week

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PLAN B

Doctors face retrial over climate action

A jury was unable to reach a majority decision on four doctors and two nurses who cracked windows at JP Morgan bank's European headquarters in London in July 2022, causing nearly £200,000 of damage in a protest over the bank's funding of fossil fuels.

Despite the judge ruling that the six had no legal defence, the jury at Snaresbrook Crown Court in northeast London failed to reach a verdict on charges of criminal damage.

The six, who included GPs Patrick Hart and David McKelvey, consultant obstetrician Alice Clack, and consultant psychiatrist Juliette Brown, cracked several panes of glass at the bank's Canary Wharf offices. They put up posters reading "In case of medical climate emergency break glass." Two days later the UK recorded its hottest day ever, at 40.3°C.

The defendants pleaded not guilty and argued their actions were justified because of the bank's role in funding fossil fuels. While Judge Gerard Ponder told the jury they should disregard the "political and philosophical beliefs" that motivated the defendants, he allowed the defendants to speak in court about their motivations.

Hart, from Bristol, who has taken part in several climate change protests, told the jury, "I believe in my heart that my actions on that sweltering July day were right and just. This

is all I need. The rest is up to you. And so it is in this same spirit of humanity that I put my trust in you, the jury. To be freely judged by my peers, by my fellow human beings, is a great privilege. Thank you."

The jury were unable to reach a majority verdict after two days of deliberations. The Crown Prosecution Service has requested a retrial, which is set for February 2026.

After the decision Clack said, "We're grateful to the jury for bringing moral sense and humanity into the courtroom. It gives an indication of the public support for medical practitioners willing to put their bodies on the line. The climate crisis is a health crisis."

Doctors convicted after climate activism action face a GMC referral to the Medical Practitioners Tribunal Service, which could suspend them or strike them off the register.

Hart, who received a suspended prison sentence after one conviction, is facing a tribunal in November after refusing to accept a formal warning from the GMC.

Doctors were outraged when Sarah Benn, a retired GP, had her registration suspended for five months in April after spending 32 days in jail for contempt for thrice breaching an injunction banning protests at an oil terminal.

Clare Dyer, *The BMJ*
Cite this as: *BMJ* 2024;385:q1330

The six healthcare workers were arrested after breaking windows at JP Morgan's London headquarters in 2022

LATEST ONLINE

- GP staff are running food banks and giving advice on dealing with poverty
- Major US church group votes to oppose IVF
- FDA expert committee recommends approval of Alzheimer's drug donanemab



SEVEN DAYS IN

Tobacco, UPFs, fossil fuel, and alcohol blamed for 2.7m deaths a year in Europe



Europe's leaders are being urged to do more to stop industry driving deaths and sickness from chronic diseases through "insidious" tactics designed to increase profits and derail public health protections.

WHO said four industries (tobacco, ultraprocessed food, fossil fuels, and alcohol) were wholly or partly to blame for 2.7 million deaths a year from non-communicable diseases (NCDs) in its European region and for 19 million deaths (34% of all deaths) a year worldwide.

It said 1.15 million deaths a year in Europe were caused by smoking, 426 857 by alcohol, 117 290 by diets high in processed meats, and 252 187 by diets high in salt. Nearly 7500 deaths a day in WHO's European region, which includes central Asia, are attributed to "commercial determinants," with industries contributing to 24% of all deaths, including significant mortality from cardiovascular disease (51% of these deaths) and cancer (46%).

WHO flagged concern over direct-to-consumer advertising of medical products and the manipulation of research evidence related to NCD causes, prevention, and management. It said applying a "commercial determinants lens" to public health issues was needed urgently, and it urged the region's 53 member states to "tackle commercial influence at all levels."

Matthew Limb, London [Cite this as: BMJ 2024;385:q1298](#)

AMR

Technology steps up fight against bacterial infections

A point-of-care diagnostic test that rapidly detects whether an infection is caused by bacteria and identifies the right antibiotic to treat it has won the £8m Longitude prize on antimicrobial resistance (amr.longitudeprize.org), funded by Nesta. The PA-100 AST system, which takes 45 minutes—rather than around three days for traditional laboratory tests—aims to transform the treatment of urinary tract infections. It was developed by the diagnostics company Sysmex Astrego and is based on technology from Uppsala University in Sweden.

Diabetes

Half a million more people are at risk, says NHS

The NHS has identified 549 000 more people in England as being at risk of developing type 2 diabetes. In the latest National Diabetes Audit, 3 615 330 people who were registered with a GP in 2023 were found to have non-diabetic hyperglycaemia, also known as pre-diabetes, up by 18% since 2022. People under 40 showed a rise of almost a

quarter in the same period, from 173 166 to 216 440. Amanda Pritchard (below), NHS chief executive, said the "concerning" figures showed why "radical action" was needed to roll out prevention services.

Climate change

Health leaders urge prospective MPs to act

More than 30 UK healthcare leaders wrote to parliamentary candidates of all parties to call for commitments to tackle the effects of the climate crisis on health. The group, members of the UK Health Alliance on Climate Change, wrote, "The next government will be leading at a pivotal moment in our nation's history when we need to transform our energy system, our food system, our health system, and our infrastructure to deliver a better, fairer, and healthier society resilient to the threats of climate change."

Sexual health

"More doctors needed" to meet demand

The British Association for Sexual Health and HIV (BASHH) launched its LoveGUM campaign, to encourage people to choose a career in genitourinary

medicine. The initiative has been launched amid rising rates of sexually transmitted infections and growing demand for care. Matt Phillips, president of BASHH, commented, "We need a robust, highly skilled workforce in place. Genitourinary medicine is an evolving specialty that truly serves



the whole population, including people who are frequently under-represented in health."

Junior doctors

Pre-election strike is "futile"—NHS leader

A five day junior doctors' strike planned to take place just before the general election will be "futile and very damaging," warned the chief executive of the NHS Confederation. In a speech to the NHS Confed Expo in Manchester on 12 June, Matthew Taylor urged political parties to promise to reopen negotiations with junior doctors within 10 days of forming a government. In return it wants the BMA to call off strikes planned for 27 June to 2 July.

Funding

Devon ICB chair quits over "unachievable" targets

Sarah Wollaston, a doctor and former MP, resigned as chair of the NHS Devon Integrated Care Board after warning of "unacceptable consequences" to services from the funding being made available. Wollaston, who had held the post since December 2021, wrote on X, "Genuinely sad to be leaving NHS Devon but in a nutshell, not happy as chair to sign off on the financials so time for me to go. No point promising the unachievable, especially if only achievable with unacceptable consequences."

Waiting lists

Elective procedure waits creep back up

The NHS waiting list for elective procedures and appointments in England increased last month after a six month decline, rising from 7.54 million in March to 7.57 million in April, figures showed. Meanwhile, emergency admissions totalled 564 693 in May, the second highest monthly figure on record and the busiest May. Rory Deighton, director of the NHS Confederation's Acute Network, said the figures were a "stark reminder of the immense pressure the NHS is under... in the face of relentless demand."

MEDICINE

SIXTY SECONDS ON... **BAD ACRONYMS**



PPE

Arrest made in pandemic contracts investigation

The National Crime Agency said that an arrest had been made regarding the criminal investigation into PPE Medpro, a company that was awarded large government contracts to supply personal protective equipment during the pandemic. The company won two contracts worth £200m shortly after being referred through the government's "high priority lane" by Michelle Mone, who sits in the House of Lords. The agency said a 46 year old man had been arrested at his north London home in connection with its investigation.



Michelle Mone (above) referred Medpro to the pandemic PPE contract fast track scheme

Bird flu

India reports human case of H9N2 in 4 year old



India has reported a human case of avian influenza A (H9N2) in a 4 year old child living in West Bengal who has since recovered, the World Health Organization said. This is the second human case of H9N2 reported in India; the first was in 2019. This latest case involved exposure to poultry at and around the patient's home. None of the child's family, neighbours, or healthcare team has reported symptoms of respiratory illness.

Emergency care

Older patients in A&E will get "health MOTs"

Offering "health MOTs" to frail older patients in emergency departments will help identify people who don't need to be admitted to hospital and will relieve pressure on departments, said NHS England's chief executive. Amanda Pritchard, speaking at the NHS Confed Expo

conference in Manchester on 12 June, said offering front door checks such as blood pressure tests, mobility assessments, and reviews of patients' respiratory and falls history would help signpost people to specialist care.

Call to prioritise gap in healthy life expectancy

The next government should commit to halving the "shocking" 18 year gap in healthy life expectancy between the richest and poorest groups as a central policy commitment, said the chief executive of the NHS Confederation in a speech to the NHS Confed Expo conference. The country risked falling into a "vicious cycle of higher sickness, lower growth, and an NHS stuck in perpetual crisis management," said Matthew Taylor. He called for a "proactive" model of prevention to help people stay healthy.

Physician associates RCP president is asked to resign over row

Senior officers at the Royal College of Physicians called on their president, Sarah Clarke, to resign, after more than 80 members expressed a lack of confidence in the college's leadership over its inaction on physician associates. A letter signed by five of six senior officers recognised Clarke's work but said they were "increasingly concerned she has lost the confidence" of membership.

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FLU CASES

In Europe the total number of influenza cases last season was **75% higher** than in 2019, after a decline in population immunity during the covid pandemic

[Analysis by Airfinity and Bloomberg News]



BRB (BE RIGHT BACK . . .)

Hear me out. Researchers have developed computer software that can detect "tortured acronyms."

ROFL! (ROLLING ON THE FLOOR LAUGHING)

Don't LOL (laugh out loud) just yet. The scientists, from Toulouse University, said these red flags can point to deeper problems with a study paper, which could help root out research misconduct. Take the acronym CNN: not the news organisation but a term apparently equated to "convolutional brain organisation," even though the acronym isn't right. The scientists said that if such a "tortured acronym" appears in a paper it probably wasn't carefully written or revised by human authors. "CNN," for instance, probably altered an earlier wording—"convolutional neural network"—to hide plagiarism. But in doing so the authors forgot to change the acronym too. And it's probably a sign of more serious problems in the paper.

TMM (TELL ME MORE)

Conference proceedings are often a standout example of "tortured articles." The Toulouse group previously flagged hundreds of papers published by the Institute of Electrical and Electronics Engineers that contained tortured phrases. They said they found similar problems in conference proceedings from 10 other publishers.

FML (ERM, FIX MY LIFE)

Indeed. And this is just the latest in a line of misconduct detectors developed by the same research group as part of their Problematic Paper Screener (PPS) tool, which launched in 2021 and is publicly available. It scans scientific papers for word replacements that don't make sense (such as "glucose bigotry" for "glucose intolerance") or non-existent cell lines. With the acronym tool, they recently reported thousands of suspicious

conference papers from 11 publishers that used tortured phrases at the World Conference on Research Integrity in Athens, Greece, which took place a few weeks ago.

TBC?

There's still a long way to go. The journal *Science* said that

PPS has so far flagged more than 15 000 papers with tortured phrases—but only 2760 have been retracted.

Mun-Keat Looi, *The BMJ*

Cite this as: *BMJ* 2024;385:q1303

Cancer treatment delays double in past year

The risk of death in patients with cancer is rising as NHS treatment delays have almost doubled in a year, largely owing to workforce shortages, experts have said.

Delays in treatment have now become routine, with nearly half of cancer centres experiencing weekly delays, said the Royal College of Radiologists, which surveyed heads of service at 60 specialist centres across the UK.

The survey, carried out last November and with a 100% response rate, found 47% of centres had weekly delays in administering systemic anticancer treatment (SACT), up by 28% on the previous year. Weekly radiotherapy treatment delays nearly doubled, from 22% in 2022 to 43% in 2023.

We simply do not have enough doctors to manage the increasing number of patients safely
Katharine Halliday (below)

Meanwhile Cancer Research UK published details of its data analysis, which found around 382 000 patients in England had not started treatment within the target time (the NHS should begin treatment for 85% of cancer patients within 62 days of an urgent referral) since December 2015.

The royal college published its annual census reports on 13 June and warned that cancer care was “in peril” because delays in diagnosis and treatment were putting patients’ lives at risk.

Almost all clinical directors (97%) said staff shortages were causing backlogs and delays at their trust or health board. Every month of delay in treatment raised the risk of death for a cancer patient by around 10%. Nearly three quarters (72%) of clinical directors said there weren’t

enough radiologists to deliver safe and effective levels of care.

The reports said there was a 30% shortfall in clinical radiologists (1962 consultants) and a 15% shortfall in clinical oncologists (185 consultants). The college estimated that without action these would rise to 40% (3670) and 21% (325), respectively, by 2028.

Another problem was demand outstripping workforce. In 2023 the demand for SACT, including chemotherapy, rose by 6-8%, while the consultant workforce expanded by only 3.5%. There are also regional inequalities in access to specialists, with some areas having significantly fewer doctors per patient.

Cancer Research UK’s analysis, also released on 13 June, said performance had improved in recent months, with England reducing the backlog to pre-pandemic levels for the first time, but challenges remained because of low staff numbers and a lack of diagnostic equipment. Despite the improvements, in April only 66.6% of patients in England started treatment within the target 62 days.

Katharine Halliday, president of the Royal College of Radiologists, said, “The crisis in the radiology and oncology workforce is jeopardising patients’ health. We simply do not have enough doctors to manage the increasing number of patients safely, and this problem will only worsen as demand continues to rise and more doctors leave the NHS.”

The NHS was treating record numbers of people for cancer, a spokesperson said, with 30% more people being treated last year than in 2015.

Adrian O’Dowd, London
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2024;385:q1316





MARK THOMAS


ELECTION WATCH How credible are the main parties’ pledges on the NHS?

Are promises from the Tories, Labour, and Liberal Democrats deliverable, asks **Matthew Limb**


What are the parties’ headline promises on health?

 Labour plans to “train thousands more GPs,” guarantee a face-to-face appointment for all patients who want one, and deliver a modern appointment booking system “to end the 8 am scramble.”
A drive to cut waiting lists, with 40 000 extra appointments, scans, and operations a week, aims to clear, within five years, the backlog of patients waiting more than 18 weeks from referral for consultant led treatment of non-urgent conditions. A Labour government would hire 8500 new staff within five years to improve mental healthcare for children and adults.


 The Conservatives promise a substantial increase in the NHS workforce, with 92 000 more nurses and 28 000 more doctors by the end of the next parliament.


 The Lib Dems want to increase the number of full time equivalent GPs by 8000—half of these by boosting recruitment and half by retaining GPs. The party said this would ensure that everyone can see a GP within seven days—or within 24 hours for urgent needs.

How do they propose to achieve this?

 By getting hospitals to perform more operations and diagnostic tests on evenings and weekends and “incentivising” staff to carry out appointments out of hours. The funding would come from a crackdown on tax avoidance and non-domicile tax loopholes.


Labour said it would take the pressure off general practices by improving access to care “through new routes,” including community pharmacist prescribing and expanding self-referral where appropriate.

 Health investment plans include £6.6bn for the NHS and £7.5bn for adult social care for the next three years, with savings on NHS management costs: employing 5500 fewer managers to free up £550m for “frontline” services and save over £640m on consultancy.

 To improve recruitment and retention of doctors, the party is proposing a fully independent pay review body, a 10 year retention plan, making flexible working a right for NHS staff from day 1, and


expanding access to flexible, affordable childcare. It is also pledging extra funding to support GP services in rural areas.

Are their ambitions achievable?

 Health analysts have welcomed Labour's ambitions to drive down waiting times, improve GP access, and reform social care. But many said they have not seen enough detail on how these will be achieved, where the funding will come from to hire and train more staff, and how NHS employers will solve retention issues without clarity on a broader NHS funding settlement.


Sarah Woolnough, chief executive of the King's Fund, said an approach to tackling waiting lists similar to that pledged by Labour had already brought some success in parts of the NHS. But, she added, "Scaling this up will rely on having enough NHS staff to take on the extra shifts—not a given when so many report high levels of stress and burnout and when industrial action remains unresolved."

The NHS Confederation said the NHS still had around 100 000 vacancies, with staff already often working beyond their set hours, while "crumbling estates" were holding back NHS productivity.

 The BMA said it expected the Tories' pledges to recruit more doctors and improve access to GP appointments, mental health services, and diagnostic checks would fall flat without detailed plans, "absent in the manifesto," for retaining doctors, which it said meant "fixing" pay and the pay review process.

Cutting 5500 managers may save cash, but this could pile more paperwork onto hard pressed clinicians, the NHS Confederation said.

Azeem Majeed, a GP and professor of primary care and public health at Imperial College London, said, "The NHS relies on managers to plan services, manage budgets, and ensure compliance with standards. These cuts could inadvertently disrupt rather than improve services."

 Recruiting 8000 more GPs was a "laudable" target but "not easy" to deliver, said Woolnough. She added, "Without more detail on how the party would achieve this goal, it is hard to see how their promise of faster access to GP appointments can be met."

Experts' verdict

Thea Stein, chief executive of the Nuffield Trust, said none of the main parties' spending plans were credible. "Our analysis shows that, even assuming all parties also raise the core revenue budget by 1% a year in line with Office for Budget Responsibility assumptions, these increases are compatible with the tightest period of funding in NHS history: 1.5% for the Liberal Democrats, 0.9% for the Conservatives, and 1.1% for Labour," she said. "This would mark an unprecedented slowdown in NHS finances, and it is inconceivable it would accompany the recovery all are promising."

Majeed said, "The challenge for the next government will be achieving targets in areas such as workforce and access to health services at a time when public sector finances are under severe pressure." All three parties were pledging to take pressure off GP services by extending prescribing rights to other health professionals and expanding programmes such as Pharmacy First, but "without proper integration and support, such measures may not significantly reduce GP workloads," Majeed added.

● DAVID OLIVER, p 400

Matthew Limb, London [Cite this as: BMJ 2024;385:q1320](#)



The plans rely on having enough NHS staff to take on the extra shifts Sarah Woolnough



These cuts could inadvertently disrupt rather than improve services Azeem Majeed



All proposed increases mark an unprecedented slowdown in NHS finances Thea Stein

Four year medical degree in 2026, says NHS England

A four year undergraduate medical degree, separate from graduate entry degree programmes, is set to launch in 2026, NHS England has said.

Elizabeth Hughes, its medical director of undergraduate medical training and education, told the NHS ConfedExpo conference in Manchester on 12 June the course has evolved from NHS England's work on widening participation in medicine. However, the rollout relies on its curriculum being tested and fulfilling the same requirements as the five year programme, said a spokesperson.

"One of the . . . things we've heard is that people find that the challenge of the debt that's encountered with the five year [undergraduate medical] degree is very significant, and this can stop people coming in from various [parts] of the population," said Hughes.

"So, one of the things we're now looking at is the four year undergraduate degree. Of course, it would still need to uphold the highest levels of patient safety. We are working very closely with the GMC, but it would allow us to grow the domestic workforce with less reliance on overseas staff and provide more choice for students who prefer a shorter programme, reducing some costs and [allowing them to start] earning quicker.

"We are in the process of working with Buckingham University and some pilot medical schools, and we are looking to commence in 2026."

Alongside a four year medical degree programme, the NHS long term workforce plan, published a year ago, set out an ambition to increase the number of medical school places from 7500 to 10 000 by 2028—and to double the number to 15 000 by 2031—with a higher number of places in areas with the most shortages.

Hughes said the increase in undergraduates may lead to "employers having multiple sets of students from different medical schools, which we do now have in some parts of the country, but increasingly that will need to occur as we increase the numbers." She added, "It's another burden potentially on

employers, because as part of this generation of a much bigger medical workforce we will have a considerably greater number of learners in the system, and that will be both from medical students but also from other parts of the NHS long term workforce plan in AHPs [allied health professionals], nurses, midwives etc."

● HELEN SALISBURY, p 402

Abi Rimmer, *The BMJ*

[Cite this as: BMJ 2024;385:q1312](#)



NEWS ANALYSIS

Why there will be fewer female representatives at the BMA annual meeting this year

Ingrid Torjesen explores the unintended consequences of changes to how representatives are selected

On 24 and 25 June BMA members will gather in Belfast for the organisation's annual representative meeting (ARM). But this year the meeting, which debates and sets BMA policy, will welcome noticeably fewer women than in previous years. This is despite a BMA pledge to tackle gender bias after an independent review almost five years ago.

Daphne Romney KC carried out the review after two female doctors alleged sexism and sexual harassment by elected members. Her 2019 report, which identified an "old boys' club" culture that left some women "undervalued, ignored, or patronised," led the BMA to apologise and commit to implementing 31 recommendations. But data shown to *The BMJ* indicate that the proportion of women selected to attend the meeting has fallen this year to a number the BMA itself acknowledges is "frustratingly low."

To understand why the gender trend is going in the wrong direction, it's necessary to look at changes to the way doctors become representatives.

? How were representatives for ARM selected?

Around half of the ARM representatives are chosen by national committees representing branches of practice such as consultants, GPs, and junior doctors. BMA members of local divisions select the other



An old boys' club culture leaves some women undervalued, ignored, or patronised
Daphne Romney

half. In previous years, divisional elections for attendance at the ARM have been restricted to those who attend meetings. But this year a rule change has allowed any BMA member to vote, regardless of attendance at meetings. Inactive local divisions that no longer have meetings, so called dormant divisions (of which there are 97, or 57% of the total), have been reactivated by the rule change, with candidates put up for election and voting going ahead online.

The BMA said that the decision to open up the divisional ARM elections was made to allow more members to stand, increase the number attending the ARM for the first time, improve geographical representation, and enable the BMA to monitor and improve the diversity of ARM representatives.

But 74% of the seats elected by divisions went to men and just 25% to women, reversing progress that had been made on gender representation over the past decade (table).

The BMJ asked the BMA to provide a full breakdown of ARM representative seats by gender for 2024, but a spokesperson said this wasn't possible as the registration period was still open. They acknowledged that the number of women applying to attend the ARM this year was "frustratingly low" and said the association was "encouraged by the number of women who have applied to attend, and committed to improving how the BMA reflects our membership."

Not only did more male than female candidates stand in the division elections (69% versus 29%), men were more likely to be selected (74% versus 25%) by the predominantly male voters (62% versus 36%).

Alex Freeman, chair of the BMA's Culture Inclusion Implementation Group (CIIG), charged with implementing the recommendations of the Romney review, explained how the voting rule changes had inadvertently led to fewer women attending the ARM this year. With seats in dormant divisions being filled this year, there were fewer seats to reallocate at a national and regional level, she said. "They would normally provide some of the balance on the geographically elected seats, and they haven't been able to do so this year."

? How was the change to the voting system made?

Critics claim that the voting changes, proposed by the BMA organisation committee and voted through by council last year, were pushed through with little consultation.

Jacky Davis, a member of the BMA UK council, complained that no analysis was done on the effect of the changes on gender representation. "The Romney recommendations were not taken into consideration when this was pushed through. Where was the analysis? What's the point in working hard to implement changes recommended by the Romney review when the leadership of the BMA allows changes to be pushed through that set us back 10 years?"

Grant Ingrams, a GP and chair of Leicester, Leicestershire, and Rutland Local Medical Committee, who has spoken in favour of motions on tackling sexism in medicine at previous ARMs, said the lack of scrutiny and consultation showed that the BMA hadn't learnt from the Romney review and hadn't put in



Not only did more male than female candidates stand in the division elections (69% versus 29%), men were more likely to be selected (74% versus 25%) by the predominantly male voters (62% versus 36%).



The 2024 ARM, which will be held at the ICC Belfast, is likely to have fewer female delegates than ever before

processes to check what effect the changes might have.

“It’s absolutely appalling,” he said. “The first time I read it I was gobsmacked. I thought, [the BMA] have not thought this through; I can see that there’s going to be unintended consequences within this.”

Wider progress on Romney review

The BMA has made patchy progress in implementing Romney’s recommendations. Several recommendations were aimed at reversing the under-representation of women on BMA committees. The association told *The BMJ* that the number of female committee members had risen by 2.8% since 2019 but would not provide figures on individual committees.

A BMA spokesperson said, “We have already increased the number of women on a number of committees; we have women chairs of the GP England Committee, SAS committee, Public Health Committee, Medical Students Committee, and a new joint chair of the Consultants Committee, as well as more women than ever on the Pensions Committee. In addition, the BMA has joint women chief executive officers.”

To date, several of the Romney’s key recommendations to tackle gender bias have not been implemented, including introducing quotas on minimum numbers of women and restrictions on the number of committees on which

members can serve and for how long, to encourage wider participation.

A BMA spokesperson said progress on the recommendations will continue. “These include introducing limits on the length of time a member can be on a committee, as well as limiting the number of committees an individual can sit on—this comes into effect after the ARM this year.” The spokesperson said that these were being phased in to avoid destabilising the work of committees and that quotas and minimum numbers of women on committees were being considered.

The BMA CIIG’s report on progress on implementing the Romney recommendations is due to be shared at the ARM and has been seen by *The BMJ*. It confirms that the groundwork for setting temporary gender quotas for committees will be a priority this year. The Romney review recommended that gender quotas should be in place for 10 years “to change the culture” and acknowledged they “will be very unpopular.”

Asked why progress had been so slow on introducing gender quotas, Freeman said, “The implementation group has been running now for two years. Before [this], we just had an oversight group, so they didn’t actually have any power to make any changes.”

In those two years the CIIG has put 55% of Romney’s recommendations “into business as usual, so actions completed, and just monitoring

GENDER OF ARM REPRESENTATIVES (%)

	Male	Female	Prefer not to say or not known
2024*	74	25	1
2023	61.7	32.7	5.6
2022	60.3	38.9	0.8
2021**	62.5	37.3	0.2
2017	66	34	–
2016	66	34	–
2015	66	34	–
2014	69	31	–
2013	74	26	–

*Figures only for representatives elected by divisions (around half of all representatives). **Virtual conference.

The total number of representatives elected to the ARM each year varies from 440 to over 600.

Source: Data seen by *The BMJ*

effectiveness,” Freeman said. “I would call that considerable progress.”

Two potential bylaw changes to be voted on at this year’s ARM should help to tackle gender bias at future ARMs if they are passed.

One, proposed by the Consultants Committee, says that, excluding three of its seats allocated to Northern Ireland, Wales, and Scotland for attendance at the ARM, “no more than four of the seven remaining representative seats may be held by men.”

The other, alluded to in CIIG’s forthcoming report, proposes replacing the current system—where the 169 BMA divisions elect at least one ARM representative each—with a system where elections are conducted across regions. These changes would merge BMA divisions into larger constituencies that are based on region or nation and allow for constraints or quotas to be set for gender, branches of practice, ethnicity, or other under-represented characteristics.

Making sure that the ARM reflects the BMA’s membership will be an important piece of work, Freeman said. “We have lots of data on our members. I’d like in future years that the ARM looks like the members in terms of gender, branches of practice, ethnicity, and geography. Ultimately, my aim is to make groups that represent groups of members look like the members that they represent.”

Ingrid Torjesen, London
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The BMA leadership has allowed changes to be pushed through that have set us back 10 years
Jacky Davis

THE BIG PICTURE

Tobacco firms use festivals and F1 to dodge advertising bans, finds report

The Estéreo Picnic music festival in Colombia is one of many mass gatherings of young people that big tobacco firms are using to get around South American marketing bans, a new report has found.

The multinationals are aggressively promoting their products to skirt national laws, researchers at the health campaign group Corporate Accountability found.

Advertising tobacco products was outlawed in Colombia in 2012, yet Philip Morris (PMI), which has sponsored Estéreo Picnic since 2022, advertised to more than 150 000 people at the event this March.

Daniel Dorado, tobacco campaign director at Corporate Accountability and a coauthor of the report, said, "The corporation's targeting of young festivalgoers is not only morally reprehensible, it also raises questions about the legality of the sponsorship."

PMI ostensibly sponsors Estéreo Picnic with e-cigarettes, which are legal to advertise, but also promotes traditional cigarettes, the campaign group said, by using playful marketing techniques to appeal to young people (below).

Luke Taylor, Bogotá

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IVAN VALENCIA/APALAMY

Foundation job allocation in the UK

Controversial new system undermines applicants' agency and should be reviewed

Newly qualified doctors in the UK complete two years of general postgraduate training after medical school—the foundation programme.¹ In March 2024, a major change was made to job allocation, with a switch from performance based selection to preference informed allocation. Preference informed allocation combines students' preference for particular regions and jobs with a randomly assigned ranking.²

The change has introduced a further dimension of uncertainty to the UK's newest doctors when the NHS is already under pressure from increasing demand,³ insufficient funding,³ poor workforce retention,³ and industrial action.⁴ In a recent cross-sectional survey of over 10 000 UK medical students, roughly a third (3392) reported that they were already considering moving abroad.⁵

Preference informed allocation is the latest attempt to make the allocation of roughly 9700 foundation programme jobs fairer across the UK.⁶ Every foundation programme applicant ranks the different training regions (called foundation schools) in order of preference.⁷ An algorithm then lists the students in random order. Starting at the top of the list and working down, the algorithm matches applicants to their highest available preference of foundation school. The process is repeated to allocate jobs. Students near the top of the random list are therefore more likely to be allocated their preferred region, and their preferred jobs. Students at the bottom lose out on both.

Need for more caution

This new regime replaces a controversial system introduced in 2011 that matched students with jobs according to ranking on educational performance combined with a



BSIP/RAQUET/SPL

Students near the top of the list are more likely to be allocated their preferred region and job

psychometric test (the situational judgment test, which assessed professional values and non-academic skills).⁸ The test was later found to have little predictive value,⁹ and the educational performance element of selection was removed to help overcome variation among (and within) institutions in how performance was measured.⁹

Educators reported that the former system encouraged an unhealthy competitive environment within medical schools, as students competed for the most sought after jobs.^{9 10}

In a 2022 consultation, 66% of roughly 14 500 medical students endorsed the switch to preference informed allocation.¹¹ The first medical students received their job allocations using the system in March 2024: 75% were allocated their first training region (compared with 71% in 2023). The proportion allocated to one of their bottom five choices was 0.8%, up from 0.3% in 2023.¹²

The specialised foundation programme—which offers new doctors opportunities in academia, education, and leadership—changed to preference informed allocation without consultation in February 2024.¹³ This unexpected change from written applications and interviews affects doctors qualifying in August 2025. NHS England and Scotland's medical directors justified the change as a way to improve diversity and inclusion in the specialised

foundation programme.^{14 15} However, both medical students and clinical academics have voiced surprise and disappointment. Implementing such a profound change without consultation damages trust¹⁶ and leaves medical students questioning how much control they will have in subsequent years of training. Given the current financial challenges facing the NHS, these changes may also have been financially motivated.

Need for more caution

The new approach has parallels with mandatory medical service, which is widely used, particularly in low and middle income countries, to help improve healthcare provision in underserved areas. Evidence evaluating mandatory medical service is sparse but suggests that outcomes are mixed and include adverse effects on workforce agency.¹⁷

The NHS also faces regional workforce inequalities. Preference informed allocation has been framed as mitigation for the inequitable distribution of doctors. However, this process risks treating individuals as a resource to be moved at whim. Increasingly, junior doctors are taking time out of training or leaving the NHS altogether—often citing rota gaps, lack of stability, and work-life balance.¹⁹ Preference informed allocation risks undermining retention further by reducing doctors' control over where they live and work during their first postgraduate role.

Decision makers should consider reversing the algorithmically generated ranking after the allocation to training regions (foundation schools). This way, medical students with lower rankings for regional allocation will have a higher ranking for job allocation, and a higher chance of receiving their preferred jobs.

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How worried should we be about bird flu?

A major human outbreak of H5N1 is plausible, and the risk is high

Concerns are mounting over the threat to humans from a highly pathogenic avian influenza virus, a threat first recognised in the late 1990s when a new clade of the H5N1 virus was detected in domestic waterfowl in China.

The first human cases, all linked with exposure to infected poultry, were reported from Hong Kong in 1997,¹ and the World Health Organization recorded a total of 463 deaths among 888 cases between January 2003 and March 2024.² Infections are under-reported, but the high ratio of deaths to cases (52%) suggests that H5N1 could cause a major public health emergency if human exposure and viral evolution lead to sustained person-to-person transmission.

We do not know if that will happen, but the likelihood seems to have risen over the past four years. One reason for this is the continuing spread of H5N1 clade 2.3.4.4b viruses in wild and farmed bird populations; thousands of outbreaks have now been recorded, from all continents. This reproductively successful clade of H5N1 is affecting poultry production and trade globally. It is also carried by migratory birds.³

The threat is magnified by frequent spillovers of virus from birds to mammals, including sea mammals that have scavenged infected seabirds and foxes, mink, and raccoon dogs on fur farms.⁴ The recent surprising discovery of clade 2.3.4.4b viruses in US dairy cows adds to the evidence that H5N1 can be transmitted to and among mammals.⁵ High titres of infectious virus are present in milk, and although the virus can be inactivated by pasteurisation, human consumption of raw milk is not uncommon.⁶

Mutations in viral genes that enhance replication in mammalian cells have been detected in the sequences released from infected cows, and viruses are being closely



HOANG DINH NAM/AFP/GETTY IMAGES

We need to put plans in place now for pandemic prevention, preparedness, and response

monitored for further adaptive signatures.⁷ At least three people have been infected during the US outbreak: two livestock farm workers in Michigan and Texas developed conjunctivitis and recovered; more worryingly, a third in Michigan had a mild respiratory illness.⁸

So far, a full set of adaptations required for airborne transmission among people, including mutations that increase binding to receptors in the upper respiratory tract, have not been found together in H5N1.⁴ But with the virus so prevalent in wild and farmed birds and mammals, people are exposed more than ever.

We need to put plans in place now for pandemic prevention, preparedness, and response. Decision makers must maximise available information about H5N1, manage uncertainty, fine tune tools for prevention and control, and align incentives for using them.⁹

Effective preparation

Information is required on infection fatality ratios; the risk of an outbreak, which depends on the source of infection, its transmissibility to and among people, and the potential for adaptive changes to the virus; and the likely timing of an outbreak, which hangs on the duration and frequency of animal-human contacts. These data are needed to evaluate threat levels and explain publicly the reasons for implementing restrictive control measures.

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We cannot be sure whether the next outbreak of transmissible human influenza will be caused by H5N1 or by another avian flu subtype. The next pandemic could be caused by an entirely different pathogen—perhaps a coronavirus, a paramyxovirus, or a retrovirus. Although the spotlight is now on H5N1, generic surveillance systems that track infections in animals, humans, and the environment can identify outbreaks caused by many different pathogens and should be implemented as a priority worldwide.

On US dairy farms, use of personal protective equipment and restrictions on farm visits could limit human exposure to H5N1, while rigorous disinfection of farm equipment and facilities will help prevent spread among cows. The current PCR and lateral flow diagnostic tests for infection in both humans and animals should be evaluated for specificity and sensitivity to the current bovine virus and modified accordingly.

Candidate vaccine viruses, generated from related H5 strains, are predicted to have antigenic overlap with the current bovine virus,¹⁰ and these could be used to generate pre-pandemic vaccines. H5N1 remains susceptible to antiviral agents oseltamivir and baloxavir marboxil.¹¹

Finally, the current, tough negotiations over WHO's pandemic accord are a reminder that real conflicts of interest exist over access to pathogens for research, benefit sharing, intellectual property, technology transfer, who provides and controls the money for pandemic control, and how signatories will be held to account.¹²⁻¹⁴ A new accord will succeed only if it appeals to reason—aligning different perceptions of hazard, risk, and urgency to offer each stakeholder sufficient benefits for the costs incurred.

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GUY CORBISHLEY/ALAMY

PRIMARY CARE

A day with London's homelessness GPs— an emerging primary care specialism

Great Chapel Street Medical Centre in Westminster aims to be a “one stop shop” for treating the complex physical and mental health conditions seen in street homeless populations.

Sally Howard visits the practice

Alina (name changed for anonymity) had been sleeping rough on the streets with her husband before she was brought into Westminster's Great Chapel Street general practice by an outreach worker from homelessness charity St Mungo's.

The 22 year old Roma woman was 24 weeks' pregnant and had received no medical care since conceiving, neither in the UK nor in her home nation, Romania, where Roma are often excluded from healthcare systems and from which she had fled with her husband after a violent physical attack.

Staff at Great Chapel Street—one of England's five homelessness specialist surgeries—know from long experience that they have a narrow window of time to tackle the multiple health inequalities faced by vulnerable patients such as Alina. On the day of her arrival, practice nurse Maggie Fielder undertook a full medical and psychological check, made referrals to safeguarding midwives and children's services, and applied for the maternity exemption

certificate that Alina would need to access antenatal care, in a process the practice calls “holistic” care.

Dana Beale and Natalie Miller, GP clinical leads at the surgery, say that trust issues are a barrier when treating such highly vulnerable patients. Romanians no longer have an automatic right to arrive in the UK as economic migrants and to access healthcare, which complicates treatment because many homeless Roma prefer to avoid all authorities, including healthcare providers, out of fear of deportation. Alina initially declined vaccinations, including for whooping cough, but with the practice nurse's support she agreed to have these. The surgery then advocated with social services for Alina to be offered accommodation, but as a women only space it excluded her husband, and Alina opted to remain on the streets.

Ultrasonography found anomalies with the fetus, so Great Chapel Street engaged the St Mungo's Roma rough sleeping team's translators to help Alina understand the complexity of the pregnancy and its implications.

“Treating street homeless patients, who face multiple deprivations as well as deepseated trust issues, is necessarily resource intensive,” Beale tells *The BMJ* when we visit the specialist Westminster practice one morning in January.

She and Miller took over the practice in 2018 from retiring GP Philip Reid. Beale had arrived at the practice in 2005 as a medical student on placement, and Miller arrived in 2011 for a salaried GP job split between Great Chapel Street and a mainstream then sister practice in Notting Hill.

It’s a rewarding but challenging specialism, they say. Street homeless populations, says Miller, are “at the very sharp end of the stick of multiple deprivation, scoring five [for most deprived] on indices of income, employment, education, health, crime, barriers to housing and services, and the living environment.” For this reason, Beale says, “the approach to providing healthcare for this population needs to be unique, as well as trauma informed.”

Isolated, underfunded, and vulnerable

A report published on 13 March from homeless healthcare charity Pathway and homelessness charity Crisis found that the average age of death for people experiencing homelessness is 46 for men and 42 for women. The report also found that people facing homelessness were “often or always discharged from hospital to the street with unmet health needs” and that specialist NHS teams and services working to support homeless patients’ needs, such as Great Chapel Street, were “often isolated, underfunded, and vulnerable to cuts.”

The government’s latest count of people experiencing street homelessness, which was conducted on a single night in autumn 2023 and published on 29 February 2024, also presents a bleak picture. In the count, 277 people were sleeping rough in Westminster, London, compared with 121 in the borough with the next highest count, Camden, London. The Westminster count was an 11%

Meet the specialist homelessness psychotherapist



John Conolly is the psychoanalytical psychotherapist at Great Chapel Street

“Much of my work is to establish sufficient trust in the patient to [enable them to] receive care.

“People arrive with years of trauma and ill treatment behind

them: I’ve had people who have been sleeping rough and been urinated on in their sleeping bags and doused with lighter fuel. They might have low blood sugar, they might not be able to concentrate, they might be sleep deprived, they might have many chronic health issues or undiagnosed personality disorders, but establishing trust is first.

“Standard NHS psychotherapeutic approaches such as short course cognitive behavioural therapy don’t work for this population: they often can’t handle questionnaires with loads of questions as they are too stressed to be able to focus, they have poor English, or are illiterate.

“I am heartened by the fact that an awareness is emerging that treating homeless populations is a specialist branch of medicine. There’s a new MSc module in exclusion health, and that’s a great sign. I would like to see commissioners being more responsive to the complex needs of homeless people, and I would like to see a minister for homelessness.”

increase on 2022 figures. There was a 27% increase nationwide over the same period, although the figures are lower than the 2017 peak.

Rough sleepers are among the most vulnerable people in the world, a cohort with increased incidences of cancers, heart disease, and diabetes, and raised prevalence of infections including hepatitis C, hepatitis B, and tuberculosis, and premature frailty and mortality. Ill health is also a trigger for street homelessness. The patients seen at Great Chapel Street Medical Centre have an average of eight long term conditions, Beale says.

There were 154 deaths in London of street homeless people in 2021. In January 2024 the Office for National Statistics (ONS) said it would no longer publish disaggregated data on the mortality rates among homeless people. But this summer Great Chapel Street will publish research on deaths across the rough sleeping pathway over four years in Westminster, with Westminster council, which finds that the average age at death is decreasing for street homeless people in the borough.

Yet Great Chapel Street is also seeing larger numbers of older rough sleepers with multimorbidities as well as higher numbers of people from harder-to-reach excluded populations, including Roma, such as Alina, undocumented migrants, and people who have been refused asylum and have no recourse to public funds. “Street homeless people are growing in number and changing in their needs,” Miller says.

Beale tells *The BMJ* that the Asylum Transformation Programme announced by the government in 2022, which aimed to “abolish backlogs” in asylum claims by the end of 2023, has also increased pressure on street homelessness services in Westminster, because asylum seekers have seen their funding for hotel and bed and breakfast accommodation cut with days’ notice and have ended up sleeping rough.

An emerging specialism

Great Chapel Street is structured as a community interest company (CIC), offering a “one stop shop” model that includes nurses, counsellors, a mental health primary care liaison nurse, and a psychiatrist, as well as GPs, a podiatrist, and physiotherapist clinics. It has around 300 patients on its books, and is commissioned by the NHS North West London clinical commissioning group on a specialist surgery Alternative Provider Medical Services (APMS) contract. It can refer into integrated care board funded health beds, and has complex caseload, Rough Sleeping Initiative, and women’s health funding.

A high proportion of the practice’s resources, says Beale, goes on the outreach required for street homeless communities, who have disordered lives, a suspicion of authorities including medical professionals, and high rates of substance abuse and mental health issues. “This is the definition of a hard-to-reach population,” Miller says.

The practice offers psychotherapy to prepare wary patients to receive healthcare, which is conducted by John Conolly, the practice’s specialist psychoanalytic psychotherapist (box

Meet the specialist homelessness nurse



Maggie Fielder is homeless health clinical nurse specialist at Great Chapel Street. Fielder also runs the practice's women's health improvement project

"It's a challenging job and some days I feel like I'm a cross between a nurse, a social worker, an advanced clinical practitioner, and a housing adviser.

"There was a big change in our work with covid. We started to go into the hotels [where homeless people were housed through the government's

'Everyone In' policy] and [homeless] hostels more, and we started complex case management.

"We have a lot of Roma patients these days who have very drastic health pictures: diseases of old age when they are in their 30s. Diabetes rates are very high too because people on the street often can't choose what they eat. We get a lot of very late presentations of pregnancy among Roma patients, say 30 weeks: quite complex pregnancies where there has been no health input at all.

"Among the non-Roma population we see pregnant women who are sleeping rough and also have substance abuse and mental health issues. We have a great relationship with midwives, but children's services can be very obstructive and unhelpful and take up a lot of my administrative time.

"With new patients, I am very proactive, aware that I have a small window to get everything under way before we might lose patients to the streets: diabetes, chronic obstructive pulmonary disease and asthma checks, cancer screening. Cervical, breast, and bowel screening rates are at worryingly low levels in this population, but that's understandable when survival is an everyday struggle."

above). "It can take several years to get patients, who might have been born amid a civil war, or abused in care, or be wary of Home Office deportation, to the point to trust us enough to tackle their chronic health issues," Conolly tells *The BMJ*.

Great Chapel Street's model exists alongside pioneering outreach led general practices: Arch Practice in Brighton, which is also run as a CIC; York Street Health Practice in Leeds, which treats homeless patients and asylum seekers and is run by a mental health charity MindWell Leeds; and the Leicester Inclusion Practice, a CIC that treats homeless and other marginalised people in the city. A fellow Westminster surgery, the Doctor Hickey Surgery, also offers a drop-in primary healthcare service for homeless people.

Awareness is building of the need for new and targeted models of treatment for excluded people, including those who are homeless, who have discrete profiles compared with other deprived groups. At the secondary care level, Pathway is helping NHS trusts to create hospital teams to support homeless patients. These teams include specialist GPs, nurses, allied health

professionals, housing experts, and, in some hospitals, "Pathway care navigators": people who were once homeless and have been trained to support homeless patients.

Hospitals involved in the programme include University College Hospital in London and Royal Sussex County Hospital in Brighton.

Better networking needed

In the context of growing street homeless populations, rising mortality, and resurgence of Home Office crackdowns on undocumented people's access to healthcare, Beale and Miller, who have two salaried GPs at the practice, Louise Myers and Zana Khan, spend an increasing proportion of their time on campaign and advocacy work.

The practice's data analysis around street mortality is in this remit of holding the system to account for the health and life outcomes of society's most vulnerable people. "With the ONS ceasing this data gathering, we needed to step into the breach," Beale explains.

The fact that GPs are independent contractors allows practices like Great Chapel Street to flourish,



but it can also, Beale regrets, lead to isolation and poor knowledge sharing, in which learnings are lost as few practices have time to keep abreast of the work of others. In 2021, for example, Great Chapel Street was awarded complex cases funding by the Department of Health and Social Care to treat homeless patients from across eight London boroughs. "But we found it really difficult to get the word out," Beale recalls. "You can put it in a newsletter, but who reads those? Or we can go to [primary care network] meetings, but I'd have to go to 50 meetings to get the message across." Both GPs would like to see more regional collaboration across general practice in the coming years.

There are also battles to fight with broader agencies, many of which are unresponsive to the homeless population's unique needs.

Miller gives an example: many of the practice's patients, she says, are biologically 30 years older than their chronological age, but, "[local authority] adult social care services don't want to place a 50 year old man into a care home, because they want to reserve care home places for older people. Yet some of our 50 year olds are so frail



MAUREEN MACLEAN/LAWRY

they need residential care.” A typical case is that of Pawel (name changed for anonymity), a 61 year old man from Poland who had been sleeping rough for 15 months in Westminster when he was brought to Great Chapel Street by his outreach support worker in 2022. Pawel was registered without ID or proof of address, and a nurse undertook a new patient check the same day, which uncovered alcohol dependency, abdominal pain, weight loss, low mood, and a history of drug use in the past, with blood and urine tests showing chronic hepatitis C and susceptibility to hepatitis A and B, abnormal liver function, and mild anaemia.

At the walk-in clinic for the Great Chapel Street GPs the same afternoon, Pawel was referred for further investigations under the rapid access suspected cancer pathway and was offered a “health bed” in a local residential hostel, which offers health monitoring, food, social support, and help with benefits and immigration claims. Here, he accessed support from the alcohol and substance misuse team and started investigations for his cognitive impairment and brain injury.



Primary care is still free if you're human and breathing in the UK
Dana Beale



Accumulated knowledge of specialist GPs should be better appreciated
Natalie Miller

Hostile environment

An unexpected benefit of the pandemic was the pause in what Beale and Miller refer to as secondary care’s “hostile environment” towards immigrant healthcare. “Before covid, we spent a lot of our time wrangling with hospital overseas visitor managers, who were trying to levy large fees for treating our patients, even for emergency maternity and cancer care,” Miller says.

The March report from Pathway and Crisis finds that two thirds of medical and healthcare professionals reported that people without proof of address or ID were refused access to GP services in England in 2023. One case haunts the Great Chapel Street GPs: a man who had cancer that without treatment was likely to be life limiting in six months. He was referred to a hospital appointment, at which the patient was erroneously told that he would have to pay for treatment upfront. “He left the appointment and was never seen again, despite the fact that this information was inaccurate,” Miller recalls.

Broader general practice, in the GPs’ view, also has a poor record when it comes to rough sleepers’ access to primary care, which the doctors seek to tackle through awareness raising work. “GP surgeries can be sticklers for rules about proof of address and patients needing two forms of ID,” Beale says. “Yet in the primary care contract, surgeries are not in fact allowed to discriminate on the basis of not being able to produce a proof of address.”

Great Chapel Street is signed up to the Safe Surgeries Network, run by Doctors of the World, which recognises general practices that take steps to tackle the barriers faced by migrants in accessing healthcare. A sign in Great Chapel Street’s reception area reads: “It doesn’t matter what your legal status is, you are entitled to register here.”

“Thankfully, primary care is still free if you’re human and breathing in the UK,” Beale wryly notes.

A case for wiser commissioning

Great Chapel Street was recommissioned at competitive tender in 2023 on a five year basis with the option for two five year extensions and in 2022 moved to its current site. Both GPs would like to see specialist surgeries such as theirs no longer being put out to open tender. “At the moment, big corporations make favourable bids for APMS contracts on the basis of income from the Quality and Outcomes Framework [annual reward and incentive programmes for general practices] for, say, diabetic checks,” Beale says. But box ticking like this, she thinks, “in no way meets vulnerable populations’ needs.”

The CIC structure means that any funds made by the practice at the end of its commission would have to be reinvested in the local community. “The accumulated knowledge of specialist GPs should be better appreciated,” Miller adds.

In their report, Pathway and Crisis called on the government, along with NHS England, to increase the availability of specialist care, including general practice, to meet the needs of people most excluded from services, with homeless people’s unmet primary care needs piling pressure on emergency departments. Great Chapel Street patients Pawel and Alina are among the lucky ones. Alina, her husband, and baby are now in accommodation together with health visitor support. Pawel is now securely housed, has joined a gardening club, and has recourse to public funds.

With rough sleeping, and its myriad associated health effects, on the rise, Beale and Miller see themselves as doctors on one hand, but as indefatigable champions for their deprived patients’ complex needs on the other.

Irritants, in a way? The GPs laugh. “Irritants, definitely, if that’s what’s needed—I like that,” Beale says. “No emollient required,” Miller adds.

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NHS mental health services are “failing Muslims”

There is a lack of cultural and religious awareness among therapists and medical practitioners, doctors and researchers tell **Angela Youngman**

“People have to explain to healthcare professionals why a hijab is important or what their concerns about Ramadan are,” says Jamilla Hekmoun, research fellow at the Cambridge based Woolf Institute.

“Our research has shown that Muslims receive less help with mental health problems than those of other faiths, and there is a lack of understanding in terms of the type of support they need.”

Hekmoun, who is also chair of the Muslim Mental Health Alliance, a community health group, is referring to the Woolf Institute’s report, *Faith in Mental Health*, published on 25 March. The institute’s research involved a study of literature and interviews with medical practitioners, patients, and Muslim community contacts. It found that existing NHS mental health services are failing Muslims because of a lack of cultural and religious awareness among therapists and medical practitioners.

Role of religion

According to the practitioners and researchers involved in the report, existing systems in the NHS do not take into account the fact that mental health treatments don’t work for everyone, or consider cultural, faith based aspects—such as fasting, mosque attendance, or clothing. As a result, medical interventions are not taking advantage of the role of religion in the Muslim community.

Imrana Siddiqui, a GP in the London borough of Newham, says, “Patients tell me how difficult it is to engage with a therapist when they don’t feel they can talk about religion. For therapies to be effective, people have to be able to talk about what matters to them. If they feel a disconnect from the angle of faith and belief, no fully meaningful discussion affecting mental health can take place.”

She continues, “Many Muslims

feel ashamed that they are feeling depressed and may see it as a punishment from God. Doctors and therapists talk about mindfulness in terms of going to yoga, for example—but daily prayers might be just as relevant a form of mindfulness to a Muslim.”

Of 45 999 Muslims in the UK referred to NHS talking therapies in 2021-22, 38% (17 264) went on to finish a course of treatment. This compared with 46% (121 877) of Christians and 43% (258 206) of those who said they had no religious affiliation.

The report shows many more Muslims indicated they would be willing to seek help if they could obtain faith informed counselling, and felt they did not risk being referred to the Prevent counter terrorism programme if they admitted to experiencing mental health problems.

Prevent was set up in 2015 and requires NHS employees to have “due regard for the need to prevent people from being drawn into terrorism.” It is a strategy that has been criticised by health workers as being too focused on Islam. Muslims are eight times more likely to be referred than non-Muslims, according

to a 2020 report published by healthcare campaign group Medact.

Young Muslims are particularly vulnerable, Siddiqui says. “Many are second generation, born in the UK. They do not have a language barrier but are coping with intense pressures from family, society, peers, their community, and social media. This is a huge and rising problem, for which tailored approaches are needed.”

Over 40% of the UK Muslim community live in economically deprived areas and do not have the resources to engage private therapists who possess greater awareness of cultural and faith matters. Success rates improve when there is greater cultural and religious awareness among health professionals, according to the Woolf Institute’s research. “Cardiff University ran an online course helping health practitioners, doctors,

nurses, and youth workers to understand Muslim health and faith requirements. It aimed at practicalities and was very well received by participants,” says Hekmoun.

Mosques can also play an important role in mental health strategies, she adds. “Muslim practitioners we spoke to say that they have found there is generally a low level of literacy on mental health among religious leaders. There is a need to accept that people can have problems and that it is not because of a weakness of faith. Islamic scholars have experienced problems and there are stories from the life of the Prophet that can be used to provide examples for faith based counselling.”

Long term training

Following the report’s publication, the Woolf Institute’s intention is to collaborate with other organisations such as the Muslim Mental Health Alliance to create an information base and improve long term training and awareness for healthcare professionals.

Such training must be carefully managed, Siddiqui says. “It shouldn’t be a tick box training session but something that actually tackles the problem. Training should be experiential, allowing people to ask questions, build relationships, and create a faith learning core for healthcare. This could result in a positive impact for the community. The potential is there, all you need are simple, practical solutions so that we can incorporate the research into our practice.”

The Woolf Institute would also like to see more research into the subject, possibly a nationwide study, alongside recognition from healthcare professionals of the importance of religion in all aspects of mental healthcare, support, and recovery.

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There are stories from the life of the Prophet that can be used to provide examples for faith based counselling
Jamilla Hekmoun

